

**Certified in Long Term Care—CLTC®**

**Master Class**

**Course Textbook**

**v. 10**

**June 2016**



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CLTC Course Handbook

Release 10.0, July 2016

ISBN: 978-0-9971607-0-3

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# Introduction

## Overview

Long-term care planning is—by necessity—a complex process; LTC insurance (LTCI) is—by necessity—a complex product.

When considering the consequences of a long-term care event there is a dynamic, wide range of impairments that require care, a broad spectrum of services, various residential settings, funding considerations, and many potential caregivers—informal and professional—to incorporate into a comprehensive plan of care.

At its simplest, LTC insurance is like any other form of insurance: it provides money when something happens. With LTC insurance, that something is an extended care event with professional care expenses. But helping clients understand and adequately plan for the consequences—both personal and financial—takes a deep level of competency in a broad range of subject matter.

## Mission and Philosophy

### Mission Statement

Our mission is to educate insurance, financial, legal, accounting, and other professionals about the need to discuss, proactively, with their middle-age clients the consequences that not having a plan for long-term care will have on the emotional, physical and financial wellbeing of their clients and clients' families during retirement. The intent is to give these professionals the competence and confidence to create such a plan and properly discuss appropriate funding solutions.

## **Our Philosophy**

The Certified in Long Term Care or CLTC® designation training program believes that the basic role of the financial service professional is to create a plan to help secure the financial future of the client. When the plan is crafted properly, financial products are suggested to fund that plan.

The fundamental role of the life insurance professional is to create a plan that mitigates the impact that an unanticipated death or incapacitation during working years would have on the financial viability of a client's financial plan and ultimately on his family. When the plan is crafted properly, life or disability insurance is suggested, not as a way to protect the client, but as a way of ensuring the viability of the overall plan.

What the life and long-term care planning professions share in common is the creation of a plan. We therefore do not support the common LTC insurance industry practice of educating a potential or existing client simply about the risk of needing care for the specific purpose of convincing him to buy a product to protect him. Such client-centric, risk-based, product-driven selling only creates an adversarial environment. That's because, paradoxically, reasonable people believe that the worst will happen to someone else. Attempting to convince him otherwise provokes an argument that leads nowhere except to frustration for both the client and the advisor.

Rather, we will employ an approach called "consultative engagement." Its goal is to educate the client about the consequences to those he or she loves if an unexpected event happens. When this is done correctly, the individual is compelled to make a decision. He may decide that the consequences are not severe and therefore there is no reason to continue the discussion, or he may decide that the consequences are so severe that they demand action in the form of a plan to protect those he loves.

This system is similar to those effectively used to sell life insurance, disability-income insurance, retirement and financial planning services.

# History and Development of CLTC®

Elder law attorney Harley Gordon, Esq., created CLTC® in 1997 because he believed that long-term care planning was an essential component to comprehensive financial, retirement, and estate planning.

Approximately 4,000 people participate in CLTC® sponsored training or continuing education events each year, of which about 1,200 earn their CLTC® designation, which is recognized by major insurance carriers and broker dealers.

In 2015 Mr. Gordon's company, the Corporation for Long Term Care Certification, Inc., and the CLTC® designation were purchased by CertiTrek, representing the world's top industry-recognized certification companies. Under CertiTrek, the CLTC® designation-granting company was reincorporated as the Corporation for Certification for Long-Term Care, LLC.

"The impact of an unexpected need for care has serious, if not irreversible consequences, to families and their ability to keep future financial commitments. The CLTC® course was specifically created to give advisors and other professionals the insight, confidence, and competence to proactively engage their clients. CertiTrek is an ideal partner to carry this mission into the future," designation founder, Mr. Gordon says.

## Course Objectives

The primary focus of this course is on giving insurance and financial service professionals the competence and confidence to address with their clients the subject of extended care and the direct and often devastating impact on the emotional, physical, and financial wellbeing of their clients' families. The six sections (A-F) of the course revolve around three themes:

1. Understanding the subject matter and the consequences

2. Explaining these consequences to clients and crafting a plan to mitigate them
3. Funding that plan

The course consists of six sections:

#### Section A: Long-Term Care Definitions

- The basic definition of long-term/extended care
- The services and facilities a client may need, such as home care, adult day care, assisted living and skilled nursing-home care
- A discussion of the two main consequences and how the two help establish the need and urgency to create a plan for extended care

#### Section B: Extended Care Planning

- Replacing the "old way": How a high-pressure focus on risk and costs creates an impenetrable psychological barrier called "Cognitive Dissonance," especially for clients with no significant personal experience with care
- Using the techniques of "Consultative Engagement" to effectively raise the subject of extended care and to help them focus on the inescapable consequences of an extended care event on those your client loves
- Providing an in-depth analysis of the CLTC® Three-Step Planning Process to establish need and urgency
- Reviewing scenarios that demonstrate how using the three-step process greatly reduces arguments and moves the extended care planning process forward
- Creating a plan of care

#### Section C: What Pays for Long-Term Care?

- A look at sources that may pay for long-term care services and facilities other than LTC insurance

- Alternatives to LTC insurance
  - Self-funding
  - Medicare & Health Insurance
  - Veterans Benefits
  - Medicaid

#### Section D: Long-Term Care Insurance

- A comprehensive look at the regulatory evolution of LTC insurance
- Policy definitions
- Types of LTC insurance
  - Traditional
  - Linked-benefit
- Tax advantages of LTC insurance
- The group market
- Partnership programs

#### Section E: Implementation of LTC Insurance Coverage

- Understanding CLTC® Client Interview “Road Map”
- Conducting the client interview
- Crafting the appropriate policy based on the needs of the family
- Reviewing case studies
- Looking at the role of the insurer

#### Section F: The Ethical Promotion of Long-Term Care Insurance

- A review of the rules of ethical conduct expected of CLTC® designees in the promotion of LTC insurance

- A look at the CLTC® Code of Professional Responsibility

## Word Usage

Words are important. They form the very essence of the interactive long-term care planning process and LTC insurance implementation that are the focus of study in the CLTC® designation coursework. In fact, properly understanding and using specific words and meanings is a core competency of this training.

One word may have a specific meaning, or while another word could mean many things, depending on the context. If an author and reader understand a word—or use of a word—differently, misunderstanding ensues. Effective communication is only possible if the author and reader bring the same meanings and understandings to the exchange.

Throughout the CLTC® Course Handbook several wording conventions are used to simplify the presentation, provide consistency to avoid confusion, and ease the understanding of key concepts:

### **Long-Term Care**

When referring to the broad subject of long-term care—the need for and delivery of care services to a client—the text will use the full term, “long-term care,” without abbreviation, or just the word “care.”

The text will also refer to long-term care as “extended care.”

### **Long Term Services and Supports (LTSS)**

A new term gaining usage—mostly in public policy circles—is “Long Term Services and Supports” (LTSS). LTSS is an attempt to differentiate the personal help, custodial care-focused needs required for extended care from skilled, short-term, acute, rehabilitative care. Much like using “extended care” instead of “long-term care.” This course will not use the term LTSS in any significant way.

## **LTC Insurance**

The abbreviation, LTC, for long-term care, will only be used in reference to and in combination with the word insurance. Simplifying the reference this way helps distinguish between references to long-term care (or “extended care”) services versus benefits from LTC insurance.

The full abbreviation for LTC insurance, LTCL, will also be used, and the words “policy(ies)” and “contract(s)” in the text will also refer specifically to LTC insurance policies.

## **Carrier**

“Carrier” will be used to refer to the LTC insurance carrier. The word “insurer” may also be used.

## **Client**

Client(s) will always be used in reference to the care recipient as a client of the professional caregiving provider’s services, e.g., the home care client(s); or as a client of an advisor. The “client” may also refer to a family member or others, such as one who has power of attorney, who are responsible for engaging and managing care services. The word client may mean both an existing client of an advisor and a prospective client (or “prospect”).

## **Policyholder**

“Policyholder” will be used to refer to the person who owns and is the beneficiary of the LTC insurance policy. Policyholder is used in the context of understanding LTC insurance coverage in relation to her (as the policyholder).

## **Formal Care**

“Formal care” is paid care, which is any care that a client pays for to help her cope with a long-term care impairment. It may also be called “professional” care.

## **Informal Care**

"Informal care" is non-paid care, generally provided by family or friends of the client. While a few LTCI policies can pay a benefit for informal caregivers, it is an exception. However, informal care is always an important component in any client's plan of care, and it must be considered in the context of professional care services, LTCI reimbursements, and other resources to help take care of the client.

## **He/She; Him/Her**

This one is tricky, because—depending on your perspective—the usage of one or the other may carry baggage and a suspicion of bias that may or may not be present. The author abhors the grammatically incorrect, and awkward, use of the plural they/them as a substitute for a proper personal pronoun. Continual use of "he or she" is exhausting—for the author and the reader. And a random exchange of one gender-specific reference for another in the name of "equality" becomes confusing.

Therefore, with every concession that inadvertent exceptions may occur, the feminine she/her will be used to refer to a care recipient/client. This carries some logic as women generally use more care services than men and have disproportionately higher claims rates with LTC insurance. She/her will also be used to refer to the caregiver personally taking care of a client. He/him will be used to refer to prospective clients for extended care planning and LTCI, as men tend to be more difficult to connect with. He/him will also be used in reference to insurance agents and other financial advisors who may be involved with you and your client in the planning process.

While at this point it could go unsaid, please note that the author fully understands that men are also caregivers, do need care, and do use LTC insurance benefits, and that many outstanding women are in the insurance and financial services professions. No bias or agenda is intended, only an attempt to simplify usage to promote clarity in communicating complicated ideas.

# **Section A:**

# **LONG-TERM CARE DEFINITIONS**



# Chapter A1:

## Extended Care

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### What is Extended Care?

You likely know that extended care is assistance that a person needs because he or she has a long-term care impairment. We often refer to this as extended care, not long-term care, because the term “long-term care” carries many misconceptions including a negative assumption to think only of nursing homes.

There are two types of impairments requiring extended care:

- Acute
- Chronic
  - Chronic impairments are further broken down as either:
    - Physical, or
    - Cognitive

### Acute Impairment

An acute impairment is a sudden event that requires immediate medical attention under a plan of care created by a physician and executed by a skilled medical and nursing staff. A heart attack, aneurysm, broken hip, stroke, and serious injury are examples. In many instances, if the condition is treated in time, the individual could

make a full recovery. Care for an acute impairment presupposes that some degree of recovery is possible and is an expectation of the overall acute care plan.

Acute impairments do not always lead to chronic, extended care, but they may. For example, a stroke is an acute impairment that, if not caught in time, could cause death. Even if the patient survives, she may have a chronic impairment that creates the need for extended care services.

## **Chronic Impairment**

A chronic impairment is a condition that cannot be cured or “fixed,” but it can be managed. Most extended care events are driven by a chronic impairment or a combination of chronic impairments.

However, a chronic impairment is not necessarily disabling. There are many chronic, on-going medical conditions that can be managed but not cured which do not require extended care services for most people. Examples include:

- Hypertension—High-Blood Pressure
- Arthritis
- Diabetes
- Emphysema—Chronic Obstructive Pulmonary Disease
- Atrial Fibrillation

Chronic impairments, especially as they relate to a need for extended care services, should be further understood as being either:

- Physical impairment
- Cognitive impairment

### Physical Impairment

A physical impairment is caused by a chronic illness or injury—one that can be managed with therapy, medication, and/or personal care, but normally cannot be

cured. As a physical impairment progresses, it compromises the person's ability to get through the most basic of daily routines, called Activities of Daily Living (ADLs).

Consider the ADLs in the order that they are normally done when you start each day: These daily activities begin in the morning when lying in bed and needing to sit up, stand, and/or get into or out of a chair (transferring). After which, you get to the bathroom to toilet and accomplish normal hygiene (toileting). Then getting into a tub or shower to bathe yourself without help (bathing). Next it is time to put on clothes (dressing). After dressing, it is time to go to the kitchen where you need to receive your nourishment by getting food to your mouth without choking (eating). Lastly, overall, there is the ability to control bowel and bladder function with a reasonable level of hygiene all day long without help (continence).

Thus, the six most common ADLs used in extended care planning are:

- Transferring
- Toileting
- Bathing
- Dressing
- Eating
- Continence

As you can see, these six things occur each day within about the first 30 minutes of waking up. Not being able to do a minimum of two of these six ADLs without assistance is considered being chronically ill in the context of LTC insurance, and as a clear line where a physical impairment begins to dramatically compromise a client's ability to function and by extension impact those he loves.

### Cognitive Impairment

A cognitive impairment is the deterioration or loss of intellectual capacity, as certified by a licensed health care practitioner (defined by the federal government as a doctor,

nurse, or licensed social worker) and measured by clinical evidence and standardized tests. Very often cognitive impairments are also referred to as memory or reasoning loss. Specialized testing can determine a deficit in:

- Short- or long-term memory
- Orientation as to person, place and time
- Deductive or abstract reasoning
- Judgment as it relates to safety awareness

A cognitively impaired person may not have a physical impairment and thus may be able to fully perform ADLs. Common causes of cognitive impairment include Alzheimer's and late-stage Parkinson's diseases, as well as other various forms of dementia. Regardless of the cause, the results are the same. As the condition progresses, it compromises the client's ability to interact safely with others and with his environment.

As you will see, the word "compromise" is critical when formulating a presentation to those who have the most difficulty in agreeing they may need care.

## **Levels of Care**

Any impairment requires a particular level of care:

- Skilled care
  - Intermediate (part-time skilled care)
- Custodial care

### Skilled Care

Extended care rarely requires skilled medical care, services that are so inherently complex that they can only be provided by a physician or under a plan of care created by a physician and executed by a skilled nursing staff or other licensed professionals. Inpatient hospitalization or formal rehabilitative services are considered skilled care.

“Intermediate care” is simply skilled care—usually rehabilitative services—performed on a less-than-daily basis, for example, receiving physical or occupational therapy visits at home two or three days a week.

### Custodial Care

Extended care typically requires custodial or non-skilled services: physical assistance with ADLs or supervision of a cognitively impaired person. Custodial care can be provided either formally, by paid professionals, or informally, by family or friends with no particular training in health care. It consists of homemaking services, such as cooking and cleaning the house, and direct personal-care assistance to help the person safely get through her daily routine. It is given in various settings.

### **Informal Care**

Informal care in the context of this course means “non-paid” care, which is typically provided by family members—spouses, partners, children, siblings, etc.—or by friends and volunteers. Do not confuse the term “informal care,” as used here, with LTCI informal caregiver benefits that may make money available to pay these types of people as caregivers.

Even though informal care is not paid care, there is still a “cost” to this type of care. The “price” of informal caregiving is the personal, emotional, and physical strain on those we love when they try to take care of us. We will explore this first “consequence” of extended care in the next chapter.

### **Professional Care**

As noted in the introduction, professional—or formal—care as used in this course means paid-for care. Professional care in this context does not only mean “skilled” care, but also includes care given by anyone who is paid to provide long-term custodial services. The following definitions examine different formal, professional providers for extended care services.

## Home Care

Most Americans want to remain home at all costs if they should need care. That desire is reflected in the history of LTCI claims: A majority of claims are for care received at home.

The formal, professional services that comprise home care may be provided by the following types of individuals.

### Social Workers and Care Managers

Social workers provide assessment and counseling services as well as referrals to other formal caregivers and support groups; if licensed, they can write the plan of care. For example, a social worker can be an efficient guide through the steps necessary to determine and settle on an appropriate care regimen. Nurses also often fulfill this assessment and referral role.

Care managers are available on an on-going basis to ensure that the plan of care is followed and that care recipients and their loved ones receive the services and support they need.

While these two professional roles—social workers and care managers—should be understood as providing different services, practically the roles often overlap and, when looking at LTCI, are more broadly understood as “care coordination.”

Both social workers and care managers can be considered “care coordinators”. In this broad role, together they:

- Determine the type of impairment (cognitive or physical)
- Determine the necessary level of care (skilled or custodial)
- Help decide whether informal or formal caregivers can provide the care and what duties each should perform
- Make referrals to appropriate professional providers

- Monitor the on-going care and a client's medical, custodial care, and social conditions and situations

Social workers and care managers do not provide daily care.

### Homemakers

Homemakers are available to help a person complete light housekeeping tasks, run errands, shop, or prepare meals. They may also escort a person to doctor's appointments and fill a valuable role by providing respite care—substituting for informal caregivers. This may include simple "companion" care.

In general, homemakers are not trained to provide direct care including physical ADL assistance or cognitive impairment supervision. LTC insurance may pay for homemaker services, but only if the policyholder has first qualified for benefits under an ADL or Cognitive Impairment benefit trigger.

Homemaker services are sometimes referred to as "Instrumental Activities of Daily Living" (IADLs). IADLs (homemaker services) include:

- Cooking
- Cleaning
- Laundry
- Housekeeping
- Telephone management
- Bill paying
- Transportation

The same person who is responsible for ADL or cognitive impairment support may also provide homemaker services, or the homemaker may be a separate person.

### Home Care Aides (Personal-Care Attendants)

Home care aides, also called personal-care attendants, are trained to assist people in their everyday activities of daily living (ADLs) and/or to provide basic supervision for cognitive impairments, but do not provide any skilled medical care. When needed, they work jointly with nurses and therapists who provide skilled medical assistance in the home as needed. Aides may provide both personal care and homemaker services.

### Skilled Medical Care Providers

A person in the advanced stages of a chronic illness, or one recovering from major surgery, may need the services of skilled medical care providers. Among them, doctors, registered nurses, licensed practical nurses (LPNs), physical therapists, speech therapists, occupational therapists, and nutritional therapists provide both generalized and specialized skilled care services in the care recipient's home.

Their services include administering medications, infusion therapy and dialysis; changing surgical dressings; providing speech, physical, and occupational therapy; and generally monitoring vital signs. Think of these skilled professionals as a "SWAT team" that drops in for brief visits only when most critically needed. They are not available for day-to-day custodial care.

### Community-based Programs

Community-based programs offer support services either at home or in a community setting. Their goal is to permit people to remain in the community. The most common community-based programs include senior centers, transportation services, and Meals-on-Wheels programs.

### Senior Centers

Most cities and towns have local organizations for older residents, providing a base of operations for various programs. These centers also serve as resources for people affected by extended care. For example, they may offer medical and food outreach programs, or furnish space for adult day center activities.

### Transportation Services

Every major city has a program that provides transportation for residents who can no longer drive and cannot rely on family members. The service is usually free or offered at a nominal charge.

### Meals-on-Wheels Programs

Meals on Wheels is the national umbrella association whose members consist of community-based senior nutrition programs that deliver food to individuals who cannot prepare meals themselves. They are nominally priced, and assure that recipients' basic nutritional needs are met. There are more than 5,000 local Senior Nutrition Programs through the Meals on Wheels Association of America, according to the association's web site [www.mowaa.org](http://www.mowaa.org). These programs provide well over one million meals to seniors who need them each day. Some programs serve meals at congregate locations like senior centers, some programs deliver meals directly to the homes of seniors whose mobility is limited, and many programs provide both services.

## **Adult Day Care Centers**

Adult day care centers are community-based services provided on a formal basis. They are intended not just as a form of support for the person needing extended care, but as a critical element of the care recipient's ability to continue living at home.

Adult day care is primarily a form of *Respite Care*. Designed to be most beneficial to the informal care providers—usually family members—adult day care allows them to go to work or to simply have a daily respite. Adult day care centers offer week-day custodial care and supervision to people with light-to-moderate impairments—generally, individuals who can walk and use the toilet independently, but may need assistance in other ADLs or supervision for mild cognitive impairments. People with Alzheimer's disease or dementias are appropriate candidates for adult day care.

The setting is often home-like, with a kitchen where meals are prepared, an activity area, television, group participation, and an area to lie down and rest. They are equipped for dispensing medicines and delivering light therapies.

According to the *Genworth 2016 Cost of Care Survey*<sup>1</sup> the national average median cost per day in adult day care is \$68.00. Costs vary depending on the services offered, type of reimbursement, and geographic region. While health insurance or Medicare do not usually cover an adult day care center, some financial assistance may be available through a federal or state program (e.g., Medicaid, Older Americans Act, Department of Veterans Affairs). Adult day care is covered by most LTCI that pays for home or community-based services.

## **Assisted-Living Facilities (ALFs)**

Assisted-living facilities (ALFs) (or communities) may also be called residential care facilities (RCF) or residential care facilities for the elderly (RCFE). They are focused on supplying increasing levels of formal care for people who, while having difficulties with ADLs or a cognitive impairment, can still get through parts of their daily routine. Most stand-alone assisted-living facilities are rentals that do not require an up-front buy-in.

ALFs generally provide care in a secure home-like environment, where residents live in their own individual apartments. Meals and services are provided in central social rooms. Since they are not subject to the same regulatory requirements as nursing homes, assisted-living facilities offer greater innovation in physical design, staffing arrangements and resident services than would be possible in a traditional nursing home.

As their residents usually do not require the skilled care needed by many nursing-home patients, assisted-living facilities tend to employ well-trained yet lower-cost

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<sup>1</sup> *Genworth 2016 Cost of Care Survey*. <https://www.genworth.com/about-us/industry-expertise/cost-of-care.html>

para-professionals. In most states, ALF licensing requires a nurse on call for residents who need limited skilled services, including medication management and delivery.

Many assisted-living facilities now have on-site Alzheimer's or dementia units. Some ALFs are specifically designed exclusively for "memory care." Although the monthly cost is greater, they offer the advantage of keeping people longer in a home-like environment. An ALF setting may be particularly appropriate for a couple when one is fairly healthy while the other needs more care. In an ALF they can continue to be in the same living area with additional services available for the more dependent spouse.

More information on assisted-living facilities is available from either of the following organizations:

**Commission on Accreditation of Rehabilitation Facilities—Continuing Care Accreditation Commission (CARF-CCAC)**

1730 Rhode Island Avenue NW, Suite 209

Washington, DC 20036

(202) 587-5001 or toll-free (866) 888-1122 fax (202) 587-5009

<http://www.carf.org>

**Assisted Living Federation of America**

1650 King Street, Suite 602

Alexandria, VA 22314-2747

1-(703)-894-1805

<http://www.alfa.org>

## **Continuing Care Retirement Communities (CCRCs)**

Continuing Care Retirement Communities (CCRCs) contain three components:

1. Independent living, which offers no support services; however, meals may be served in common dining areas
2. Assisted-living
3. Skilled nursing-home care

Whereas stand-alone ALFs are typically rentals, CCRCs usually require a significant "buy-in." This may be described as a lifetime right to access care in that specific residential continuum. Depending on the facility and its location geographically, the entrance fee may range from \$100,000 to \$500,000. There is a monthly maintenance charge as well, which is subject to increase with inflation.

The entrance fee guarantees the buyer a bed in the ALF or skilled nursing unit of the CCRC campus. It does not, however, provide home care to occupants who are still in their independent living units. This is not always understood prior to the purchase, and it is an important consideration in assessing whether the CCRC will provide care to its occupants free of further charges.

The one-time entrance fee does not earn interest and does not increase with the market value of the unit. At death, the estate or family may, for example, receive 75% to 100% of the entrance fee depending on the CCRC contract.

A careful review of the purchase contract is essential to discover which levels of care are included in the entrance or monthly maintenance fees and what, if any, return of payments are included.

### Other CCRC Considerations

Older clients and their financial counsel should carefully study the contract governing admissions to and residency at each CCRC of interest. Although CCRCs imply that they provide lifetime care, many such facilities list certain causes for which a resident

may be required to move to a different level of care within the facility. Another concern is that CCRCs are loosely regulated, and there is usually no guarantee that the entrance fee will be repaid if the developer runs into financial difficulty.

Furthermore, under the *Deficit Reduction Act of 2005 (DRA '05)*, a CCRC resident applying for Medicaid to pay for nursing-home care within the complex must first spend down the pre-paid entrance fee to the individual Medicaid limit if the applicant is not married, or to the maximum the spouse is allowed.

That, of course, raises the interesting question: where does the resident get the money? As mentioned, the entrance fee is refunded only upon the resident's death, depending on the CCRC contract.

It is anticipated that the CCRC will take the resident on a private-pay basis, keep track of the monies due to the facility, and run a credit account against the entrance fee until the total equals the amount the individual would have to spend down to qualify for benefits. The CCRC recovers the money, likely with interest, when the resident dies and before it can be repaid to the estate. The CCRC thus secures a private rate from this resident, but must wait for the resident's death to be paid.

Finally, most CCRCs do not accept residents with existing physical (ADL) or cognitive impairments. Some potential LTC insurance clients may wish to avoid or delay purchasing LTCI because they anticipate moving into a CCRC. The problem, of course, is that if they delay the purchase and subsequently suffer an impairment, they likely will become ineligible for admission and also then, of course, for LTCI.

Anyone considering a CCRC is advised to read the American Bar Association's Checklist for Analyzing CCRC Contracts, obtainable from:

**American Bar Association  
Commission on Law and Aging**

740 15th Street, NW  
Washington, DC 20005-1019

(202) 662-8690

<http://www.abanet.org/aging>

[abaaging@abanet.org](mailto:abaaging@abanet.org)

Before choosing a CCRC, potential residents should check to see if it is accredited by contacting:

**Commission on Accreditation of Rehabilitation Facilities— Continuing Care Accreditation Commission (CARF-CCAC)**

1730 Rhode Island Avenue NW, Suite 209

Washington, DC 20036

(202) 587-5001 or toll-free (866)888-1122

fax (202) 587-5009

<http://www.carf.org>

Accreditation may also be checked through the extended care provision industry's self-regulatory body:

**American Association of Homes and Services for the Aging (AAHSA)**

2519 Connecticut Avenue, NW

Washington, DC 20008

(202 )783-2242

fax (202 )783-2255

<http://www.aahsa.org>

[info@aahsa.org](mailto:info@aahsa.org)

## **Institutional Care**

Institutional care is defined as skilled or rehabilitative services provided in settings that are licensed to provide them. These services may be covered by health insurance plans, including Medicare.

## **Skilled Nursing Home Care**

Nursing-home care today is typically provided in skilled-nursing facilities (SNFs). These are licensed by the state and federal governments to provide skilled or rehabilitative services, and thus can be reimbursed by Medicare or third-party payers.

A skilled-nursing facility has two components:

1. A unit or services that provide skilled, rehabilitative nursing care as defined by Medicare (Chapter C2, page #106)
2. The balance of the facility, which provides long-term, non-skilled (custodial) care

SNFs are misnomers. The reality is that the vast majority of SNF patients require only assistance with ADLs or supervision due to a cognitive impairment. A SNF is licensed to receive Medicare payment or other insurance funding. As such, it must comply with strict licensing requirements and must be equipped to manage the most complex and severe extended care needs.

In theory, the initial goal of every skilled nursing facility is to rehabilitate the patient so he or she can return home. In practice, many patients are unable to return home, and are transferred to the SNF's non-skilled, custodial unit, where they receive ongoing care.

There are facilities that specialize only in skilled care. They are generally known as rehabilitation centers. Their patients are expected to return home.

## **Hospitals**

It is important to discuss the role of hospitals in extended care. They serve patients with acute illnesses or emergency conditions. They do not offer non-skilled (custodial) care. Their role in the continuum of extended care services is often as “gateways” to nursing homes, used either in isolated acute medical conditions or when ongoing chronic problems flare up into acute care situations.

Medicare is the primary source of payment for hospital services to people over age 65. It uses a Prospective Payment System (PPS) (Chapter C2, page #110) that puts hospitals under great pressure to discharge patients as soon as possible. Discharged patients are next directed to either \*a sub-acute care facility or a skilled nursing home. See Section C, Medicare, for an in-depth analysis of this system.

Inpatient hospitalization is not covered by LTC insurance.

## **Sub-Acute Care**

Sub-acute care is comprehensive, inpatient rehabilitative care designed for someone who has an acute illness, injury or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after, or in many instances in place of, hospitalization. Inpatient sub-acute care is not covered by LTC insurance.

## **Care means Consequences**

The need for care comes with steep consequences, which we cover in the next chapter and which you need to understand so they can be used to educate clients. If you do so correctly, clients will likely take action to protect their families.

# Chapter A2:

## The Consequences

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### **Extended Care is Not a Place or a Condition, It is a Life-Changing Event**

We suggest that, in educating clients who have not had a prior experience with extended care, you frame the discussion not by focusing on nursing homes or the conditions that may cause assistance, but rather on the fact that extended care is a life-changing event.

As impairments worsen, they compromise the person's capacity to safely interact with their environment, which compels others to get involved.

This causes the first of two sets of irreversible consequences: personal consequences.

### **Personal Consequences**

The first consequences are personal: providing care seriously impacts the emotional and physical wellbeing of the caregiver.

For our purposes, a caregiver is an unpaid individual (a spouse, partner, family member, friend, or neighbor) involved in assisting others with activities of daily living (ADLs), coping with a cognitive impairment and/or other medical tasks. Formal caregivers are paid care providers providing care in one's home or in a care setting (daycare, residential care facility, etc.). Recent data shows:

- 65.7 million caregivers make up 29% of the U.S. adult population providing care to someone who is ill, disabled or aged.<sup>1</sup>
- 52 million caregivers provide care to adults (aged 18+) with a disability or illness.<sup>2</sup>
- Approximately 34.2 million Americans have provided unpaid care to an adult age 50 or older in the prior 12 months<sup>3</sup>, and more than 15 million Americans provide unpaid care for people with Alzheimer’s disease and other dementias.<sup>4</sup>
- More women than men are caregivers, 60%. Eight in 10 are taking care of one person (82%).<sup>5</sup>
- Male caregivers are less likely to provide personal care, but 24% help a loved one get dressed compared to 28% of female caregivers; 16% of male caregivers help with bathing versus 30% of females; and 40% of male caregivers use paid assistance for a loved one’s personal care. Out of the

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<sup>1</sup> The National Alliance for Caregiving and AARP (2015), *Caregiving in the U.S.* National Alliance for Caregiving. Washington, D.C.

<sup>2</sup> Coughlin, J., (2010). Estimating the Impact of Caregiving and Employment on Well-Being. *Outcomes & Insights in Health Management*, Vol. 2; Issue 1—Updated: November 2012

<sup>3</sup> The National Alliance for Caregiving and AARP (2015), *Caregiving in the U.S.* National Alliance for Caregiving. Washington, D.C.

<sup>4</sup> Alzheimer’s Association, *2015 Alzheimer’s Disease Facts and Figures*. Available at [https://www.alz.org/facts/downloads/facts\\_figures\\_2015.pdf](https://www.alz.org/facts/downloads/facts_figures_2015.pdf).

<sup>5</sup> The National Alliance for Caregiving and AARP (2015), *Caregiving in the U.S.* National Alliance for Caregiving. Washington, D.C.

43.4% of caregivers who care for an older family member, approximately 14.5 million are men.<sup>6</sup>

- The gender balance shifts to close to equal participation among 18- to 49-year-old care recipients (47% of caregivers are male), while among the 50+ recipients, it tips to females (32% male, 68% female).<sup>7</sup>
- Research suggests that the number of male caregivers may be increasing and will continue to do so due to a variety of social demographic factors.<sup>8</sup>
- The Home Alone study—a study of family caregivers who provide complex chronic care found that nearly half of the 1,677 caregivers surveyed (46% or 777) performed medical & nursing tasks. More than 96% of those also provided activities of daily living (ADLs) supports (e.g., personal hygiene, dressing/undressing, or getting in and out of bed) or instrumental activities of daily living (IADLs) (e.g., giving prescribed medications, shopping for groceries, providing transportation or using technology) supports, or both. Of these caregivers, nearly two-thirds (501) did all three types of tasks. Of the non-medical family caregivers, two-thirds (605) provided IADL assistance only.<sup>9</sup>

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<sup>6</sup> The National Alliance for Caregiving and AARP (2009), *Caregiving in the U.S.* National Alliance for Caregiving. Washington, D.C. — Updated October 2012.

<sup>7</sup> The National Alliance for Caregiving and AARP (2009), *Caregiving in the U.S.* National Alliance for Caregiving. Washington, D.C. — Updated October 2012.

<sup>8</sup> Kramer, B. J. & E. H. Thompson, (eds.), *Men as Caregivers*, (New York: Prometheus Books, 2002). — Updated: November 2012.

<sup>9</sup> *Home Alone: Family Caregivers Providing Complex Chronic Care*, AARP with United Health Hospital Fund October 2012 — Updated: November 2012.

- A Gallup survey found 72% of caregivers cared for a parent, step-parent, mother-in-law or father-in-law, and 67% of caregivers provided for someone age 75 or older.<sup>10</sup>
- Most care recipients live in their own homes (58%), and one in five (20%) live in their caregiver's home.<sup>11</sup>
- Among working caregivers caring for a family member or friend, 69% report having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.<sup>12</sup>
- 57% turned down a promotion, 4% chose early retirement and 6% gave up working entirely. Difficulties due to work and caregiving are even more challenging among those caring for someone with dementia.<sup>13</sup>
- Caregiving has been shown to reduce work productivity by 18.5% and increase the likelihood of leaving the workplace.<sup>14</sup>
- The cost of informal caregiving in terms of lost productivity to U.S. businesses is \$17.1 to \$33 billion annually. Costs reflect absenteeism (\$5.1 billion), shifts

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<sup>10</sup> Gallup Healthways Wellbeing Survey, Most Caregivers Look After Elderly Parent; Invest a Lot of Time, July 2011 — Updated: November 2012.

<sup>11</sup> National Alliance for Caregiving and AARP (2009), *Caregiving in the U.S., A Focused Look at Those Caring for Someone Age 50 or Older*, Bethesda, MD: National Alliance for Caregiving, Washington, D.C.—Updated: November 2012.

<sup>12</sup> Valuing the Invaluable: 2011 Update: *The Economic Value of Family Caregiving*. AARP Public Policy Institute.—Updated: November 2012.

<sup>13</sup> National Alliance for Caregiving and AARP (2009), *Caregiving in the U.S. A Focused Look at Those Caring for Someone Age 50 or Older*, Bethesda, MD: National Alliance for Caregiving, Washington, D.C.—Updated: November 2012

<sup>14</sup> Coughlin, J., (2010). Estimating the Impact of Caregiving and Employment on Well-Being. *Outcomes & Insights in Health Management*, Vol. 2; Issue 1—Updated: November 2012.

from full-time to part-time work (\$4.8 billion), replacing employees (\$6.6 billion), and workday adjustments (\$6.3 billion).<sup>15</sup>

- A Gallup poll shows caregivers who do not live with their care receiver live the following distances from those for whom they care.<sup>16</sup>
  - 10 miles or less            66%
  - 11–25 miles                13%
  - 26 miles or more        21%
- 9 in 10 (96%) caregivers of veterans are female, and 70% provide care to their spouse or partner. Of veterans' caregivers, 30% care for 10 years or more, compared to 15% of caregivers nationally. 88% report increased stress or anxiety as a result of caregiving, and 77% state sleep deprivation as an issue.<sup>17</sup>
- Some 22% of informal caregivers to the elderly are depressed—around twice the rate in the population as a whole.<sup>18</sup> 55% of caregivers who live with dementia patients suffer clinical depression.<sup>19</sup>

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<sup>15</sup> MetLife Study of Working Caregivers and Employer Health Costs: National Alliance for Caregiving. 2010—Updated: November 2012.

<sup>16</sup> Gallup Healthways Wellbeing Survey, Caregiving Costs U.S. Economy \$25.2 Billion in Lost Productivity, July 2011—Updated: November 2012.

<sup>17</sup> National Alliance for Caregiving and United Health Foundation, *Caregivers of Veterans: Serving on the Home Front* (2010) — Updated: November 2012.

<sup>18</sup> See, for example, Foundation for Accountability, *A Portrait of Informal Caregivers in America*, Robert Wood Johnson Foundation, Princeton  
[http://www.markle.org/resources/facct/doclibFiles/documentFile\\_432.pdf](http://www.markle.org/resources/facct/doclibFiles/documentFile_432.pdf).

<sup>19</sup> End-of-Life Care and the Effects of Bereavement on Family Caregivers of Persons with Dementia, Richard Schulz, Ph.D., Aaron B. Mendelsohn, Ph.D., William E. Haley, Ph.D., Diane Mahoney, Ph.D.,

- An elderly informal caregiver has a significant risk of death as a result of his or her sick spouse's hospitalization. The risk to spouses was highest when the hospitalization was for a chronic disabling illness like dementia. "What this shows is that people are interconnected, and their health is interconnected, and seeing a person that you love suffer, seeing them ill harms you," said study coauthor Dr. Nicholas Christakis of the Harvard Medical School.<sup>20</sup>
- Elderly informal caregivers run a 63% higher risk of dying from stress-related illnesses.<sup>21</sup>
- Informal caregivers who responded that their health had gotten worse as a result of caregiving most commonly reported a loss of energy and sleep (87%), stress or panic attacks (70%), aches or pain (60%), depression (52%), headaches (41%), and weight gain or loss (38%). In addition, they tend to spend less time with family or friends (69%) and at work (37%).<sup>22</sup>
- Abuse of the elderly by family members has risen significantly.<sup>23</sup>

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Rebecca S. Allen, Ph.D., Song Zhang, M.S., Larry Thompson, Ph.D., and Steven H. Belle, Ph.D., for the Resources for Enhancing Alzheimer's Caregiver Health (REACH) Investigators, November 13, 2003.

<sup>20</sup> N. Christakis, P. Allison, "Mortality after the Hospitalization of a Spouse," *The New England Journal of Medicine*, vol. 354, issue 7 (February 16, 2006), pages 719-730.

<sup>21</sup> R. Schulz, S. Beach, B. Lind, L. Martire, B. Zdaniuk, C. Hirsch, S. Jackson, L. Burton, "Involvement in Caregiving and Adjustment to Death of a Spouse: Findings From the Caregiver Health Effects Study," *JAMA*, June 2001; issue 285, pages 3123-3129 <http://jama.ama-assn.org/cgi/reprint/285/24/3123>.

<sup>22</sup> *Evercare Study of Caregivers in Decline*, National Association of Caregiving, 2006 <http://www.caregiving.org/data/Caregivers%20in%20Decline%20Study-FINAL-lowres.pdf>.

<sup>23</sup> Sue Shellenbarger, *The Wall Street Journal*, July 17, 2003.

## Power Phrases

Power Phrases are short powerful thoughts to convey the above facts in a manner that compels your clients to think differently about the subject.

- Providing care to a chronically ill person often makes healthy caregivers chronically ill.
- At least one of your children, likely your daughter, will have little choice but to put aside her life to help provide care. Since care is rarely shared equally with the other siblings, it may cause hard feelings that could very likely survive your death.
- Providing care doesn't bring families together, it often tears them apart.
- My experience tells me that there may well be irreversible damages to your children's relationships should you need care.
- If you ever need care over a period of years, your life is not going to end. Someone else's life—or lifestyle—is going to end.  
  
"I appreciate your efforts, but I'll take care of my mother."

If this objection is ever raised, the suggested response is: "I know you will; I need to talk to you about a way you can do it longer and better."

- Children do not want to take care of their parents; they will do it because it is the right thing to do and they are worried about their safety.
- Suggesting that you know they will care for their parents gives you an opening to speak to the essence of LTC insurance: it allows children to provide the care better and longer by bringing in formal caregivers to handle the work that children and spouses find the most time-consuming, embarrassing and stressful.
- To put it another way, LTCI allows children to maintain their relationship as children supervising care, not children providing care. It serves no lesser a purpose for a spouse, siblings or friends.

- Suggesting this concept may turn an antagonist in your client’s family into a proponent, one that may even help pay for the cost of the policy.

## **Extended Care is Rarely Nursing-Home Care**

From the mid-1960s to the early 1990s, LTCI was presented as a solution to pay for nursing-home care. Its high cost and statistics indicating high probabilities of its use were used to try to motivate clients to purchase LTCI. This tactic is often expressed in the following statement:

“Do you know that the chances of going into a nursing home past age 65 are 43%?”

“I’ll never go to a nursing home.”

“But look at the statistics.”

“I’ll be one of the 57% who doesn’t.”

The figure of 43% was extracted from a forecast in *The New England Journal of Medicine’s* 1991 report on nursing-home care, that of the 2,200,000 people turning 65 in 1990,<sup>24</sup> 946,000 (43%) would spend at least some time in a nursing home in the future—including stays as short as one day and those following hospitalization. The report never stated, as insurance agents so often have suggested, that 43% would spend the rest of their lives in a facility.

Here are the facts:

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<sup>24</sup> Kemper P, Murtaugh C. Lifetime Use of Nursing Home Care. *N Engl J Med.* 1991; 324:595-600. February 28, 1991. Surprisingly, these are the most recent statistics available.

- There are 40 million Americans 65 or older,<sup>25</sup> of which 37% (12.6 million) reported that they were limited by moderate to severe chronic conditions.
- Of those 12.6 million, only 1.6 million (10%) are permanently confined to nursing homes, with older people more likely to be so.
  - There is no credible statistic up to age 65.
  - 0.9% of those between the ages of 65 and 74 are permanently in nursing homes.
  - 3.5% of those between the ages of 75 and 84 are permanently in nursing homes.
  - 14.3% of those 85 or older are permanently in nursing homes.

Focusing on the risk of needing nursing-home care and its cost as a marketing strategy shows a fundamental misunderstanding of where the majority of damage in an extended care situation takes place: it takes place at home. As discussed, there are serious consequences emotionally and physically to those who have no choice but to provide care.

It would therefore seem logical that families would see the care receiver's placement in a nursing home as a way to substantially lessen the impact. In fact it is, but people find it very difficult to do so, even though told by doctors and others that a placement is essential. The reason they hesitate? Because placing their loved ones in a nursing home breaks their hearts.

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<sup>25</sup> U.S. Census, 2010; National Nursing Home Survey, U.S. Centers for Disease Control <http://www.cdc.gov/nchs/nnhs.htm>.

## **Consequences Begin at Home, Not in Nursing Homes**

Anyone who has had to provide care over a period of years will tell you that, without question, the overwhelming emotional and physical damage caused by providing that care took place at home. It had to and has to, because of the nature of extended care. Placement in a nursing home is actually a relief, but families find it almost impossible to make that placement because, again, doing so breaks their hearts.

A simple discussion replaces a debate. Now the focus is ...

... not on the risk of needing care, which will end up leading to a nursing home placement, but rather...

... on the consequences providing that care at home will have for those your client loves.

An example:

"Alan, if I may ask, what's important to you as you look into retirement? In other words, which obligations do you now have or anticipate that you may not have had ten or fifteen years ago?"

The client tells you what they are.

"I need to talk to you about how severe the consequences would be to Carol and the children, emotionally, physically, and financially, if in living a long life you need care over a period of years."

"What do you mean?"

"Do you believe it's possible that you could live a long life?"

"I hope to."

"Do you think that if you live long enough, it's possible you could become frail and need care?"

"I don't like to think about it, but it could happen."

"Do you understand what consequences providing care would have for the emotional and physical wellbeing of your family?"

"Not really."

"What would the impact of paying for this care be on them and on your other commitments?"

This assumes that you don't already know what these obligations are from your previous discussions with this client. If you do, this is a good time to remind him of them.

What about the client that has just told you he has no prior experience with extended care? You now have the opportunity to explain what extended care is and what it will do to his family, emotionally and physically:

"Alan, what do you think extended care is?"

"A nursing home?"

"No."

"An illness like Alzheimer's or a stroke?"

"No."

"Then what is it?"

"Alan, extended care is not a condition; it's a life-changing event that's caused by a physical or cognitive impairment. By definition, these illnesses

would so compromise you that your wife and family would have no choice but to provide care for you.”

(NOTE: A short reply in this example compels the client to give you another answer. The goal is to get him to say: “So, what is it?!”)

This permits you to explain that:

- Extended care is all-consuming because a physical or cognitive impairment compromises the client’s ability to get through the most basic of daily routines.
- If the client ever needs care over a period of years, his life is not going to end; someone else’s life—lifestyle—is going to end.
- Providing care often makes healthy caregivers as chronically ill as those to whom they are providing care.
- If a child has to step up, it will severely impact her life and relationship with her siblings who do not help.

“Do you begin to understand how severe the consequences would be?”

“I am beginning to.”

“So, if I may ask, do you have a plan to deal with these consequences?”

“What do you mean?”

“What thoughts do you have on protecting your family?”

“I haven’t thought about it.”

“I want to put together a plan with you that will protect them. Can we do that?”

"Please, let's go ahead."

Let's take another quick look at classic objections and how to overcome them:

"What if I don't live a long life?"

"You may not, but what if you did and ever needed care over a period of years? What do you think providing that care would do to the emotional and physical wellbeing of your wife and children? What would the impact of paying for this care be on them and on your other commitments?"

"What if I never need care?"

"I never said you would. The issue is not the risk of you needing care but the consequences that providing it to you will have for those you love. That's why I need to bring it to your attention. I never want to get a call from your wife or child, telling me something happened to you and knowing I am not able to protect them."

"I don't want my kids to get involved. It's my issue."

"Respectfully, what choice will they have if you don't have a plan?"

The sample discussions will be fully integrated into an overall scenario in Section E.

## **Financial Consequences**

The second consequence is financial: Paying for care disrupts every plan to secure your client's future financial viability. It is important to view the second, financial consequences, in the context of discussing the first, personal consequences, as the financial consequences of an extended care event do not just flow from the fact that an individual needs care. Rather, the financial consequences begin to accrue when families seek to relieve the burden of personal consequences to those trying to provide care.

Paying for care causes a reallocation of resources, starting with income. The issue is that the majority of successful people live on all or close to all of their income in the future as they did during working years. Shifting income to pay for care has a direct impact on the client's ability to keep financial commitments. These may include:

- Maintaining lifestyle expenses, including hobbies, travel, a vacation home, a boat, club memberships, etc.
- Helping a child who has not made the best decisions in life
- Providing for a child or grandchild with special needs
- Helping pay for a grandchild's education
- Continuing obligations to a former spouse
- Tithing
- Making charitable contributions

We hope you understand that, although in theory many of these expenses may be considered "discretionary," in the world of the successful they are nondiscretionary. Asking income to both pay for care and cover lifestyle expenses is, for practical purposes, double-counting it.

If you have clients with what they believe to be sufficient assets, you may hear:

"I never thought about it like that, but I'll simply use my assets."

The traditional response would make reference to the highest possible cost of care in a nursing home and what the inflated costs are likely to be in the future, resulting in a substantial if not total loss of assets. Remember that many people do not believe care will ever be needed, let alone care in a nursing home.

Therefore, when an advisor tries to use high costs as a lever to force the purchase of insurance, a client's response, is likely to be that he has enough money.

A better approach is to agree that the client has sufficient assets and then educate him about the following issues.

Assets in a portfolio are really “capital” in nature; that is, their purpose is not to be used to pay for care—or any other expense in life—but to generate predictable streams of income that will keep up with a rising cost of living and that the client cannot outlive.

Using capital to pay for care creates unintended issues with:

- Unnecessary taxes
- Market timing
- Liquidity issues
- Leaving a legacy

And perhaps most importantly, every dollar used to pay for care is one dollar less available to generate income to keep future commitments. These ideas will be further explored in Section C.

For the less affluent, using assets to pay for care could start a financial death spiral. Assuming the majority of assets are used to generate income, here is what can happen:

Year 1: The client tries to continue covering expenses with income generated by assets, while also paying for care from them. If care is paid from qualified or low-cost-based assets, a tax is incurred. The sale of assets is subject to market conditions.

Year 2: Since there are now fewer assets to generate income, more assets have to be used to make up the difference. Of course, those assets are subject to the same taxes and market conditions. This is on top of the additional assets needed to pay for care.

Year 3: See year 2.

Year 4: See year 3.

In fact, this is exactly what clients are concerned about when they tell financial advisors:

“I want to avoid going into the principal.”

You may want to convey this thought to your client: Asking assets—capital—to generate income while paying for care is double-counting it as well.

“Paying for extended care will likely force a reallocation of both your income and assets. The problem is that none of the money was ever meant to pay for care, which means using it disrupts every plan you created to secure financial viability during retirement.

“I never thought about it like that.”

## **Universal Consequences**

There are several analogies that may help explain how a reallocation of income and assets affects promises to keep financial commitments:

- Uninsured medical expenses force either a reallocation of income and potentially assets or a severe diminution of lifestyle.
- An uninsured disability causes either a reallocation of assets which were not intended to cover a loss of income or a severe diminution of lifestyle.
- An unexpected death during working years leads to a substantial loss of income, forcing an unintended use of assets or a severe diminution of lifestyle.

Now that you have a clear understanding of extended care and its consequences, the next step is to match this understanding to a set of principles that permit you to

convey the consequences in a manner that compels clients to take action to protect those they love.

Mention that you don't think decrepitude, senility and dependency are in the client's future, because the client believes that they will not be. By making this statement, you agree with what the client thinks and therefore become free to focus on something more important: the consequences to the client's family if he needs care.

### Death: Mirroring the Consequences of an Unexpected Death during Working Years

Loss of income due to death during working years has a direct and devastating impact on the emotional, physical and financial wellbeing of the client's family:

- Lifestyle, which is just another term for financial commitments, would be devastated. How could the lost income be made up?
- The surviving spouse could get a job. But is she employable? If so, what is she worth in today's market? What if she were older?
- The emotional stress of trying to keep the family together while the surviving spouse is working is substantial. This would have a direct bearing on her health.
- Think of the emotional stress the children would be under. Would they have to drop out of private school or college?

### Disability: Mirroring the Consequences of an Unexpected Disability during Working Years

Loss of income during working years due to disability has a direct and devastating impact on the emotional, physical and financial wellbeing of the client's family:

- Lifestyle, which is just another term for financial commitments, would be devastated. How could the lost income be made up?

- The surviving spouse could get a job. But is she employable? If so, what is she worth in today's market? What if she were older?
- The emotional stress of trying to keep the family together while the spouse is working is substantial. This would have a direct bearing on her health.
- Think of the emotional stress the children would be under. Would they have to drop out of private school or college?

We cover the second set of consequences in more detail in Section C—those of paying for care, especially the consequences of self-funding.



# Section A

## Summary

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Anyone who has had to provide care over a period of years will tell you that, without question, the overwhelming emotional and physical damage caused by providing that care took place at home. It had to and has to, because of the nature of extended care. Placement in a nursing home is actually a relief, but families find it almost impossible to make that placement because doing so ... breaks their hearts.

## Key Points A

### Extended Care (Page #11)

Long-term care, or extended care, is assistance a person needs because she has an impairment which compromises her ability to safely get through the day.

### Two Types of Impairments (Page #11)

#### 1. Acute Impairment

An acute impairment is a sudden event that requires immediate medical attention under a plan of care created by a physician and executed by skilled providers. Treatment for an acute impairment assumes that some degree of recovery or "cure" is possible and sought.

#### 2. Chronic Impairment

A chronic impairment is a condition that cannot be cured or “fixed,” but it can be managed. Most extended care events are driven by a chronic impairment or a combination of chronic impairments.

For the purposes of extended care planning, chronic impairments are broken down into two sub-types:

- Physical
- Cognitive

### **Physical Impairment (Page #12)**

A physical impairment compromises the person’s ability to perform basic daily routines, called Activities of Daily Living (ADLs). The six ADLs most commonly used in LTC insurance and extended care planning are:

- Transferring
- Toileting
- Bathing
- Dressing
- Eating
- Continence

### **Cognitive Impairment (Page #13)**

A cognitive impairment is the deterioration or loss of intellectual capacity measured by clinical evidence and standardized tests focusing on the loss of memory or reasoning ability. Examples include Alzheimer’s, other dementias, or even a head injury that compromises a person’s:

- Short- or long-term memory
- Orientation as to person, place and time

- Deductive or abstract reasoning
- Judgment as it relates to safety awareness.

## **Level of Care (Page #14)**

Any impairment requires a particular level of care, either:

- Skilled
- Custodial

Extended care rarely requires skilled medical care. Extended care typically requires only custodial or non-skilled services: assistance with ADLs or supervision of a cognitively impaired person.

## **Informal Care (Page #15)**

Non-paid-for care is the care given by family, friends or volunteers, typically in a client's home.

## **Formal (“Professional”) Care (Page #15)**

Formal, or “professional care,” is paid-for care. It is given in various settings:

- Home Care
- Adult Day Care
- Assisted Living Facility (ALF)
- Continuing Care Retirement Community (CCRC)
- Nursing Home (Skilled Nursing Facility—SNF)

Providers of home care services include social workers and care managers, homemakers, homecare aides (personal care attendants), skilled medical providers, and adult day care centers.

## **Social Workers and Care Managers (Page #16)**

Social workers provide counseling, assessment, and referral, to other formal caregivers, agencies, or facilities. As part of the assessment service, a licensed social worker (or nurse) writes the plan of care.

Care Managers provide on-going monitoring and assistance to clients and their family members to ensure the plan of care is implemented and continues to be effective.

Together the services of a social worker and care manager are referred to as "Care Coordination." Social workers, care managers, or care coordinators do not provide direct care.

## **Homemakers (Page #17)**

Homemakers help a person complete light housekeeping tasks, run errands, shop, prepare meals, or provide transportation. Homemaker services alone do not qualify a person for LTC insurance benefits, but most LTCL policies do pay for homemaker services once benefit eligible.

## **Home Care Aides (Personal-Care Attendants) (Page #18)**

Home care aides, also called personal-care attendants, are trained to assist people in Activities of Daily Living (ADLs) and/or provide basic supervision for cognitive impairments; they do not provide any skilled medical care.

## **Skilled Medical Care Providers (Page #18)**

Skilled medical care providers include doctors, nurses, licensed practical nurses, physical therapists, speech therapists, occupational therapists and nutritional therapists who provide both generalized and specialized skilled care services at the care recipient's home.

## **Adult Day Care (Page #19)**

Adult day care centers help people with extended care needs stay at home more effectively by providing a respite for informal caregivers during the day.

Long-term care facilities include assisted-living facilities, continuing care retirement communities, hospitals, and nursing homes (also called skilled nursing facilities).

## **Assisted-Living Facilities (ALF) (Page #20)**

Assisted-living facilities (ALF) or communities provide increasing levels of formal care for people who, while having difficulties with ADLs or a mild to moderate cognitive impairment, can still get through some of their daily routine.

Most assisted-living facilities are rentals—that is most do not require a large “buy-in,” and many ALFs now have on-site Alzheimer’s, dementia, or “memory care” units.

## **Continuing Care Retirement Communities (CCRCs) (Page #22)**

CCRCs contain three components:

1. Independent living,
2. Assisted-living facilities, and
3. Skilled nursing-home care

CCRCs usually require residents to purchase lifetime use rights to their units, usually single-level or duplex apartments. This entrance fee generally runs from \$150,000 to \$500,000, depending on the area of the country. There is a monthly maintenance charge as well, which is subject to increase.

The entrance fee guarantees the buyer a bed in the nursing unit of the CCRC campus. A careful review of the purchase contract is essential to discover which levels of care are included in the entrance or monthly maintenance fees.

## **Hospitals (Page #26)**

Hospitals only serve patients with acute impairments or emergency conditions. They do not offer non-skilled (custodial) care.

## **Nursing Homes (Skilled-Nursing Facility—SNF) (Page #25)**

Nursing home care today is typically provided in skilled-nursing facilities (SNFs). These are licensed by the state and federal governments to provide skilled or rehabilitative services, as well as highly complex custodial care, and thus can be reimbursed by Medicare or third-party payers

## **Consequences of Extended Care (Page #27)**

1. The first consequence of extended care is a personal one: providing care seriously impacts the emotional and physical wellbeing of the caregiver. Extended care is a life-changing event that will impact the life of a family member or friend by requiring them to change the way they conduct their own life, family and career. Mitigating this first consequence leads to the second.
2. The second consequence is a financial one: paying for care disrupts every plan to secure your client's future financial viability. In addition, paying for care causes a reallocation of resources starting with income. Shifting income to pay for care has a direct impact on the client's ability to keep financial commitments, especially to continue to provide for the ongoing lifestyle of a spouse or partner. If care lasts long enough, or as it becomes more complex, paying for care may lead to an unintended invasion of principal.

## Section A Quiz

1. The two types of impairments are:
  - A. ADL and IADL
  - B. Cognitive and physical
  - C. Chronic and acute
  - D. Custodial and acute
2. Which of the following is NOT considered a chronic impairment?
  - A. Diabetes
  - B. Dementia
  - C. Heart attack
  - D. High blood pressure
3. Long-term care includes all of the following EXCEPT:
  - A. Custodial care
  - B. Intermediate care
  - C. Informal care
  - D. Assisted living
4. Informal caregivers are generally understood to be:
  - A. Non-paid
  - B. Associated with a home care agency
  - C. Covered by LTC insurance
  - D. Available to work at any time.

5. Care coordination includes all of the following EXCEPT:
- A. Needs assessment
  - B. Professional referrals
  - C. Family counseling
  - D. IADL assistance
6. Which of the following services typically carry the lowest hourly cost?
- A. Care coordination
  - B. Personal care, e.g., bathing, dressing, supervision
  - C. Instrumental Activities of Daily Living
  - D. Rehabilitation
7. Adult day care is primarily a benefit for:
- A. The impaired person
  - B. The informal caregiver
  - C. Insurance companies
  - D. Home care aides
8. Assisted living facilities provide all of the following EXCEPT:
- A. Memory care
  - B. ADL assistance
  - C. Skilled care
  - D. Homemaker services

9. Continuing care retirement communities (CCRCs) require:
- A. Means testing
  - B. Initial entry into independent living
  - C. At least one spouse to need care before admission
  - D. Medicare approval
10. The two main consequences of an extended care event are:
- A. Personal and financial
  - B. Financial and cognitive
  - C. Personal and institutional
  - D. Assets and income



**SECTION B:**

**EXTENDED CARE  
PLANNING**



# Chapter B1:

## Traditional Principles

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We start with how you may be currently engaging your client—or rather why you are not—because this is how you have been taught and it simply does not feel comfortable—to you or your client. Your current client engagement can probably be summarized as follows:

1. The client is educated about the risk of needing care as he ages. This is supported with statistics and cost surveys.
2. The client is educated about the terrible things that will happen to him including:
  - Loss of independence
  - Inability to choose where and how care is provided
  - Being a burden to his family
  - Loss of assets paying for care
3. LTC insurance (in whatever form) is then quickly positioned as a solution to the issues. If the client buys the insurance he can:
  - Maintain independence
  - Choose where and how care is provided for
  - Prevent being a burden to his family
  - Protect assets

The presumption is that the client will be motivated by these hard-pressed facts and will take steps to protect himself. The reality is that it is just that, a presumption. The fact is, no one—not even those who have purchased the product—is interested in listening to the utterly depressing news that decrepitude, senility and dependence caused by chronic illnesses, inevitably leading to a nursing home, lies in their future. So the question is: when presented with the reality of aging, why won't clients—particularly healthy men with no prior experience—take steps to protect themselves by purchasing LTCI in any form?

The answer is Cognitive Dissonance.

## **Cognitive Dissonance**

Cognitive Dissonance is the psychological discomfort created when a person's beliefs are undermined by facts to the contrary.

People structure their lives on a set of beliefs—right or wrong. Challenging those beliefs by facts to the contrary causes this well-studied condition: Cognitive Dissonance. People deal with the psychological discomfort created in three common ways:

- Ignore the factual evidence (or similarly focus only on information that supports the existing belief)
- Rationalize behavior
- Change behavior

## **Belief versus Facts and Cognitive Dissonance: A Lifestyle Example**

People like to smoke. Smokers will tell you straight out that it is part of their lifestyle. The problem is that this belief collides with the fact that smoking causes severe health risks and will shorten your life considerably. There are three ways to address the discomfort when a smoker's beliefs are undermined by these facts:

- Ignore the subject
  - Don't read or accept information that challenges the belief; only focus on information that supports it or minimizes the discomfort. Tell do-gooders it's none of their business.
- Rationalize behavior
  - "We all have to die of something." "If I stop smoking I'll put on weight."
- Change behavior
  - Stop smoking

## **Cognitive Dissonance and Extended Care**

How people deal with the issue of an unexpected need for care often is predicated on what they perceive their role in the family to be. That role is dictated on one level by genetics as well as social convention. There are two roles: primary earners and primary caregivers.

### **Primary Earners**

The role of primary earners is to provide for and protect those they love.

- If men, they are generally hardwired to so.<sup>1</sup>
- If women...hold that thought.

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<sup>1</sup> B. Mark Schoenberg, *Growing Up Male*, (Bergan & Garvey 1993); X.T Wang; Daniel J. Kruger, Andreas Wilke, "Life History, Variables & Risk Taking Propensity," *Evolution and Human Behavior* 30 (2009) 77–84; Leonard Sax MD, *Why Gender Matters*, (Broadway Books, 2006)

## Primary Caregivers

The role of primary caregivers is to create a stable environment in which to raise and nurture children (if any).

- If women, they are generally hardwired to do so.<sup>2</sup>
- If men...hold that thought.

If men are primary earners:

- Genetics and social convention generally dictate men believe they will always be available to keep their essential directives regardless of age. Therefore, in their mind the risk of needing care is ...
- Essentially zero, because believing needing care would directly impact those self-guiding directives of providing for and protecting their families. This is also why we perceive men as being greater “risk takers” than women.

If women are primary earners:

- Women’s response is more nuanced. They also likely believe they are not going to need care, but they tend to look at the event through a different prism because of how they are wired.
- Women—either through nature, social convention, or both—are more likely to be nurturers; therefore, they are more likely to assume the responsibilities of providing care, whether to a spouse, parents and/or children. With those responsibilities comes a more natural awareness of the emotional and physical consequences of providing such care.
- They also better understand the financial consequences of not having resources to support these commitments at all stages of life.

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<sup>2</sup> *Hardwired to Connect*, edited by Stephen Bavolek, Dartmouth Medical School.

- Which in turn, leads to their nuanced response when the issue of an unexpected need for care is brought up in a meeting.

Where men generally believe there are no ifs, ands, or buts about the event ever happening: it just won't. Many women, when asked if they believe they will need care, will usually hesitate and then answer:

They *hope* they don't need care. However, they understand the serious consequences to their families if they did.

In other words, women take the event and refract it through a prism resulting in a series of consequences. Another way of expressing it:

- A husband believes that there is a 0% risk of needing care. Therefore, there can be no consequences to his family, obviating the need to purchase insurance.
- His wife hopes her husband doesn't need care because it would refract into 100% of consequences to the family.

Consider that these roles and views do not always follow strict gender lines, and that partners in same-sex relationships may have a view of risk, consequence, and responsibility that should not be stereotyped, but should be carefully listened for and understood nonetheless.

No effort to try and persuade healthy men with no prior experience to purchase LTCI can succeed unless you eliminate Cognitive Dissonance.

An incorrect philosophy creates Cognitive Dissonance.

As stated, the presumption is that the client will be motivated to purchase a product once educated about the issues caused by needing care. The fact is just the opposite: It does not create need; it creates Cognitive Dissonance. Please remember that healthy men, particularly those with no prior experience, believe that care will never be needed. You have just gone out of your way to try to educate him that statistically, he will need, thus creating the need for a product.

The client's belief that care will not be needed is undermined by to present "irrefutable facts" that it will be needed. The client can handle the discomfort in three ways:

1. Ignore the fact:

- Don't meet with a producer.
- Meet with a producer because he was were compelled to do so, listen politely and then do ... nothing.

2. Rationalize behavior:

- "I won't live a long life."
- "I'll never need care."
- "I am not going to a nursing home."
- "I'll put a gun in my mouth."
- "I can self-insure."

3. Change behavior:

- Be willing to entertain the subject if presented correctly.

This "risk-based philosophy" creates a mismatch of interests leading to a "selling environment." A mismatch of interests occurs when your objectives are not in line with those of your client. In this case, your interest in educating the client about the likelihood of needing care is not matched with an interest on your client's behalf in listening to it. Not only has it created Cognitive Dissonance, the client quickly believes the information was shared to sell a product. The result? A selling environment has been created.

A selling environment exists when a client concludes that the conversation is based not on his interests—protecting his family, business, or keeping a commitment to

charities, for example—but, rather, on your interest in trying to sell him something to make a commission.

Do you see the consistent theme inherent in risk-based selling?

“Wait a minute. I am confused because this has worked for me.”

You may believe that risk-based selling works, but think about the people who have primarily purchased the product. Over the years, most producers we have asked have stated unequivocally that they have made the bulk of their sales to:

- People with existing health problems who today would likely be declined for coverage.
- People with a prior experience or those who know someone who has provided care.
- Men (usually) who listened to their spouses—the family caregivers.

The first two groups do not have to be sold anything; they are self-selectors, that is, motivated buyers. The motivating factor is not their acceptance of the risk that they might need care but, rather, their understanding of the real-life consequences to those they love if they do. They bought LTC insurance regardless of the selling system employed.

Query regarding the third group: Would they have met with a producer on their own?

Do you still believe that a risk-based philosophy is effective? What happens when you use it on healthy men with no prior experience? Instead of coming to an agreement, you create an argument featuring the classic objections mentioned above.

## **The Importance of Establishing a Matching of Interests**

In order to work with those who have no prior experience with caregiving—and to the affluent—there must be a match of interests between you and the client. As the advisor, it is therefore your responsibility to understand what interests your client.

This can be accomplished by asking the key question, “What is important to you?” People insure things that are important to them. Once you understand what is important to your client, you can develop a message that focuses on those interests. If you do so correctly, the buyer will be motivated to act.

For example, in the life insurance field, producers are taught that clients are not interested in recitations about the risk of dying during their working years for the simple reason that they don’t believe this will happen. Clients will, however, respond to a message based on the consequences to family members if they ever did.

Here’s an illustration of how you can match your interest with that of your client in the sale of life insurance:

### **Your interest:**

You need to educate a client (let’s say he is a primary earner) about the severe consequences to family members—emotional, physical, and financial—if he dies unexpectedly during working years.<sup>3</sup>

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<sup>3</sup> In this course, we will set forth how severe those consequences would be to those the client loves in such detail as to give him a compelling reason to take action.

**The client's interest:**

A person who loves someone will always want to be advised about a hazard that, if left unattended, could cause severe harm to those he loves. If you accomplish this correctly, he will overcome his natural aversion to thinking about the possibility of his own unexpected death or disability.

**Equal:**

This matching of interests is likely to result in a sale of life insurance. We refer to this equation as a mutuality of interests: the interests of the producer and buyer match.

The same equation should be applied to the sale of LTC insurance in any form. Growing the market requires reaching out to those who have not had any prior experience with extended care. This cannot be accomplished by using the traditional principles of risk-based selling because of a fundamental mismatch of interests: the interests of the producer (trying to sell a product to mitigate the risk and cost of needing care) will never match that of the buyer because the buyer believes care will never be needed.

Did you just notice, if you had not previously, that the consequences to a client's family of providing care are largely the same as if the client died or became disabled during working years?



# Chapter B2:

# Consultative Engagement<sup>SM</sup>

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*Consultative Engagement* is a planning approach that seeks to avoid or overcome Cognitive Dissonance.

As just discussed, effectively motivating the unmotivated requires focusing not on risk, but on something more instinctual, more atavistic in nature: in this case, how a need for care would severely disrupt their ability to provide for and protect those they promised to take care of. This approach allows you to proactively raise the subject of extended care with every client.

Consultative Engagement provides that education. Clients are engaged in a discussion about:

- How a need for care would so compromise the individual that he would no longer be able to execute his primary directives
- How not being able to execute his primary directives would cause serious consequences to those he loves and has promised to take care of

Once again those consequences are:

1. First, providing care seriously damages the emotional and physical wellbeing of caregivers.

2. Second, paying for care disrupts every plan created to secure financial viability into an unknown future.

Consultative Engagement:

- Does not create Cognitive Dissonance because the conversation does not focus on what will happen to him, but rather on what would happen to those he loves if care was necessary
- Does, however, make the client uncomfortable
- That discomfort is caused by his conscience weighing the consequences of inaction, which is exactly the point of the discussion.

Consultative Engagement creates a matching of interests: Your interest in educating the client about what would happen to those he promised to take care of is matched with his interest in listening to you explain that any event, if left unattended to, would cause serious consequences to those he loves.

None of this can happen unless you know what is of interest to the client. That's why it is absolutely essential to integrate into the discussion the question:

"Who and what is important to you?"

A sample dialogue:

"Paul, if I may, who and what is important to you?"

"What do you mean?"

"What responsibilities do you now have which you didn't think you would have ten or fifteen years ago?"

The client tells you what they are (or you remind him if he has already shared them with you).

What you likely will hear are the responsibilities those in their 50s to mid-60s are taking into retirement. They may include:

- Financial obligations
- Lifestyle commitments such as a vacation home, memberships in clubs, etc.
- Financial or moral commitments from a first marriage
- Business succession
- A child who has not made the best decisions in life
- A child or grandchild with special needs
- Tithing
- Building a legacy

If the client tells you nothing has really changed, ask...

“Do you see taking many, if not all, of the financial responsibilities you had during working years into retirement?”

or

“Do you anticipate assuming any additional financial responsibilities during retirement?”

You can then educate the client about the effect on his ability to pay for things that are important to him if he ever needed care and had to reallocate income and assets to pay for it. If you do so correctly, he will be compelled to make a decision:

- He may decide that the consequences are not that severe. If so, no further action can be taken.
- However, he may decide that the consequences to those he loves would be severe. If so, he will ask you for ideas about plans to protect them.

His family is protected not by a policy but by a plan, the goal of which is to mitigate the consequences of providing care.

Once the plan is in place, LTC insurance is positioned as a strong funding source for that plan.<sup>4</sup>

Consultative engagement is a universal platform that you are likely using with other plans and insurance products. It is also effectively used when discussing life insurance and disability income insurance.

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<sup>4</sup> The assumption at all times in this course, except when stated otherwise, is that the client has the resources to afford the policy.

# Chapter B3:

## The CLTC® 3-Step Planning Process

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This chapter integrates all we have previously learned into a universal approach to clients. The most common objections are also discussed. A comprehensive list of objections (as well as *Power Phrases*) is contained in the *CLTC® Client Interview Road Map* in Chapter E1, page #279.

“Alan, any questions on the (financial or insurance) portfolio we just reviewed?”

“No, I am up to date.”

“I haven’t asked you this in a while, but tell me what’s important to you as you look forward to the future (or retirement)?”

“What do you mean?”

“What responsibilities do you now have that you didn’t think you would have ten to fifteen years ago?”

The client tells you what they are. If he states, “Not that many,” then ask...

“Do you see taking most, if not all, of the financial obligations you have now into the future?”<sup>1</sup>

The client gives you a list of responsibilities.

“I need to talk to you about what would happen to Ellen and your children emotionally and physically should you live a long life and ever need care over a period of years. I also need to discuss what paying for that care would do your ability to keep your financial commitments.”

“I appreciate the subject but I’ve got to tell you no one in my family has lived a long life, so I am not sure it would be an issue.”

“I am not suggesting you will live a long life, but if you did and needed care over a period of years, there would be serious consequences to your family.”

“But what if I never need care? No one in my family had been sick for years before they died.”

“I am not suggesting that you will, but if I may ask, if you did need care, what do you think providing that care would do to the emotional, physical and financial wellbeing of your wife and children?”

“I am not sure.”

Then ask:

“Have you rolled up your sleeves and been directly involved in providing care to a chronically ill person, or do you know someone who has?”

A prior experience of extended care

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<sup>1</sup> This assumes that you don’t already know what these obligations are from your previous discussions with this client. If you do, this is a good time to remind him of them.

If the answer is “yes,” consider asking any number of the following questions:

- What happened?
- Where was the care provided and who provided it? What effect did it have on the care providers?
- What impact did it have on the family’s finances?
- How did paying for care impact the family’s ability to keep commitments?
- If it’s your turn, how do you want your experience to compare?

There are four reasons to ask these questions:

1. Experience is persuasive: the client is more likely to listen to your ideas about creating a plan to protect his family if he has seen first-hand the severe consequences of not having a plan.
2. By asking, you let the client know that you understand the business of extended care.
3. It gives you an opportunity to share your experiences, creating a bond. Ensure, however, that you do not focus on what happened to the person because, again, men tend not to believe that they will need care. Rather, focus on what providing care did to those other people the person loved.
4. Many people are confused by the definition of long-term care (extended care). They think it’s a heart condition, arthritis or cancer, for example. If, in fact, that is what a client thinks, and he is stuck in this understanding, consider treating him as having no prior experience.

No prior experience of extended care

If the client has no prior experience of extended care:

“Alan, if I may, what do you think extended care is?”

“A nursing home?”

"No."

"Dementia or something like that?"

"Again, no."

"Not being able to take care of yourself?"

"No."

Alan then asks...

"What is it?"

"Alan, it's not a condition like Parkinson's or dementia because I have to believe that you don't think these things will ever happen."

The client answers:

"I hope not."

"By the way, who are nursing homes for?"

"Old people."

"Correct. Extended care has nothing to do with you because we both agree it's not going to happen to you, and, for that matter, to me. It is, however, a life-changing event that would, not could, have serious consequences to your family who would then have no choice but to put their lives aside to provide what amounts to 24/7 care."

Then continue by explaining what causes a need for extended care, always emphasizing the impact on others:

"Extended care is assistance you would need because you have one or more impairments. There are two types:

"A physical impairment, which is a chronic medical condition such as Parkinson's, multiple sclerosis, stroke, or diabetes. These illnesses can be managed with medication and therapy, but cannot be cured. As the illness progresses, it compromises your ability to get through the most basic of daily routines.

"Or it could be a cognitive impairment, which is a marked or measurable decline in intellect such as Alzheimer's or other forms of dementia. As the illness progresses, it compromises your ability to interact safely with your environment or those around you. By definition, those you love would have no choice but to put aside their lives to make sure you are safe. Here are the direct consequences:

"Providing care to you may make your wife as chronically ill as you are.

"It will likely force one of the children—most likely your daughter or daughter-in-law—to put aside her life to help. This will impact not only her family but also her relationships with her siblings who may not be helping to provide care. I have often seen that when a child is involved, it doesn't bring the family together; it tears them apart.

"I can't imagine you would want that?"

"Absolutely not."

"Respectfully, Alan, my experience tells me that they won't have much of a choice.

"Then there is the issue of paying for care. It will likely force a reallocation of both your income and capital ... the money in your portfolio that has only one purpose, generating income. The problem is that these funds were never meant to pay for care.

"Putting it simply, paying for care will disrupt every plan you created to secure financial viability moving into the future.

“Now, I am not suggesting that any of these things will happen, but do you begin to see what would happen to those you love emotionally and physically if you needed care?”

“I never thought about it like that.”

## **Transitioning to the Three Key Agreements**

Once the client is introduced to the consequences that not having a plan would have on those he cares about, start the transition to the *Three Key Agreements*:

1. The client must agree that he could live a long life, and if he does, he may need extended care.
2. The client must clearly understand the emotional, physical, and financial consequences to those he loves, should he need care.
3. The client must understand that LTCI is necessary to help fund the plan.

## **First Key Agreement**

The client must agree that he could live a long life, and if he does, he may need extended care.

“So, Alan, let me ask you, do you believe it’s possible that you could live a long life?”

“I hope to.”

“If you did, do you think it’s possible, if not probable, that you could need care for a few years along the way?”

“Possible.”

The client has just accepted the first key agreement. If he has not, see the section on overcoming objections in the *CLTC Client Interview Road Map*, Chapter E1, page #293.

Step 1: Establish that the client believes he could live a long life, and that if he does, he could become frail and need care over a period of years.

As with life insurance, you can deal only with people who:

- Are reasonable
- Love their families
- Are successful

Reasonable people believe that it is possible they could live a long life. This is why they have retirement portfolios intended to support them to age 95 or beyond, not age 65.

Reasonable people believe that living longer creates the possibility of needing care. This is why they promise themselves that their investment portfolios (as distinguished from qualified funds, which will be drawn down to support lifestyle) will remain intact; they don't know what might come up in the future.

These two beliefs<sup>2</sup> are made evident every time a client asks you:

“Are you sure there is enough?”

By replacing risk with consequences, Step 1 can now establish the need to create a plan for extended care through a simple dialog. Here is a conversation with built-in objections to demonstrate how easily you can overcome them when the focus is on consequences, not risk.

“Any questions on the portfolio going forward?”

“No, I understand the plan.”

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<sup>2</sup> These points are confirmed by every survey ever conducted on the top concerns of retirees: Outliving their income, and becoming so ill as to affect their financial viability.

“Alan, if I may ask, what’s important to you as you look into retirement? In other words, which obligations do you now have or anticipate that you may not have had ten or fifteen years ago?”<sup>3</sup>

The client tells you what they are.

“Look, I need to talk to you about how severe the consequences would be to your wife and children emotionally and physically should you live a long life and ever need care over a period of years. We also need to discuss the impact of paying for this care on them and on your other commitments.”

“I appreciate your concern, but no one in my family has lived past 65, so it’s not a concern.”

“You may be right. But if you did live a long life and needed care, what do you think providing it to you would do to the emotional, physical and financial wellbeing of your wife and children?”

“I am not sure but it probably won’t matter; everyone in the family was healthy until the day they died.”

“Alan, listen to me. You may never need care, but if you did, please, tell me in your own words what you think taking care of you would do to your family.”<sup>4</sup>

That’s a worst-case scenario. As long as family, not product, is the focus, here is how the client is likely to respond:

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<sup>3</sup> This assumes that you don’t already know what these obligations are from your previous discussions with this client. If you do, this is a good time to remind him of them.

<sup>4</sup> It is a better practice to have the client tell you what he thinks the consequences are rather than tell him. When he tells you, he is, in effect, owning the consequences.

“Alan, if I may ask, what’s important to you as you look into retirement? In other words, which obligations do you now have or anticipate that you may not have had ten or fifteen years ago?”<sup>5</sup>

The client tells you what they are.

“Look, I need to talk to you about how severe the consequences would be to your wife and children emotionally and physically should you live a long life and ever need care over a period of years. We also need to discuss the impact of paying for this care on them and on your other commitments.”

“What do you mean?”

“Let me ask you a question: Do you believe it’s possible that you could live a long life?”

“I hope to.”

“Do you think that if you live long enough, it’s possible you could become frail and need care?”

“I don’t like to think about it, but it could happen.”

The client has just accepted Key Agreement 1.

## **Second Key Agreement**

The client must clearly understand the emotional, physical, and financial consequences to those he loves should he need care.

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<sup>5</sup>This assumes that you don’t already know what these obligations are from your previous discussions with this client. If you do, this is a good time to remind him of them.

"I think you now understand that providing care would have devastating consequences to your family. So the question is, what's your plan to mitigate those consequences?"

"I never thought about it like that. I really don't have a plan."

"I want to help you develop your plan that would permit you to remain safe at home while preserving the emotional, physical, and financial wellbeing of those you care about [substitute specific names if appropriate]."

"May I do that?"

"Let me hear your ideas."

The client has just accepted the second key agreement.

The plan, as previously stated, is to allow the client to remain at home while mitigating the two sets of consequences we discussed:

1. To protect the emotional and physical wellbeing of the client's spouse and children by having others provide the care he may need.
2. To protect the client's ability to maintain financial commitments by having someone else pay for that care.

If the client says that this makes sense, the next step is to ask...

"What do you think will pay for it?"

## **Third Key Agreement**

The client must understand that nothing will pay for the plan except LTCL.

This is addressed in Section C.



# Chapter B4:

## The Extended Care Plan

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The plan usually is to allow your client to remain safe in the community (at home or in an assisted living facility), while protecting the emotional, physical, and financial wellbeing of those the client loves. This is done by:

- Having others provide care and thus relieving the primary caregiver
- Ensuring that regular income and capital do not have to be reallocated to pay for it

Here is another way of expressing the goal.

The goal of a plan is to restore the family, as much as possible, back to where they were emotionally, physically, and financially prior to an unexpected:

- Death
- Disability
- Medical event
- Need for care over an extended period of years

Once again you see the great similarity between LTCI insurance and life, disability-income, and medical insurance.

“Why do I have to talk about a plan? Why not just now focus on selling LTCI now that the client understands what would happen to his family?”

If you look closely at the plan’s goal, it is not to sell product, but to address the issues you brought to the client’s attention. Bringing product up prior to creating a plan disrupts the delicate balance of mutuality of interests. It may lead the client to conclude that everything you educated him about, and the questions you asked, were nothing more than a ruse to sell him a product.

By allowing you to put together a plan, the client is asking you in effect to protect his family. You are not telling the client to put one together; he or she is asking you to do so. That being so, you have every right to ask the question, once the plan is together, “What do you think will fund it?” This is how life and disability-income insurances are sold.

***CASE STUDY: MIRRORING THE CONSULTATIVE ENGAGEMENT APPROACH IN A DISCUSSION OF AN UNEXPECTED DEATH***

In this case, the client is educated on how severe the consequences to those he loves would be if (not when) he died during working years. Educated properly, he will be compelled to make a decision.

If he believes that those consequences would not be severe, he might say:

“I don’t want to think about it.”

“Let my wife remarry.”

or

“I won’t be around anyway.”

In that case, a plan cannot be created to protect them because he doesn't care.

If, however, he believes that the consequences would be severe, he will let you put together a plan to mitigate them even though he still believes that the event will most likely never happen. Once the plan is in place, life insurance is positioned as a funding solution.

Consider that a discussion about dying during working years creates the same result as a discussion about needing care: Cognitive Dissonance. Here are some statements you may want to avoid:

"I would like to review your life insurance needs."

"I would like to gather some information to help determine how much insurance you need."

Instead, suggest that this is not a discussion about his (or her) risk of dying during working years and then immediately change the focus to a set of consequences:

"Tom, this is not a discussion about your risk of dying during working years because I have to believe that you don't think it's going to happen (Question: What do you think Tom's answer will be?) But if you are willing to spend some time, it may be because there's a little voice that nags you; it nags you when you look at your wife and kids. That's your conscience saying: 'What if you did?'"

***CASE STUDY: MIRRORING THE CONSULTATIVE ENGAGEMENT APPROACH IN A DISCUSSION ABOUT AN UNEXPECTED DISABILITY***

Here, the client is educated on how severe the consequences to those he loves would be if (not when) he lost the ability to generate income because of a disability during working years. Educated properly, he will be compelled to make a decision.

If he believes that those consequences would not be severe, he might say:

"My wife can go to work."

“We’ll just have to cut back on our expenses.”

“I won’t have that many obligations if I do become disabled.”

In that case, a plan cannot be created to protect them.

If, however, he believes that the consequences would be severe, he will let you put together a plan to mitigate them even though he might still believe that the event will never happen. Once the plan is in place, disability income insurance can be positioned as a funding solution.

Consider this: A discussion about a substantial disability during working years creates the same result as a discussion about needing care: Cognitive Dissonance. Here are some statements you may want to avoid:

“I am not sure you know this but you are four times more likely to become disabled than die during working years.”

“I would like to show you how insurance can help you pay your bills if you become disabled.”

Instead, suggest that this is not a discussion about the client becoming disabled and then immediately change the focus to a set of consequences:

“Tom, this is not a discussion about the risk of a serious injury during working years because I have to believe that you don’t think it’s going to happen (Question: What do you think Tom’s answer will be?) But if I may, please tell me what you think would happen to your ability to keep your commitments?”



# Section B

## Summary

Keeping your focus on postponing the discussion of product, benefits and features, while helping the prospective client develop a plan for their care will change the way they think of you and they will engage in developing their plan with you. Once you know the dynamics of the family; who is the primary earner and who is the primary caregiver, you will ask, "Who is important to you to protect should you require care in the future."

Using the *Three Key Agreements* you will guide your prospective client in the direction of consultative engagement which will, in turn, move them on into the funding stage.

## Key Points B

In reality, no one is interested in listening to the utterly depressing news that decrepitude, senility, and dependence caused by chronic illnesses, inevitably leading to a nursing home, lies in their future. (Page #58)

Why will potential clients not take steps to protect themselves and their families by purchasing LTCI in whatever form? (Page #58)

People structure their lives on a set of beliefs. When those beliefs are challenged by facts to the contrary; it causes Cognitive Dissonance. There are three ways a person can deal with the discomfort created:

- Ignore the factual evidence
- Rationalize behavior

- Change behavior

**Cognitive Dissonance:** Cognitive Dissonance is the discomfort created when a person's beliefs are undermined by facts to the contrary. No effort to try and persuade healthy men with no prior experience to purchase LTCI can succeed unless you eliminate Cognitive Dissonance. (Page #58)

How people deal with the issue of an unexpected need for care is predicated on how they perceive their role in the family. That role is dictated on genetics and social convention. (Page #59)

**Primary Earners:** The role of primary earners is to provide for and protect those they love. (Page #59)

**Primary Caregivers:** Their role is to create a stable environment to raise and nurture children. (Page #59)

**Risk-based Philosophy:** A risk-based philosophy creates a mismatch of interests leading to a selling environment. (Page #62)

A mismatch of interests occurs when your objectives are not in line with those of your client. In this case, your interest in educating the client about the likelihood of needing care is not matched with an interest on your client's behalf in listening to it. Not only has it created Cognitive Dissonance, the client quickly believes the information was shared to sell a product. A selling environment has been created.

### **The Importance of Establishing a Matching of Interests: (Page #64)**

In order to work with those with no prior experience of caregiving—and to the affluent—there must be a match of interests between you and the client. As the advisor, it is therefore your responsibility to understand what interests your client.

This can be accomplished by asking the key question, "What is important to you?"

People insure things that are important to them. Once you understand what is important to your client, you can develop a message that focuses on those interests. If you do so correctly, the buyer will be motivated to act.

Growing the market requires reaching out to those who have not had any prior experience with extended care. This cannot be accomplished by using the traditional principles of risk-based selling because of a fundamental mismatch of interests: the interests of the producer (trying to sell a product to mitigate the risk and cost of needing care) will never match that of the buyer because the buyer believes care will never be needed.

### **Consultative Engagement: (Page #67)**

Consultative engagement is a philosophy that avoids Cognitive Dissonance.

As just discussed, effectively motivating the unmotivated requires not focusing on risk, but on something more instinctual, more atavistic in nature: in this case, how a need for care would severely disrupt their ability to provide for and protect those they promised to take care of.

Consultative engagement provides that education. Clients are engaged in a discussion about...

- How a need for care would so compromise the individual that he (or she) would no longer be able to execute their primary directives...
- Therefore, causing serious consequences to those he (or she) loves and has promised to take care of

### **Three Key Agreements: (Page #76)**

First key agreement: The client must agree that he could live a long life, and if he does, he may need extended care.

Second key agreement: The client must clearly understand the emotional, physical, and financial consequences to those he loves, should he need care.

Third key agreement: The client must understand that nothing will pay for the plan except LTCI.

### **The Plan: (Page #83)**

The plan is to allow your client to remain safe in the community (at home or in an assisted living facility), while protecting the emotional, physical, and financial wellbeing of those the client loves.

By allowing you to put together a plan, the client is asking you in effect to protect his family. That being so, you have every right to ask the question, "What do you think will fund it?" This is how life and disability-income insurance are sold.

## Section B Quiz

1. Focusing on the risk of needing care supported by statistics creates:
  - A. Interest and need
  - B. An educational environment
  - C. Cognitive Dissonance
  - D. Consultative Engagement
  
2. Consultative Engagement does all of the following EXCEPT:
  - A. Overcomes Cognitive Dissonance
  - B. Matches the interests of the advisor and client
  - C. Creates fear as a motivator
  - D. Creates a planning environment
  
3. The CLTC® 3-Step Planning Process<sup>SM</sup> includes, in order, these actions:
  - A. Establishing the risk, exploring the consequences, and creating meaningful funding solutions.
  - B. Discussing prior experience, identifying the consequences, and presenting LTC insurance
  - C. Consequences, cost, and coverage
  - D. Statistics, cost of care, LTC insurance solutions

4. In establishing the risk of needing care, a CLTC® designee should focus on:
  - A. Prior experience
  - B. Overcoming denial with well-referenced statistics
  - C. Personal stories about longevity and the consequences of care
  - D. The reasonable belief the client already has about living a long life.
  
5. What type of client will actually seek out and request information about LTC insurance?
  - A. Healthy and wealthy
  - B. Men with no prior experience
  - C. Clients with existing health problems
  - D. Younger clients with children at home
  
6. The best prospect for immediate long-term care planning and LTC insurance is someone who:
  - A. Has a lot of money to afford the premiums
  - B. Has had a significant personal experience with extended care
  - C. Sees himself as a primary provider
  - D. Is healthy and wealthy

7. CLTC® designees should proactively raise the subject of extended care with:
  - A. Every client
  - B. Clients over the age of 50
  - C. Clients who express an interest in the subject
  - D. Clients who can't easily qualify for Medicaid, but don't have enough money to self-insure
  
8. When initially raising the subject of long-term care, you should expect the client to:
  - A. Readily agree to a planning conversation
  - B. Understand what the core issues are
  - C. Mentally shut down or deflect the subject
  - D. Imagine a low-acuity home-base care scenario
  
9. Which of the following should properly create uncomfortableness in the client's mind?
  - A. Fear of needing care
  - B. Loss of assets
  - C. Imagining being in a nursing home
  - D. The consequences to those he loves

10. All of the following responsibilities may be important in extended care planning EXCEPT:

- A. Ongoing lifestyle of a spouse or partner
- B. Business succession
- C. Covering high Medicare co-payments
- D. Special needs

# **SECTION C:**

# **WHAT PAYS FOR EXTENDED CARE?**



# Chapter C1:

## Self-Funding

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Now that the client is willing to establish a plan to protect his family, the next step is to ask, “What do you think will fund it?” Remember, the client has asked you to help him protect his or her family from the consequences of providing and paying for care; this is done in the form of a plan. In turn, this permits you to suggest a suitable funding source for that plan. We start with overcoming the misconceptions people have about what those funding sources are:

- Self-funding
- Medicare
- The Department of Veterans Affairs
- Medicaid

After you learn that none of the above are viable funding sources for a plan to protect the emotional, physical, and financial wellbeing of your client’s family, we then turn to LTC insurance and other alternative funding solutions in Section D.

It should be noted that, immediate annuities, income annuities, second mortgages, reverse mortgages, family loans, are all ways to use a client’s own money, or in other words are just vehicles to assist in self-funding.

### **The Objection: Self-Funding**

“Now that the plan is in place, what do you think will fund it?”

The client responds:

“I have sufficient assets.”

or

“My financial advisor / attorney / CPA told me I have enough assets to pay for care.”

Perhaps no other thought is as ingrained into the LTC insurance selling lexicon than the belief that the product is primarily suited to protect assets. It therefore, makes it virtually impossible to sell to higher net worth clients who, believing that care will not be needed in the first place (primary earners, particularly men), simply tell you they have enough assets.

Take a step back to consider what actually pays for care. Is it assets (capital) or income? If you answered the latter, your thinking is in line with every insurance professional that sells life and disability income insurance.

The client may respond: “I understand, but if I need care I can simply use my assets to pay for it.”

Simply, paying for care is just another expense in life. Expenses should be covered by cash flow (income), not by invading capital. It is fair to presume the following when working with those who have found success in life:

- They live on most, if not all, of their income.
- There is no such thing as a discretionary expense.

Reallocating income to pay for care raises the question of how can the client pay for care and keep all his other financial commitments at the same time. Asking income to do both is, in effect, double counting it, which even the most rudimentary of budgeters will realize is impossible.

## Self-Funding is the Default Plan

Consider asking the client if he or his other advisors have ever “run the numbers” on what care would actually cost and what the consequences would be to all his financial plans would be. Position yourself and your presentation to guide clients to this very understanding.

## Consider Assets as “Capital Account”

The client may respond that, nevertheless, he still has enough assets to cover the cost of care. Instead of engaging the client in a debate you are likely to lose, consider changing the terms of engagement. Consider replacing the word “asset” with the words, “capital assets.” The purpose of a capital asset is to generate a stream of income. You can present a credible case that a portfolio is a capital asset.

Here is an illustration:

Capital Asset	Income
\$ 500,000	\$ 25,000 per year
\$ 700,000	\$ 35,000 per year
\$1,000,000	\$ 50,000 per year
3,000,000	\$150,000 per year

That, by the way, is based on three unlikely assumptions:

- The assets earn enough for a consistent 5% withdrawal rate
- 100% of the portfolio is dedicated to generating income
- No taxes are deducted

Which side of the formula are people planning for their future years concerned about: The left (capital) or the right (income generated by the capital)?

The fact is that the client may have enough capital. Rather than argue, we suggest that you remind the client of the portfolio's purpose: To produce income to support lifestyle, growing with inflation, and that cannot be outlived.

The client may be willing to use assets to pay for care, but would he think differently having considered that these are actually capital, and that using capital to pay for care would have serious consequences to the overall plan of generating income for as long as necessary? Here are some things to consider:

- Taxes: Liquidating qualified funds or low-cost-based assets creates unnecessary and potentially serious tax liabilities, reducing income.
- Market conditions: Paying for care may end up actualizing a loss, reducing income.
- Liquidity: Can the client raise enough cash to pay for care, and if so, would assets have to be sold at a loss, reducing income?
- Legacy assets: Would family property have to be sold or, in the alternative, could it continue to be supported?
- Lost investment opportunity: This is a very powerful argument because the client may have told you that paying LTCI premiums would be a lost investment opportunity. You can now use that same logic if capital has to be used to pay for extended care.
- Diminished income: Every dollar used to pay for care is one less dollar available to generate future income.

Reasonable people plan ahead for care and the costs associated with it because they have a lot to lose.

What about those who have many millions of dollars? There are cases to be made for the very affluent, none of which should focus on the following:

- He may run out of money.
- He's not worried.

- “You insure your house and your car don’t you?”

No client—affluent or otherwise—considers these forms of coverage to be optional. They have and always will have homeowners and automobile coverage. Ask the same people, particularly primary earners with no prior experience, what they consider LTC insurance to be and they will likely tell a person that it is optional; they can cover the expense.

Find other areas that are important to them and explore the consequences—personal and financial that would be problematic if they need extended care.

## **Charitable Endeavors are at Risk**

Charitable endeavors are perhaps the most powerful case you can make against self-funding. A 2009 Harvard Business School study, “Feeling Good About Giving”<sup>1</sup> gave three reasons why people make a financial commitment to a charity:

- Purpose in life
- Social injustice
- Selfless giving as a key component to many spiritual and religious belief systems

It is not unreasonable to assume that these commitments are not discretionary. What are the consequences then of self-funding?

- Every \$1.00 used to pay for care is \$1.00 less a charity receives.
- Every \$1.00 used to pay for care deprives the client of a charitable deduction.

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<sup>1</sup> Lalin Anik, Lara B. Akin, Michael I. Norton, and Elizabeth W. Dunn. “Feeling Good About Giving: The Benefits (and Costs) of Self-Interested Charitable Behavior.” Working Paper 10-012. Harvard Business School. 2009. Available at: <http://www.hbs.edu/faculty/Publication%20Files/10-012.pdf>

## **Self-Funding Does Not Eliminate Consequences**

Another case to be presented against self-funding centers on three critical issues:

- What type of professional is going to provide care and how would your family find the individual?
- Where would the care be provided?
- How would care be coordinated over the period of years care might be necessary?

The client may argue that he has the money to address these essential concerns. He or she should be reminded, however, that if care were ever needed, it is because of a physical or cognitive impairment. These concerns would have to be dealt with by the client's spouse (if there is one), who may also be frail, or, more likely, by an adult child or children, forcing them to place their lives on hold. This is compounded by the reality that they would not know where to turn to establish and execute a plan to keep a parent safe. This is exactly what the client wants to avoid.

The answer? Perhaps the most important section of a LTC insurance policy is the Care Coordination Benefit, which was created to address the above concerns. This is explored more fully in Chapter D2, page #219.

## **Nothing is Discretionary to a Successful Client**

"If I need care, I won't have much of a lifestyle anyway. The money I save can be used to pay for my care."

Once again, this client is thinking that extended care is all about him, not about those he loves. A thought about discretionary and nondiscretionary expenses:

People of means do not consider any aspect of their lifestyle to be discretionary. Which of the following lifestyle items would the client or the client's family want to give up?

- A summer or winter second home?
- A membership in a golf club or country club?
- Hobbies?
- Horses?
- Providing for a child who has not made the best decisions in life?
- Assuming some if not all of the cost of educating grandchildren?
- Family vacations?

**EXAMPLE:**

- Michael and Laura are 75.
- They have accumulated \$2 million, of which \$1.5 million is in qualified funds and cash equivalents.
- The investment portfolio generates \$75,000/year.
- Social Security generates another \$40,000/year.
- Besides their own lifestyle, here is how their income is used:
  - Supporting an adult child who is unemployed.
  - Helping pay for their grandchildren's education.
  - Funding Laura's horse.
  - Making a capital commitment to their church.

Michael is diagnosed with Alzheimer's.

The question: What has been allocated from the retirement portfolio to pay for his care for the next eight to ten years?

- A. None of it
- B. All of it.

Answer: B. All of it. Where else can the money come from? When nothing is allocated from the portfolio to pay for care over an extended period of years, all of it becomes available and is at risk. The problem is that those assets were supposed to be allocated to generate income. This is a powerful case to be made not just to clients, but also to their advisors.

Do you begin to see how difficult it would be for your client to keep the above commitments if care was needed? These issues become even more acute if the client has less than \$3 million, because it is even more likely that all of the income generated is committed to support their lifestyle.

## **Putting it all Together**

“Michael, as you know, you and Laura will live on the income generated from the portfolio, plus a small percentage of the principal. When combined with Social Security and your pension [if there is one], it will allow you to cover your commitments in retirement.”

“I understand.”

“And you understand there will likely be little income left over after honoring these commitments?”

“Yes.”

“Here’s the problem: I cannot assure you that if either of you need care over a period of years, there will be sufficient cash flow to keep those commitments and pay for care at the same time.”

## **Conclusion**

What you have done is to clearly set out the serious consequences of using income and/or capital to pay for care by showing that using either or both would disrupt every other plan created to secure financial viability moving into the future.

# Chapter C2:

# Medicare and Health Insurance

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## **The Objection: Medicare (or My Health Insurance) will Pay**

This chapter focuses on Medicare—which is health insurance for Americans over age 65 or those with a qualifying disability. However, the main principles also apply to major medical health insurance for working-age adults:

**Medicare and health insurance do not pay for extended care.**

**They may pay for short-term care, but only if it is skilled or rehabilitative in nature.**

Be prepared for the objection. As you have done with self-funding, solicit what the client thinks will fund the plan, using this statement:

“Now that you understand the plan and agree it is important, the next question is...what do you think will fund it?”

A likely answer may be:

“Medicare will pay for my care.”

or,

“I have excellent health insurance at work, it will pay.”

## **Medicare Benefits**

Medicare is an entitlement program that provides health insurance for people age 65 and older, for people of any age who are Social Security Disability Insurance (SSDI) for two years or who have End Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant. It is administered by the *Centers for Medicare and Medicaid Services (CMS)*, and consists of four different parts:

- Parts A and B, also called Original Medicare
- Part C, also called Medicare Advantage
- Part D, also called the Prescription Drug Program

## **Medicare’s Definition of Care**

Medicare Parts A, B, and C cover skilled and rehabilitative care only.

### Skilled Care

Skilled care is defined as services provided by, or under the supervision of, licensed medical professionals including doctors, nurses, and therapists. It can be performed in a hospital, or in subacute, intermediate care, rehabilitation, or skilled nursing facilities; Medicare-covered skilled care can also be given at home. All care must be administered under an individual plan of care prescribed by a physician.

Outside of acute, inpatient hospitalization, in order to meet Medicare’s skilled care definition, a person must require at least one skilled service as defined by Medicare including, for example: Physical therapy, occupational therapy, respiratory therapy, speech therapy, post-surgical wound management, intravenous therapies, muscular injections on a regular basis, tube feeding, continuous oxygen, treatment of deep skin lesions, suctioning or close monitoring.

## Rehabilitative Care

Medicare's definition of skilled care requires both a skilled service as just noted, and the care must be rehabilitative—recuperative, restorative—in nature. The goal of rehabilitative services is to put the patient back, as much as possible, in the position she was in prior to the medical event which lead to the need for rehabilitation. The services are provided under a plan with ascertainable goals. (Refer back to our basic definitions of an "Acute Impairment" and "Skilled Care" in Section A.)

In the past, Medicare used a strict "progress toward recovery" standard to determine ongoing coverage of rehabilitative services. In other words, as long as the patient was making measureable improvement, Medicare would continue to consider the care as covered skilled care up to any applicable time limits. But if the patient were to stop improving, or to reach a therapeutic "plateau," then any ongoing care would no longer be considered skilled, rehabilitative care, but rather "maintenance" care that Medicare did not consider to be skilled.

This progress toward recovery standard frustrated patients and their families as Medicare-paid services often ended after only a few days or weeks. For example, physical therapy following a surgery or stroke would reach the point where further rehab produced no medical or physical improvement, but the patient remained so impaired she could no longer live alone. Or in some cases, physicians would often say that even though continued therapy would not improve a condition, ending therapy could cause a loss or regression of function, yet Medicare would no longer pay for it. This is where Medicare-covered skilled care changed, by Medicare's own definition, to uncovered custodial, extended care.

As a result of a federal lawsuit, CMS is developing new standards of treatment and payment to allow Medicare to cover some ongoing "maintenance of effort" therapy as skilled, rehabilitative care. How this will impact patients and the Medicare budget is still to be seen. While some patients may now receive Medicare-paid skilled services for longer than in the past, the program remains a health insurance program designed to pay for acute, skilled, rehabilitative services for a limited period of time.

**Medicare and health insurance do not pay for extended care.**

**They may pay for short-term care, but only if it is skilled or rehabilitative in nature.**

## **Why then Discuss Medicare?**

Prior to 1998, the Medicare program was subjected to extensive abuse by providers who, understanding that the program would not pay directly for custodial care, used confusing definitions and payment rules to provide and get paid for services that were primarily custodial in nature. For this and other reasons, some consumers may still believe that Medicare will pay for extended care. It is therefore necessary to be prepared to explain the program in the context of what steps Medicare has taken to end this abuse.

In addition, clients' overall concern about paying for health care in their future has become a critical issue in retirement planning. Understanding what Medicare does and does not cover is a key competency in the extended care planning process.

## **Medicare Part A: Hospital Insurance Program**

A covered worker—a person who has worked and paid Social Security and Medicare taxes—becomes eligible for Part A at age 65. The covered worker may have to pay a premium if, over her lifetime, the worker or the worker's spouse has not accumulated sufficient employment on which Social Security taxes were paid. Employment is measured in credits: one credit is given for each \$1,260 (2016) earned, up to a maximum of four credits per calendar year.<sup>1</sup>

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<sup>1</sup> 42 U.S.C. §1395c, 1395d

## Medicare Part A Premiums

SS/Medicare Credits	2016
40 or more	No premium
30–39	\$ ____/month
Fewer than 30	\$411/month

Although workers may retire at age 62 and qualify for Social Security retirement benefits (albeit reduced), they must still wait to qualify for Medicare Parts A and B at age 65.

Part A benefits include:

- Inpatient hospital care
- Sub-acute, inpatient rehabilitation
- Skilled Nursing Facility (SNF) care
- Medically-necessary home health care
- Hospice care
- Blood

## Inpatient Hospitalization

Medicare Part A covers reasonable charges for semi-private rooms in accredited hospitals. Part A covers only charges billed by the hospital; it does not cover the charges of physicians, surgeons, or anesthesiologists who provide services in the hospital. Those services are covered separately through Part B.

## Part A Benefit Period

Part A measures benefits and applies deductibles and copayments in Benefit Periods. A Benefit Period begins when the patient is admitted to a hospital, and it ends after the patient has been out of the hospital (or SNF following hospitalization) for 60 consecutive days. A patient could have multiple Benefit Periods in the same calendar year or could have the same Benefit Period continue into a new calendar year.

Medicare covers up to 90 days of hospitalization in each Benefit Period. These 90 days reset with each new Benefit Period. There are also 60 Lifetime Reserve Days which can be used if care extends beyond 90 days in any one Benefit Period, but the Lifetime Reserve Days do not reset once used.

For each Benefit Period, the patient is responsible for:

- A deductible of \$1,288 (2016); all charges for the first 60 days are covered by this Benefit Period deductible.
- A copayment of \$322 per day (2016) for days 61–90
- A copayment of \$644 per day (2016) for Lifetime Reserve Days—maximum of 60 days

Many clients who receive services directly under Part A have Medicare Supplement insurance that pays most or all of these out-of-pocket costs.

A new Benefit Period begins after the beneficiary has gone 60 consecutive days without hospital or SNF care.

## The Prospective Payment System (PPS)

Prior to 1983, Medicare paid hospitals based simply on “reasonable costs” for Medicare patients. Essentially, any Medicare patient needing hospital care was able to stay in a hospital until he or she fully recuperated.

Facing near-certain bankruptcy by the early 1980s, Medicare changed its rules on reimbursement to hospitals and adopted a price-tag system of reimbursement—the

Prospective Payment System (PPS). Since 1983 under PPS, hospitals are paid a predetermined rate for inpatient hospital care furnished to Medicare Part A beneficiaries.

The PPS reimbursement rates are based on a *Diagnostic-Related Group (DRG)* system that assigns a flat reimbursement rate to each of hundreds of diagnostic groups. The payment is adjusted for regional differences in health care costs. That is the only amount Medicare pays a hospital for an incidence of that DRG, regardless of the length of stay or amount of care the patient actually needs.

Hospitals are thus under pressure to keep their actual costs of treating Medicare patients under the program's fixed reimbursement level. This is why hospitals are very quick to move patients to "step down" units, a rehab unit or floor, or even discharge them to a Skilled Nursing Facility.

## **Skilled Nursing Facility (SNF) Care**

Medicare Part A covers skilled care provided in a nursing home which Medicare calls a Skilled Nursing Facility (SNF). The full cost of such care is covered for only the first 20 days.

A daily deductible of \$161 (2016) is applied for care received from the 21st to the 100th day. Medicare SNF coverage ceases after 100 days in any Benefit Period.

Many people assume that Medicare will pay for care, at least in part, for all 100 days. That is not always true. All of the following conditions must be met to qualify for Medicare-paid SNF care:

1. The patient must receive inpatient hospital care for at least three nights—or three, full 24-hour days.

(In 2013 a new explanation of the inpatient hospitalization rule was made: Time spent in observation status or in the emergency room, or in lieu of

inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay.)<sup>2</sup>

2. The patient must enter a SNF within 30 days of that hospital stay.
3. The patient must enter the SNF for the same medical reason that required the qualifying hospital stay.
4. The care must be skilled, defined as "...services so inherently complex that they can be safely and effectively performed only by, or under the supervision of, technical or professional personnel..."
5. The patient must be receiving daily rehabilitative care under a medical plan of care with ascertainable goals.

The full entitlement to 100 SNF benefit days is renewed each time the individual begins a new Benefit Period. A new Benefit Period begins after the beneficiary has gone 60 consecutive days without hospital or SNF care.

#### Fee-for-Service versus Flat Fee

Prior to July 1, 1998, SNF care was paid on a fee-for-service basis. The SNF simply billed Medicare for its services, and Medicare in turn paid the bill. The average Medicare-funded stay in a SNF was approximately 50 days. Because of this arrangement, Medicare believed it was being billed for extra days that effectively amounted to custodial services, which did not meet Medicare's definition of skilled care.

As it had done earlier with hospitals, Medicare, effective January 1, 1998, under authority of the *Balanced Budget Act of 1997 (BBA '97)*, switched SNFs to a flat-fee payment system.

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<sup>2</sup> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>

Skilled Nursing Facility reimbursement is now based on a Prospective Payment System (PPS) like that used for hospitals. The SNF PPS flat fee is based not on diagnosis but on *Resource Utilization Groups Version III (RUGs)*, an assessment system similar to DRGs that categorizes beneficiaries into several dozen different groups according to the type and intensity of rehabilitative services Medicare determines they need. These revisions have the direct effect of determining not only how much a facility is paid, but whether the services will be covered at all.

Like a hospital, if a SNF can provide the care for less than the flat fee amount paid by Medicare, it keeps the difference. If not, it absorbs the loss.

After this change in 1998, the average SNF rehabilitation charge per hospital stay dropped by 44.6%, from \$421 in 1997 to \$233 in 2000. The timing of this drop corresponds precisely with the phasing in of the new rules on reimbursement.<sup>3</sup>

The average Medicare-funded stay in a SNF is now approximately 21 days.

## **Home Health Care**

Medicare Parts A or B cover home health services, which include limited, reasonable, and only medically necessary, skilled part-time care and services such as nursing care, physical, occupational and other skilled therapies, home health aide services, speech language pathology and medical social services. It also includes certain home-use medical equipment (wheelchairs, hospital beds, walkers, oxygen), and other medical supplies. See Part B for Medicare home health eligibility details.

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<sup>3</sup> Chapin White: "Rehabilitation Therapy In Skilled Nursing Facilities: Effects Of Medicare's New Prospective Payment." *Health Affairs* 22, no. 3 (2003) <http://content.healthaffairs.org/content/22/3/214.full>

## **Medicare Part B: Medical Insurance**

Medicare Part B is a voluntary program that Medicare beneficiaries must opt into and pay for usually at the same time they become eligible for Part A. Some individuals who are still actively working and who are covered by a "large group" employer health care plan may defer Part B without penalty. The question of who may and may not properly postpone Part B enrollment at age 65 is complex and should be addressed by an experienced benefits professional.

Beneficiaries who decline Part B coverage when they first become eligible may enroll later, but at a higher premium, unless the reason for the delay was continued employment with qualified large-group employer-sponsored health insurance. Employer-paid retiree health coverage does not qualify for a waiver of the Part B delayed enrollment penalty. The penalty is 10% per year of improper enrollment delay; the premium penalty is permanent.

Premiums for Part B coverage, which are now adjusted based on income, are typically deducted from the beneficiary's monthly Social Security retirement income check. If the beneficiary does not receive Social Security, Part B premiums are directly billed. In 2016, the Part B premiums (without the penalty for delayed enrollment) are:

### Medicare Part B Monthly Premium by Income

The standard Part B premium amount in 2016 is \$121.80 (or higher depending on your income). However, most people who get Social Security benefits will continue to pay the same Part B premium amount as they paid in 2015 (standard amount \$104.90/month). This is because there was not a cost-of-living increase for 2016 Social Security benefits. Beneficiaries are subject to the increased Part B premiums if:

- You enroll in Part B for the first time in 2016.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.

- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of \$121.80.)
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount.

If you're in one of these five groups, here's what you'll pay in 2016:

<b>Single Income</b>	<b>Married Filing Jointly</b>	<b>Monthly Premium (2016)</b>
\$85,000 or less	\$170,000 or less	\$121.80
\$85,001–\$107,000	\$170,000–\$214,000	\$170.50
\$107,001–\$160,000	\$214,001–\$320,000	\$243.60
\$160,001–\$214,000	\$320,001–\$428,000	\$316.70
Above \$214,000	Above \$428,000	\$389.80

Part B benefits (subject to deductible and coinsurance limits) include:

- Physician services
- Outpatient hospital care
- Home care services not covered by Part A
- Surgical services and supplies
- Physical and speech therapy
- Ambulance trips
- Diagnostic tests
- Durable medical equipment
- Prosthetic devices

- Blood

## The Part B Annual Deductible and Coinsurance

Service	Patient's Responsibility
Physicians' services	\$166 deductible (2016) + 20% of the Medicare-approved amount
Outpatient mental health services	45% of the Medicare-approved amount after deductible
Durable medical equipment	20% of the Medicare-approved amount
Blood	First 3 pints covered + deductible + 20% of any additional Medicare-approved amount

The \$166 (2016) deductible applies only once per year for all Part B services received.

## Medicare Payment of Home Health Care Costs

Home health care under either Part A or B is covered when it is limited, reasonable, and medically necessary, part-time skilled care. This includes services such as skilled nursing care, physical, occupational and other skilled therapies, home health aide services, speech language pathology and medical social services. It also includes certain home-use medical equipment (wheelchairs, hospital beds, walkers, oxygen), and other medical supplies.

Home health care services are reimbursed on four conditions:<sup>4</sup>

1. A physician must decide that skilled medical care at home is needed and make a plan for that care to be given at home.

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<sup>4</sup> 42 U.S.C. §1395(a)(2)(C)

2. The patient must need intermittent (less than daily) skilled nursing care, physical therapy, speech/language therapy, occupational or other skilled therapy.
3. The home health agency caring for the patient must be approved by the Medicare program (be "Medicare-certified").
4. The patient must be homebound, or normally unable to leave home without help. To be homebound means that leaving home takes considerable and taxing effort. A patient can be homebound and still leave home for medical treatment or short, infrequent absences for non-medical reasons, such as trips to a barber or church. Using adult day care does not keep one from getting Medicare-paid home health care.

If eligible, Medicare covers the following services on a part-time, intermittent basis:<sup>5</sup>

- Nursing care provided by, or under the supervision of, a registered professional nurse; e.g., wound care
- Physical, occupational, speech or other approved skilled therapies
- Medical social services under the direction of a physician
- Services of a personal-care attendant (home health aide); e.g., a bathing and dressing visit, but only while qualified for skilled care noted above
- Durable medical equipment acquired for at-home use, after a 20% copayment

Medicare does not cover the following:

- Custodial care "shifts" for on-going assistance with ADLs or cognitive supervision
- 24-hour-a-day care at home

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<sup>5</sup> U.S.C. §1395x(m)(1)-(4)

- Meals delivered to the home
- Homemaker services
- Custodial care

Note that Medicare does not require a prior hospitalization in order to receive home health care, although Medicare-paid home health care often follows discharge from a hospital or SNF. The 100-day SNF maximum also does not apply to home health care.

### Fee-for-Service versus Flat Fee

Prior to January 1, 1998, both Parts A and B covered what amounted to an unlimited number of home health care visits, without coinsurance or deductible requirements.<sup>6</sup> Providing services for extended periods of time was possible because providers were paid on a fee-for-service basis.

As with SNFs, this ended on January 1, 1998 when, in accordance with the Balanced Budget Act (BBA) of 1997, Medicare started reimbursing home health care agencies on a flat-fee basis. The impact was immediate, with many home health providers going out of business or filing for reorganization.

Home health care (HHC) providers now receive a flat-fee, prospective payment for care based on a predetermined set of diagnostic and rehabilitation criteria similar to the SNF *Resource Utilization Groups (RUGs)*. There is no financial incentive to provide any more care than is necessary for effective rehabilitation. After 1998, the average number of Medicare-paid home health care days dropped from 111 to 55 for for-profit providers (55% decrease) and from 60 to 44 for not-for-profit providers (a 27% decrease).<sup>7</sup>

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<sup>6</sup> Medicare Part A Intermediary Manual and Part B Carrier Manual.

<sup>7</sup> Rachel L. Murkofsky, Russell S. Phillips, Ellen P. McCarthy, Roger B. Davis, Mary Beth Hamel: "Length of Stay in Home Care Before and After the 1997 Balanced Budget Act", *JAMA* vol. 289, no. 21 (2003) <http://jama.ama-assn.org/content/289/21/2841.full>

While technically, Medicare-paid home health care days are still unlimited, the Prospective Payment System practically limits benefits to only a couple of months.

“Do you know what will fund the plan we discussed to keep you in the community?”

“Medicare will.”

“No, it won’t.”

“But it paid for my father-in-law for more than year.”

“When was that?”

You can then reference the limitations brought about by the *Balanced Budget Act of 1997*. It is usually all you need to overcome the objection.

## **Medicare Supplement (Medigap) Insurance**

Medicare Supplement or Medigap insurance is private insurance that, as its name suggests, covers “gaps” in Original Medicare coverage. Medigap is standardized into plans designated by letters in all but three states (MA, MN, WI), which use their own standardization.<sup>8</sup>

Although privately offered, it is highly regulated by the federal government. For example, each Medigap plan; e.g., “Plan F” must cover the same items no matter which insurance company writes it. Medigap is separate from and does not coordinate with Medicare Advantage,<sup>9</sup> the Medicare Prescription Drug Program,<sup>10</sup> nor tax-free Medicare Medical Savings Accounts (MSAs).<sup>11</sup>

Like the Medicare program itself, Medigap policies do not pay for long-term custodial care.

## **Part C: Medicare Advantage**

Medicare offers beneficiaries the option of receiving coverage completely through private health care plans instead of Original Medicare’s system of deductibles and copays already discussed. Known as Medicare Part C or Medicare Advantage, (originally called “Medicare+Choice”) this is an attempt by the government to save money by moving beneficiaries from a fee-for-service system to a managed care system by using the expertise and administration of private insurance companies to control costs.

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<sup>8</sup> <http://www.medicare.gov/supplement-other-insurance/compare-medigap/com-pare-medigap.html>

<sup>9</sup> <http://www.medicare.gov/supplement-other-insurance/medigap/medigap-and-medicare-advantage/medigap-and-medicare-advantage-plans.html>

<sup>10</sup> <http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html>

<sup>11</sup> Ibid.

For every person who signs up for a Medicare Advantage plan, Medicare pays the private insurance company a set of flat fees to cover the cost of that beneficiary's care. To enroll in a Medicare Advantage plan, a beneficiary must be enrolled in Parts A and B, and must continue to pay the Part B premium. Medicare then passes through to the Medicare Advantage plan the monthly Part B premium, and a geographically-adjusted annual payment that represents an average cost per person for Part A benefits. This system is called "capitation."

Medicare Advantage plans have an incentive to enroll as many people as possible in order to collect enough capitated income and spread the cost of care among healthier, low-usage beneficiaries and sicker, high-usage beneficiaries. The insurance provider, in turn, makes money by promoting preventive care, negotiating discounts with health care providers, and controlling expenses just like it does in a traditional private-sector health insurance plan.

Medicare Advantage is not technically Medicare Supplement insurance.

The insured is offered a variety of plans to best suit his health needs and may cover more services than Original Medicare; for example, many Medicare Advantage plans cover preventive care, wellness visits, podiatry, routine optometry, and eyeglasses. Most Medicare Advantage plans include qualified Part D prescription drug benefits. Medicare Advantage plans may have no monthly premium, or a very modest premium that is usually significantly less than the monthly cost of a traditional Medicare Supplement. But like Original Medicare and Medicare Supplements, there is no coverage for long-term custodial care.

## **Types of Medicare Advantage Plans<sup>12</sup>**

Common types of plans available:

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<sup>12</sup> <http://www.medicare.gov/supplement-other-insurance/compare-medigap/com-pare-medigap.html>

- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Private Fee-for-Service Plans (PFFS plans)
- Medicare special needs plans (SNPs)

### Health Maintenance Organizations (HMOs)

Although HMOs are required to provide the full range of medical benefits offered by fee-for-service Parts A and B, they do so through a pre-arranged network of providers with strict referrals required to see specialists. An HMO appeals to cost-conscious individuals who like the additional benefits, such as prescription eyeglasses and preventive services. Some HMOs charge a modest monthly fee in addition to the Medicare premiums.

### Preferred Provider Organizations (PPO)

PPOs differ from HMOs in two key ways: Medicare PPOs cover some of the costs of care received outside of their network of physicians and hospitals. Medicare PPOs generally do not require that the subscriber see a primary care physician and receive a referral before consulting a specialist.

Regional PPOs became available under Medicare in 2006. These plans are similar to local Medicare PPOs, but serve a larger geographic area (either a single state or a multistate area), and must offer the same premiums, benefits and cost-sharing requirements to all beneficiaries in the region.

Regional Medicare PPOs offer all Medicare benefits, including the prescription drug benefit; however, unlike traditional Medicare, these plans have a single deductible for hospital and physician services and an annual out-of-pocket limit on cost sharing for benefits covered under Medicare Parts A and B. That limit varies from plan to plan. As with local PPOs, individuals who sign up for a regional PPO will typically pay more if they go to providers outside of the network.

### Private Fee-for-Service Plans

Private fee-for-service plans cover Medicare benefits such as hospitals and physicians' services, much like Medicare HMOs and PPOs. Unlike Medicare HMOs and PPOs, private fee-for-service plans do not have a formal network of doctors and hospitals. Still, not all doctors and hospitals are willing to treat members of a private fee-for-service plan.

Private fee-for-service plans are not required to offer the Medicare drug benefit, but many do. A beneficiary who enrolls in a private fee-for-service plan without drug coverage may also enroll in a stand-alone Medicare Prescription Drug Plan (PDP). Because private fee-for-service plans offer greater flexibility, they require greater out-of-pocket cost-sharing from the beneficiary than Medicare HMOs and PPOs.

### Medicare Special Needs Plan (SNPs)

Medicare Special Needs Plans (SNPs) are usually HMOs or PPOs available to eligible individuals with serious and disabling health conditions caused by chronic diseases. Some examples of chronic diseases include auto-immune disease, end-stage liver disease, neurological disorders, heart failure, stroke, diabetes and dementia. Institutional SNPs may be available for individuals who live in a nursing home or need a nurse at home. Dual Eligible SNPs may be available to someone eligible for both Medicare and Medicaid.

## **Part D: Medicare Prescription Drug Program**

From January 1, 2006, Medicare beneficiaries, regardless of income, health status, or prescription drug usage, have had access to prescription drug coverage. Medicare contracts with private companies, which offer a variety of coverage options; the more benefits, the higher the cost. Medicare Prescription Drug Plans (PDP) are voluntary and can be offered on a stand-alone basis, or included with a Medicare Advantage plan.

Part D is guaranteed-issue, but if the beneficiary does not enroll within a prescribed period after reaching 65, the beneficiary is penalized 1% per month times the

average monthly national premium until he or she does enroll and pays the higher amount thereafter.

In general, Part D works as follows<sup>13</sup>: An enrollee pays a monthly premium in addition to any premium for Medicare Part A and Part B (Part D benefits may also be included without additional charge in a Medicare Advantage plan).

While most plans offer a per-drug copay “formulary” for generic and name-brand drugs and may or may not have a deductible, the ultimate benefit for beneficiaries must follow the following broad formula for what a beneficiary pays out-of-pocket:

A deductible: The first \$360 (2016) per year for prescriptions. (Some plans do not impose a deductible)

After the \$360 yearly deductible, the participant pays:

- 25% of yearly drug costs from \$360 to \$3,310 (2016)
  - The plan pays the remaining 75% of the costs.

Once you have spent the equivalent of \$3,310 (2016) on covered drugs, benefits are limited (this is the so-called “doughnut hole”). Originally beneficiaries paid 100% of their drug costs in the donut hole, but because of the Affordable Care Act (ACA) the “donut hole” is slowly closing. In 2016 beneficiaries will pay:

- 58% for generic drugs
  - The plan pays 42%.
- 95% for brand-name drugs
  - The plan pays 5%.

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13 Source: <http://www.medicare.gov> ; For more information see: <https://www.medicare.gov/Pubs/pdf/10050.pdf>.

- Drug manufacturers must offer a 50% discount to Part D enrollees in the “donut hole.” This reduces a beneficiary’s effective OOP cost for brand-name drugs to 45% co-insurance. (2016)

The “donut hole” will be eliminated by 2020.

After total drug costs have reached \$4,850 (2016)—the “Out-of-pocket Threshold”, then “catastrophic” coverage applies. At this point, a beneficiary pays 5% and the plan generally pays 95% of further drug bills for the remainder of the calendar year.

### **Qualified Medicare Beneficiary (QMB)**

Low-income beneficiaries are entitled to use Medicare Part A and Part B free of charge for the premiums, deductibles, and coinsurance. The federal government mandates that states pay such beneficiaries’ out-of-pocket costs from their Medicaid programs. The *Qualified Medicare Beneficiary (QMB)* program is open to individuals with minimal assets and income as determined by each state.



# Chapter C3:

## Veterans Benefits

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Veterans' benefits are administered by The Department of Veterans Affairs—formerly the Veterans Administration (VA).

The next objection you may encounter is the VA. As we have done with other objections (self-funding and Medicare), we will solicit what the client thinks will fund the plan:

“Now that you understand the plan and agree it is important, the next question is ... what do you think will fund it?”

The answer from those who served in the military could be:

“I'm a vet. The VA will pay for my care.”

### **VA Extended Care Services**

The VA does offer veterans some extended-care services in some locations. However, access is not universal. Most long-term services (those expected to continue beyond 180 days) are available only to veterans who either have severe service-connected disabilities or pass strict means tests on their and their spouses' income and assets. Most services are also subject to copayment based on means, up to \$97 or more per day. The copayment also depends on the service provided and on the veteran's VHA Priority Group. Services are often not available everywhere, have long waiting lists, or are otherwise difficult to get into. In sum, they are usually not relevant to any client

who was not severely disabled in the line of duty and whose goal is to avoid becoming impoverished if care is needed.

## **Home-Based Primary Care (HBPC)**

The VA's highly regarded Home-Based Primary Care (HBPC) program is "a home care program that specifically targets individuals with complex chronic disabling disease, with the goal of maximizing the independence of the patient and reducing preventable emergency room visits and hospitalizations. HBPC programs provide comprehensive longitudinal primary care by an interdisciplinary team in the homes of veterans with complex chronic disease, who are not effectively managed by routine clinic-based care. HBPC is very different from and complementary to standard skilled home care services in population, processes and outcomes. HBPC targets persons with advanced chronic disease, rather than remediable conditions."<sup>1</sup>

This program is widely commended for improving outcomes while reducing costs, and is suggested as an example for Medicaid to emulate. Last year it dropped its copayment requirements<sup>2</sup> and is now available through three-quarters (116 of 152) of VA hospitals.<sup>3</sup>

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<sup>1</sup> L. Beales, T. Edes, "Veteran's Affairs Home Based Primary Care," *Clin Geriatr Med*.

2009 Feb;25(1):149-54. The authors were VA employees at the time of publication.

Abstract: <http://www.ncbi.nlm.nih.gov/pubmed/19217499>

<sup>2</sup> Partnership for Quality Home Healthcare. "Veterans Affairs Eliminates Copayment to Increase Patient Access to Skilled Home Healthcare." May 7, 2012.

<http://www.homehealth4america.org/media-center/52>

<sup>3</sup>E. Egan, *VA Home Based Primary Care Program: A Primer and Lessons for Medicare*. American Action Forum. November 1, 2012

[.http://americanactionforum.org/sites/default/files/VA%20HBPC%20Primer%20](http://americanactionforum.org/sites/default/files/VA%20HBPC%20Primer%20)

Nonetheless, in practice, the program is poorly accessible to veterans who need extended care. It currently serves just 12,000 of the almost nine million people enrolled in the VA health care system.<sup>4</sup> Although it does not impose Medicare's requirement that the patient be homebound, it is dwarfed by the 3.5 million patients who receive Medicare-funded home health care even with Medicare's restrictions.<sup>5</sup>

HBPC's other requirements:

- A complex, chronic disabling disease that necessitates care by an interdisciplinary team
- High risk for recurrent hospitalization or nursing home placement
- Determination by the HBPC team that the home is the most appropriate venue for care<sup>6</sup>
- By design, its "participants are among the sickest in the VA health system, with an average of 19 clinical diagnoses and 15 medications."<sup>7</sup>

A patient who simply needs assistance with ADLs or is cognitively impaired stands little chance of being admitted to the program.

## **Nursing Home Services**

The VA offers three types of nursing homes to extended-care patients:

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<sup>4</sup>Ibid.

<sup>5</sup> Partnership for Quality Home Healthcare. "New Analysis of VA Home Based Primary Care Program Offers Lessons to Medicare for Reducing Costs, Improving Patient Care." November 2, 2012. <http://www.homehealth4america.org/media-center/89>

<sup>6</sup> Home Based Primary Care (HBPC). <http://www.benefits.gov/benefits/benefit-details/302>

<sup>7</sup> E. Egan, *VA Home Based Primary Care Program: A Primer and Lessons for Medicare*. American Action Forum. November 1, 2012. <http://americanactionforum.org/sites/default/files/VA%20HBPC%20Primer%20FINAL.pdf>

1. VA Community Living Centers (formerly termed "VA nursing homes")
  - Stays beyond 90 days are typically available only to veterans rated at least 70% disabled or 60% disabled and unemployable.
  - Patients whose disabilities are not service-connected must pass admission means tests on assets and income.<sup>8</sup>
  - Patients without severe disabilities are accommodated as space and resources permit, with priority given to veterans with service-connected disabilities and those who need post-acute-care rehabilitation.<sup>9</sup> Copayment is required based on means.<sup>10</sup>
2. Community Nursing Homes, operated for the VA under contract
  - Same terms as Community Living Centers
3. State Veterans Homes, which are operated by each state and receive partial VA funding
  - Admission criteria vary by state;<sup>11</sup>the VA will not pay for veterans' non-veteran spouses and parents even if the state does.
  - Means-tested admission<sup>12</sup>; standards vary by state. Copayment based on means; standards vary by state. Long waits of weeks or months for admission are typical; sometimes more for Alzheimer's units.<sup>13</sup>

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<sup>8</sup> "Nursing Homes for Veterans." February 26, 2009. "Planning for Eldercare" Articles. <http://www.longtermcarelink.net/article-2009-2-26.htm#>

<sup>9</sup> Ibid.

<sup>10</sup> Application for Extended Care Benefits (VA Form 10-10EC). <http://www.va.gov/vaforms/medical/pdf/vha-10-10EC-fill.pdf>

<sup>11</sup>. Geriatrics and Extended Care. U.S. Department of Veterans Affairs [http://www.va.gov/geriatrics/guide/longtermcare/state\\_veterans\\_homes.asp](http://www.va.gov/geriatrics/guide/longtermcare/state_veterans_homes.asp)

- Availability varies substantially by geographic area.

The best source for determining what assistance is available for VA health-care services is the social work department at the local VA facility.<sup>14</sup>

### Adult Day Health Care

Adult Day Health Care (ADHC) is similar to other adult day care programs, providing skilled services, case management, and assistance with ADLs or instrumental activities of daily living (for example, preparing meals and taking medicines). It is for veterans who need such services, are isolated, or whose caregiver is experiencing burden. ADHC may be provided at VA medical centers, state Veterans Homes, or community organizations.<sup>15</sup>

As part of the *VHA Standard Medical Benefits Package*, ADHC does not means-test to determine admission, but it does require a copay based on means and is not available everywhere. Admission is based on clinical need.

### Hospice and Palliative Care

Hospice is a comfort-based form of care for veterans who have a terminal condition with six months or less to live. Palliative care is a form of treatment that emphasizes comfort care but does not require the veteran have a terminal condition. These services are available to those who meet the clinical need, without means-testing or copayment.

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<sup>12</sup> "Nursing Homes for Veterans." February 26, 2009. "Planning for Eldercare" Articles. <http://www.longtermcarelink.net/article-2009-2-26.htm#>

<sup>13</sup> Ibid.

<sup>14</sup> Facility search: [http://www2.va.gov/directory/guide/division\\_flesh.asp?dnum=1](http://www2.va.gov/directory/guide/division_flesh.asp?dnum=1)

<sup>15</sup> Geriatrics and Extended Care. U.S. Department of Veterans Affairs. [http://www.va.gov/GERIATRICS/Guide/LongTermCare/Adult\\_Day\\_Health\\_Care.asp#](http://www.va.gov/GERIATRICS/Guide/LongTermCare/Adult_Day_Health_Care.asp#)

### Domiciliary Care Program

VA provides custodial care at home under the *Domiciliary Care Program*. The primary funding mechanism is the *Aid and Attendance Pension* (A&A, also known as the Enhanced Pension, Improved Pension or Special Pension), available to those veterans who do not have service-related disabilities and have limited means.

## **Aid and Attendance Pension**

The *Aid and Attendance Pension* (A&A) program is for veterans who meet strict service, income, and asset criteria (see below).<sup>16</sup> The program offers modest compensation for veterans over 65 and/or surviving spouses who require the regular attendance of another person to assist in performing ADLs, and have a substantial cognitive impairment or another qualifying disability. The applicant's physician must confirm that his physical or cognitive condition has deteriorated to the point that the applicant requires daily assistance from others.

A&A is a pension benefit, offered independently of any service-related injuries. If all requirements are met, the VA determines eligibility by examining the veteran's or surviving spouse's total household income excluding unreimbursed medical expenses. If the remaining income amount falls below the annual income threshold for the benefit, VA pays the difference between the claimant's household income and the A&A threshold.

### Service Criteria

The veteran must have been on active duty (not necessarily "in theatre") for at least one day during the official periods of war including:

- World War II (Dec. 7th, 1941–Dec. 31, 1946)

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<sup>16</sup> VeteranAid.org. <http://www.veteranaid.org/index.php>

- Korean War (June 27, 1950–Jan. 31, 1955)
- Vietnam War (“in country” before Aug. 5, 1964 and/or Aug. 5, 1964–May 7, 1975)
- Gulf War/Mideast Conflicts (Aug. 2, 1990 to a date to be determined) and served at least 90 days of total active duty

The eligible arms of service are Army, Navy, Air Force, Marines, Coast Guard and for World War II oceangoing Merchant Marine civil-service crew. The veteran must have been discharged under honorable conditions to be eligible.

### Financial Criteria

#### ASSETS

As a general rule household assets cannot exceed \$80,000. But there is no specific test in the regulations. Veterans Service Representatives in the regional office are required to file paperwork justifying their decision if they allow assets greater than \$80,000. Thus this amount has become a traditional ceiling. Concerning the asset test, the service representative is encouraged to analyze the veteran’s household needs for maintenance and weigh those needs against assets that can be readily converted to cash and whether the income from that cash will cover the difference in the household income and the cost of medical care over the care recipients remaining life span.

In the end, the decision regarding allowable assets is a subjective one made by a service representative. In certain cases a benefit award could be denied unless assets are below \$20,000 or even \$10,000.

A personal residence, a reasonable amount of land on which it sits, personal property and automobiles for personal use are exempted from the asset test. There is currently no “look-back” or “penalty” for transferring assets out of the veteran’s name in an attempt to qualify, though this is being actively discussed.

## INCOME

The household income of the veteran or the surviving spouse cannot exceed the *Maximum Allowable Pension Rate (MAPR)* for that category of application. As an example, using rates for 2016, a husband and spouse with no medical rating cannot have a combined income of more than \$1,381 a month or \$16,569 a year from all sources. As another example, a single surviving spouse with an A&A medical rating cannot make more than \$1,130 a month or \$13,562 a year from all sources.

The household income can be reduced to meet the income test under certain special conditions. Households earning \$2,000 to \$6,000 a month or more might still qualify even though their income does not meet the income test.

### Benefit

A&A benefits are paid tax-free. They increase with inflation but have increased by only one or two percent in total since 2008. The maximum benefit in 2016 is:

- Up to \$21,466 for an unmarried veteran
- Up to \$25,488 for a married veteran or a veteran with one dependent
- Up to \$13,794 for a surviving spouse

## **Homemaker and Home Health Aide Services**

The VA provides Homemaker and Home Health Aide services under contract, but again with strict limitations:

The patient must need assistance with at least three ADLs, or have significant cognitive impairment, or have a more complex combination of conditions.<sup>17</sup>

Patients with at least 50% or service-connected disability receive priority.<sup>18</sup>

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<sup>17</sup> Homemaker/Home Health Aide. PN Online. August 2010.  
[http://pvamag.com/pn/article/3813/homemaker\\_home\\_health\\_aide](http://pvamag.com/pn/article/3813/homemaker_home_health_aide)

Continued need for services is evaluated every six months for first year and annually thereafter.<sup>19</sup> There is means testing at acceptance.<sup>20</sup> Co-payment is based on means.<sup>21</sup> This program not available everywhere

## **TriCare**

*TriCare* is VA-administered health insurance for active and retired military personnel. Like the CHAMPUS (Civilian Health and Medical Program of the Uniformed Service) program it has replaced, it pays for medical necessities. Like a conventional health insurance program, it provides no coverage for extended care—except for short periods after acute illness. There are multiple TriCare programs.

### TriCare Standard

TriCare Standard is the traditional CHAMPUS program. It is available to active duty personnel, retirees from active-duty service, retirees from the National Guard and Reserve of age 60 or older, and eligible family members.

#### **ADVANTAGES**

- Broad choice of providers widely available services
- No enrollment fee

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<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> Geriatrics and Extended Care. U.S. Department of Veterans Affairs.  
[http://www.va.gov/GERIATRICS/Guide/LongTermCare/Homemaker\\_and\\_Home\\_Health\\_Aide\\_Care.asp#](http://www.va.gov/GERIATRICS/Guide/LongTermCare/Homemaker_and_Home_Health_Aide_Care.asp#)

[Health\\_Aide\\_Care.asp#](http://www.va.gov/GERIATRICS/Guide/LongTermCare/Homemaker_and_Home_Health_Aide_Care.asp#)

<sup>21</sup> Ibid.

## DISADVANTAGES

- Deductibles and coinsurance
- No primary care manager

## TriCare Extra

Anyone eligible for TriCare Standard is also eligible for TriCare Extra, a PPO-style program.

## ADVANTAGES

- Copayment 5% less than TriCare Standard
- No balance billing
- No enrollment fee
- No deductibles when using retail pharmacy network
- No forms to file

## DISADVANTAGES

- Deductibles and coinsurance
- Limited provider choice
- Services not universally available
- No primary care manager

## TriCare Prime

All active duty personnel are enrolled in TriCare Prime. Family members and survivors of active duty personnel as well as retirees and their family members and survivors under 65 are eligible. TriCare Prime is an HMO-style program. Most services are furnished at military treatment facilities augmented by a TriCare contractor's preferred provider network.

## ADVANTAGES

- No enrollment fee for active duty personnel

- Lower copayments and no deductibles
- Option of choosing a point of service that covers treatment outside the preferred provider network
- Primary care manager who follows a patient's case and refers him to specialists

#### DISADVANTAGE

- Requires referrals and authorizations for specialist care
- Copayments, although small

#### TriCare Reserve Select

TriCare Reserve Select offers benefits similar to TriCare Standard and Extra to members of the Selected Reserve part of the National Guard and Reserve (generally, those in drill pay, also known as paid, status who are not federal civil service employees) and their families. It is also available to retirees from such service who have reached age 60 and their families. It is a premium-based plan, but the Department of Defense shares the cost.

#### TriCare Reserve Retired

TriCare Reserve Retired offers benefits similar to TriCare Reserve Select to retired National Guard and Reserve personnel under age 60 and their families. The premiums are higher than in TriCare Reserve Select because the Department of Defense does not share the cost.

#### TriCare for Life

TriCare for Life provides expanded medical coverage for uniformed-service beneficiaries who have reached age 65, are Medicare-eligible and have purchased Medicare Part B.

## ADVANTAGES

- Medicare-eligible family members, widows/widowers, certain former spouses, and beneficiaries under age 65 entitled to Medicare Part A because of a disability or chronic renal diseases are also eligible.
- Beneficiaries do not need Medicare supplement insurance.

## DISADVANTAGES

- It does not cover long-term care, custodial care.

### **NONE of the TriCare Plans Cover Extended Care**

Conclusion: Coverage, or lack thereof, is best summed up in a statement made by the Office of Personnel Management:

"Most health insurance programs, including the Federal Employee Health Benefit (FEHB) program, TriCare and TriCare for Life provide little or no coverage for long-term care. This is why the U.S. Office of Personnel Management sponsors a LTCI program for members of the federal family. Long-term care insurance can be a smart way to protect your assets and remain financially independent, should you need extended care services."<sup>22</sup>

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<sup>22</sup> The Federal Long Term Care Insurance Program. <https://www.ltcfeds.com/index.html>

# Chapter C4:

## Medicaid

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The last objection may be Medicaid. As you have done with self-funding, Medicare and the VA, you solicit what the client thinks will fund the plan you have created to protect his or her family:

“Now that you understand the plan and agree it is important, the next question is ... what do you think will fund it?”

One of the most common objections is:

“Medicaid will pay for my care.”

or

“I’ll just give all my money away, wait out the penalties and let the state take care of me.”

Remember the two goals of an extended care plan: First, to allow the client to remain safe at home while preserving the emotional and physical wellbeing of those the client loves; second, to allow the client to keep financial commitments. You will quickly notice that Medicaid cannot be a viable funding source for that plan for two reasons:

1. Medicaid is not a viable funding source to pay for care in the community.

2. Medicaid is not free.

## **Objection: Medicaid**

Perhaps no other objection to the purchase of LTCI has caused insurance producers to respond more inappropriately than has Medicaid. To malign this program for the express purpose of selling LTC insurance is counterproductive, particularly when the client has been told by an attorney that he or she can get benefits essentially free of charge. It is also not in your interest—and untrue—to be derogatory of nursing homes that accept Medicaid. Regardless of what you have been told, here are some facts:

There is no difference between a facility that takes Medicaid and one that does not. If a nursing home has an inferior reputation, it does so whether it takes Medicaid or not. If you doubt this statement, think of skilled nursing facilities (SNFs) run by the religious and fraternal organizations. They are universally thought of as providing first-rate care. Nearly every one of them takes Medicaid.

Nursing homes rarely discriminate. Statistically, 90% of permanent placements started as referrals from hospitals for skilled or rehabilitative care. SNFs do not ask hospitals for financials from those referred because it is illegal and impractical—they would not get many referrals. The flat fees paid by insurers put pressure on hospitals to discharge patients as quickly as possible. SNFs are interested in taking these patients because, while they lose money on Medicaid, they make up the difference with Medicare skilled rehab and private pay. There are far more SNFs than hospitals, so if SNFs conditioned acceptance on financial viability, few hospitals would send them patients.

As we will demonstrate, when Medicaid is explained correctly, it ceases to appear as competition to LTC insurance, and actually helps you sell the product.

## Medicaid Overview

Medicaid, like Medicare, is primarily a health insurance program. And because of their similarity of names and common history, Medicaid is often confused with Medicare. Their roles in funding extended care, however, are quite different:

## Medicare versus Medicaid

Medicare	Medicaid
Is a health insurance program	Is a health insurance program
Pays for skilled and rehabilitative care	Pays for skilled and rehabilitative care
Is an entitlement program	Is means-tested
Is funded by the federal government	Is jointly funded by the state and federal governments
Is managed by the federal government	Is managed by the state government
Does not cover custodial care	Covers custodial care but primarily only in SNFs

## The HCBS and PACE Waiver Programs

Medicaid can pay for care in the community—services at home, adult day care and assisted living—under a federal waiver program for which states may apply called a *Home & Community Based Services (HCBS) waiver*.

For those 55 or older, there is the HCBS waiver program called *Program of All Inclusive Care for the Elderly (PACE)*. At first glance then, it appears that Medicaid would be a formidable competitor. A close look proves just the opposite.

The criteria for eligibility include:

Assets: generally, under \$2,000.

Income: generally, countable income under \$2,134 per month in 2015.<sup>1</sup>

Your client can likely qualify for the first criterion by giving assets away. The question is, what kind of assets are being gifted?

If qualified funds, then there is an immediate federal and state tax. If low-cost-based assets, then there is an unnecessary capital gains tax; had the money been in the individual's name at death, there would have been a free step-up to fair market value; the value of the investment at date of death would become the new cost basis.

If your client is still inclined to gift assets, the next hurdle is income. If he has more than \$2,134, then he does not qualify. If less, then the client will qualify, but then is unlikely to have been your client to begin with.

No attorney who understands Medicaid will tell long-term care planning clients with assets and income that PACE is a viable source to pay for care at home. Such an attorney will tell them that Medicaid is a viable funding source only for skilled nursing-home care. Therefore, if your client's goal is to remain in the community, and the client has assets and income, Medicaid is not a viable resource to pay for care.

## **Qualifying for Medicaid Eligibility**

There are two criteria in qualifying for Medicaid: medical and financial.

Medical qualification is determined by the state, but it is sufficient to say that a person who needs ongoing support with multiple ADLs or supervision for a cognitive impairment would likely qualify for Medicaid medically.

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<sup>1</sup> Not countable are the first \$20 of total income, the first \$65 of earned income, half of earned income over \$65, any government aid, and goods and services received in-kind.

Financial qualification is based on an applicant's assets and income.

### Assets

Assets are divided into three categories:

- Countable assets (called non-exempt or available assets in some states)
- Non-countable (also called exempt) assets
- Inaccessible assets

#### COUNTABLE ASSETS

Countable assets are any personal financial resources owned or controlled by the applicant included for Medicaid benefit eligibility. Medicaid considers them available to pay for care. They include:

- All investments (stocks, bonds, real estate, etc.)
- Deferred annuity cash value. (A SPIA or annuitized annuity is not an asset, but is considered income)
- Cash value in life insurance if the death benefit exceeds \$1,500
- All cash, CDs, money-market, checking and other liquid funds
- All tax-qualified pension plans if applicant is retired
- All other residences or property (some states exclude investment property if it is rented for fair market value, but the rent is considered income)
- Assets in a revocable (living) trust

#### NON-COUNTABLE ASSETS

Non-countable assets are acknowledged by Medicaid, but are not used in determining eligibility. They generally include:<sup>2</sup>

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<sup>2</sup> 42 U.S.C. §1382b

- A small sum of cash, called the cash allowance, usually about \$2,000 (for the amount in your state, see Appendix 3).
- A prepaid burial account
- Term life insurance
- A car for personal use (states likely cap its value)
- Business assets, if applicant derives livelihood from them
- Personal items
- A primary residence, if the equity does not exceed a cap, set by the state, of between \$552,000 to \$828,000 in 2016, and a spouse or other protected party does not live in it

#### INACCESSIBLE ASSETS

Inaccessible assets are assets that would have been countable but to which the applicant cannot get access. They include, for example, stock in closely held companies and accounts that require the applicant to give consent to disbursement which the applicant cannot give because of dementia. In the latter case, the state gives the family a limited period of time to file a petition to obtain access.

People who need care often seek to take countable assets and make them inaccessible by giving them away outright or placing them in an irrevocable trust in order to qualify for Medicaid. But Medicaid rules make that strategy complicated and pose significant limitations to this idea.

### **The Look-Back and Ineligibility Periods**

The Look-Back Period is a time span used by Medicaid to review all transfers when an application for long-term care benefits is submitted. All states use a five-year (60 months) period. Any gifts or transfers to a trust during the Look-Back Period create a period of ineligibility that begins on the date an application is submitted. The larger

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the amount of the gifts/transfers, the greater the disqualification. States use the following formula:

- All gifts made during a five-year period are aggregated.
  - Assume that total is \$100,000.
- The total amount is divided by what your state considers the average monthly cost of a semi-private room in a skilled nursing facility.
  - Assume your state sets that figure at \$5,000/month.
- The total period of ineligibility would be 20 months.
  - ( $\$100,000 \div \$5,000/\text{month} = 20 \text{ months}$ ).
- The period of ineligibility is brought forward to begin as of the date of application or later if not yet eligible because additional assets must still be spent down.

One option, then, is to simply give away all your assets and wait five years. If that is what a client wants to do, you may wish to educate him about a number of issues that are in direct conflict with many existing tax and estate planning strategies:

- Immediate, lump-sum distribution taxes on the transfer of qualified funds
- Potential gift-taxes
- Taxes on appreciated assets
  - Assets with a capital gain (the positive difference, if any, between the acquisition and disposal prices) are not taxed if they appear in the individual's estate at death. However, if given away, they incur a capital-gains tax liability, albeit a delayed one, when their recipients' sell them.

If the goal of the extended care plan is to stay at home, Medicaid cannot be counted on a viable funding source.

Timing large gifts when faced with an emotionally challenging and ever-changing care situation is nearly impossible and must be balanced with how to pay for care during the five-year look back as well as how to effectively continue lifestyle expenses for a still-independent spouse.

## **Medicaid Treatment of a Couples' Assets**

All countable assets in a marriage are considered jointly held and available to be spent on the institutionalized spouse's care, subject to certain spousal allowance limits.

A provision called the spousal impoverishment rule allows the *Community Spouse* (CS—the spouse who is not chronically ill) to retain a certain amount of assets and income.<sup>3</sup>

Beyond this allowance, all of the couple's countable assets, held separately in the name of either spouse or jointly, are generally considered available to determine Medicaid eligibility.

The Community Spouse's assets are considered countable even if:

- There is a premarital agreement.
- The institutionalized spouse never contributed to them.
- The couple lives in a community-property state (assets brought into the marriage are not subject to division in a divorce).
- There is an exception to this rule in a few states. If the Community Spouse has a pre-tax account (e.g., an IRA) that currently prohibits access, it may not be considered as part of the institutionalized spouse's assets. Please check your state policy—or ask an elder law attorney about your state's position—on qualified plans for Community Spouses who have not yet retired.

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<sup>3</sup> 42 U.S.C. §1396r-5(e)(2)

### Community Spouse Resource Allowance (CSRA)

A “snapshot” is taken of the couple’s countable assets on the day one spouse goes into a medical institution or nursing home where that institutional spouse is expected to stay more than 30 days. The Community Spouse gets to keep a certain amount of those assets, calculated by the *Community Spouse Resource Allowance (CSRA)* formula.<sup>4</sup>

The CSRA was established to allow the Community Spouse to survive financially if her spouse needed SNF care. The Community Spouse is allowed to keep half of the couple’s combined, countable assets, but:

- No less than a minimum (the floor) of \$23,844 in 2016
- No more than a maximum (the ceiling) of \$119,220 in 2016.<sup>5</sup>

States have the option of raising the floor; New York, Florida, California and Massachusetts are examples of states that have raised it from \$23,844 to \$119,220. In those states, the Community Spouse gets to keep the first \$119,220 in combined assets. (2016)

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<sup>4</sup> 42 U.S.C. §1396a(a)(10)(A)(ii)(V)

<sup>5</sup> The various amounts used in the spousal impoverishment rules are adjusted annually for inflation and are available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/spousal-impoverishment-page.html>

**EXAMPLE:**

Alan and Rebecca, both widowed, marry. Prior to their wedding, they signed a prenuptial agreement to define what would happen to their separate holdings in the event of a divorce or death. Rebecca entered into the marriage with over \$500,000. Alan brought his home and \$220,000 into the marriage.

Alan suffers a serious stroke that leaves him paralyzed. After four years of trying to care for him at home, Rebecca places her husband in a nursing home on January 1, 2014.

The snapshot of their assets on that date shows \$720,000 (remember, all assets are considered jointly held). To qualify for Medicaid coverage, the couple will be required to spend down their combined assets to the maximum CSRA ceiling of \$119,220 for Rebecca, the Community Spouse, and \$2,000 (the "Cash Allowance") for Alan, the Medicaid beneficiary (check your state). Medicaid will not recognize the prenuptial agreement.

## **Income**

### Income: Individuals

All income, regardless of how earned or when received, is considered available to be spent on the Medicaid beneficiary's care, with three exceptions:

- A personal monthly needs allowance, usually between \$30 and \$60 per month (for the amount in your state, see Appendix 3), to cover such items as clothing, toiletries, and medical expenses not covered by Medicaid or Medicare
- The beneficiary's Medicare Part B and Medicare supplement insurance premiums
- Other small deductions permitted by state law.

### Spend-Down Program

More than half the states employ a so-called spend-down program in which the beneficiary's monthly income goes to the nursing home, with Medicaid making up any difference at its rate. The only condition is that, in the aggregate, the monthly income must be less than the private-pay cost of a room.

### Income Cap States

The following states cap the amount of monthly income a Medicaid applicant can have. They include:<sup>6</sup>

<ul style="list-style-type: none"><li>• Alabama</li><li>• Alaska</li><li>• Arizona</li><li>• Arkansas</li><li>• Colorado</li><li>• Delaware</li><li>• Florida</li><li>• Georgia</li><li>• Idaho</li></ul>	<ul style="list-style-type: none"><li>• Iowa</li><li>• Kentucky</li><li>• Louisiana</li><li>• Mississippi</li><li>• Nevada</li><li>• New Jersey</li><li>• New Mexico</li><li>• Oklahoma</li><li>• Oregon</li></ul>	<ul style="list-style-type: none"><li>• South Carolina</li><li>• South Dakota</li><li>• Tennessee</li><li>• Texas</li><li>• Wyoming</li></ul>
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These states grant eligibility only if the monthly income of the applicant is at or less than a cap, \$2,199/month in 2016.<sup>7</sup> Those whose income exceeds the cap, even by a

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<sup>6</sup> Medicaid and CHIP Eligibility Levels. <https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html>

penny, do not qualify for Medicaid unless they establish a *Qualified Income Trust*, commonly called a *Miller Trust*.

### How a Miller Trust Works

Established either by the family of the applicant or the nursing facility, the Miller Trust must have the following provisions:<sup>8</sup>

- The beneficiary is the Medicaid applicant.
- The beneficiary's income is deposited into the trust.
- The trustee distributes to the nursing home no more than \$2,199 per month.
- The applicant is now under the cap and can qualify for Medicaid.
- The balance remains in trust and is paid to the state upon the beneficiary's death.

### Income: Couples

In looking at income, Medicaid uses a "name on the check" rule to allocate income between spouses. The Community Spouse's monthly income is never used in determining the Medicaid eligibility of her institutionalized spouse. A Community Spouse can keep unlimited income in her own name. (New York is the only state that requires a CS to contribute a percentage of income if it exceeds a certain amount.)

### Minimum Monthly Maintenance Needs Allowance (MMMNA)

Since most couples applying for assistance have minimal income, the state and federal governments (which jointly fund Medicaid) have attempted to leave those in the community with a livable income. The CS is allowed to keep a Minimum Monthly Maintenance Needs Allowance (MMMNA) if her own income falls below the minimum.

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<sup>7</sup> 42 U.S.C. §1396a(a)(10)(ii)(V)

<sup>8</sup> 42 U.S.C. §1396p(d)(4)(B); see also *Miller v. Ibarra*, 746F. Supp. 19 (D. Colo. 1990)

The MMMNA in each state has to equal at least a floor of \$1,967/month in 2016 and can be as high as the ceiling of \$2,980/month.<sup>9</sup> For the MMMNA in your state, see Appendix 3.

These rules only apply if the CS's monthly income is less than the floor. If, for example, her income is \$3,000 per month, she gets to keep all of it but would not qualify for a MMMNA allowance.

Here's an example of how devastating qualification for Medicaid benefits is to the people who could afford LTCI: the moderately affluent.

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<sup>9</sup> 42 U.S.C. §1396r-5(d)(3-4). The MMMNA amounts are valid until July 1, 2016.

**EXAMPLE:**

- Susan and Frank are in a second marriage.
- They have the following assets:
  - Susan has a \$150,000 IRA; Frank has an IRA converted from a 403b worth \$100,000.
  - Susan has stocks worth \$100,000; Frank has stocks and bonds worth \$167,240.
  - Total assets: \$517,240.
- Their income is:
  - Susan receives \$25,000 from her IRA and Social Security retirement benefit; Frank has a pension of \$52,000 and investment income (including a draw-down of the IRA) of \$15,000 per year.
  - Total income: \$92,000.
- They have a standard premarital agreement stating that in a divorce or at death, their assets would go to their respective children, not to each other.
- Frank is diagnosed with early-onset dementia in 2009. After keeping him home for four years, Susan decides she has no choice but to place him in a nursing home. Here is what happens to their assets and income in Massachusetts; a similar scenario would follow in other “spend-down” states.

There are two stages:

**Assets**

- Medicaid takes a snapshot of the assets when Frank is admitted to a nursing home. Susan gets to keep one-half, but no more than a federal and state ceiling, of \$119,220.
- Medicaid disregards premarital agreements. Therefore, the total Susan keeps is \$119,220. The excess of \$398,020, which includes much her assets, must be

spent on her husband's care.

- Once the couple is down to \$119,220, Frank will qualify for benefits.

#### Income

- By law Susan keeps her \$25,000, but because this is above the MMMNA, nothing from her husband's income.
- Frank's pension of \$52,000 must be paid to the nursing home. The income from his IRA is extinguished because the asset had to be spent-down to pay for his care.
- Here is the result of their relying on Medicaid on the basis of what they heard or were told by attorneys at a "free" seminar:
  - The couple started with \$517,240. Susan is left with \$119,220.
  - The couple started with \$92,000 per year in income. Susan is left with \$25,000.

## Annuitizing the Spend-Down

Whether or not to annuitize the spend-down is not an easy or simple answer. Many states give Susan the option of annuitizing the spend-down of \$398,020 into an income stream based on her age. Most states allow funds that otherwise would be spent on nursing-home care to be transferred to the Community Spouse. They can then be annuitized into an income stream under the following conditions. The annuity must be:

- Actuarially sound based on a Medicaid-set impaired life expectancy at the date of purchase
  - See Appendix 5 for the appropriate table.
- Issued on a period-certain basis; it must amortize 100% during the Medicaid life expectancy
- Non-assignable

- Payable to the state as the remainder beneficiary if the Community Spouse dies before the annuitization period has expired

While preferable to a spend-down, annuitization does entail costs:

- Transferring assets, such as an IRA, to the spouse creates a lump-sum distribution and serious ordinary income tax liability.
- Liquidating stocks creates capital-gains tax liability.
- What if the funds are sold in a down market?
- Furthermore, many states, including Alabama, Arkansas, Idaho, Colorado, Connecticut, New Jersey, Nevada and Wisconsin, do not allow this type of annuitization.

### Medicaid Planning: Transferring Assets

Medicaid planning is the practice of taking countable assets and making them inaccessible by either giving them away or placing them in trust. However, Medicaid, intended for the financially needy, has in recent year's severely restricted opportunities for such planning.

### Giving Assets Away

Here is a recap of the tax consequence of giving assets away:

- Transfers from tax-qualified retirement plans create an immediate income-tax liability of up to the maximum federal and state income tax rates. In addition, transfers before age 59½ incur a 10% penalty.<sup>10</sup>
- If your client has stock or other assets with a low cost basis, gifting them will create a future tax when the children decide to sell.<sup>11</sup>

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<sup>10</sup> Internal Revenue Code §402 (a)

<sup>11</sup> Treasury Regulations §25.2511

- If, however, these assets remained in the client's name and became part of his estate at death, they would receive a free step-up to current market value. The sale of such assets then entails little or no capital-gains tax liability.<sup>12</sup>
- The transfer of your client's home would both:
  - Forfeit the capital gains exclusion for home sales (\$250,000 per individual or \$500,000 per couple)
  - Saddle the recipient with the grantor's low cost basis, thus creating substantial tax on the sale of the property

### Transferring Assets to a Trust

The second option used to make countable assets inaccessible is the use of trusts.

A trust is a legal instrument established by an individual or couple to hold assets. The person funding the trust generally is referred to as a donor (or grantor if he or she transfers real estate). Assets held in the trust are for the benefit of persons called beneficiaries, and one or more trustees manage the trust. All trusts must have at least:

- A donor or grantor who makes the initial rules of the trust and funds it with assets
- One trustee (the person responsible for making decisions about the trust)
- One beneficiary who will receive the benefit of the trust's assets

There are two basic types of trusts: revocable and irrevocable.

### **REVOCABLE TRUSTS**

Revocable trusts are instruments that allow the donor to maintain control of the assets. He may modify or terminate the trust and is always able to receive the

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<sup>12</sup> Internal Revenue Code §2031

benefits of the assets held in it. Revocable trusts are primarily used to avoid probate and manage assets if the donor becomes incapacitated.

They are of no value in protecting assets for Medicaid. Both the federal and state governments take the position that if the applicant is the donor and/or trustee and beneficiary, assets in the trust are countable and must be spent on his care.

### **IRREVOCABLE TRUSTS**

An irrevocable trust bears many of the same characteristics as a revocable trust. The one notable difference involves the donor's control over it. As the title suggests, an irrevocable trust, once established, may not be revoked or changed in any manner by the donor. The donor has no control of, or interest in, the assets.

Because of this characteristic, irrevocable trusts have been widely used in Medicaid planning. To understand the issues involved in transfers to irrevocable trusts, it is helpful to review the history of their use.

### **IRREVOCABLE DISCRETIONARY TRUSTS BEFORE 1986**

The most popular type of Medicaid trust was commonly called an irrevocable discretionary trust. It typically worked like this:

- The donors created an irrevocable instrument and placed assets in it.
- They named themselves beneficiaries.
- They named a family member as the trustee.
- They gave the trustee authority to distribute all or none of the principal and interest at the trustee's discretion.

The underlying assumption was that if one of the donor-beneficiaries needed skilled nursing care and wanted to apply for Medicaid, the trustee would exercise his discretion and not make the principal or interest available to him.

## **COBRA '85: Congress Steps In**

Congress restricted the use of such trusts in the *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85)* effective in June 1986. All these trusts were classified as a *Medicaid Qualifying Trust*,<sup>13</sup> which means their assets are not protected, if:

- The trust is established by the applicant or the applicant's spouse other than by will and provides that either or both are beneficiaries.
- The trustee has been given discretion to distribute assets or income to either or both beneficiaries; Medicaid presumes that the trustee will do so.
- Medicaid deems those assets countable, which means they must be spent on care.

This legislation was retroactive.

### Trusts Established between 1985 and 1993

Income-only trusts were established when attorneys shifted their planning strategies away from asset and income discretionary trusts and came up with an income-only instrument.

The concept is simple enough. Set up the same type of trust that was prohibited in 1985, but leave out one feature: discretion over principal. Such income-only trusts immediately became popular among Medicaid planners, because the state could not force the trustee to distribute principal. They typically worked like this:

- The donors created an irrevocable trust and placed assets in it.
- They named themselves beneficiaries.

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<sup>13</sup> 42 U.S.C. §1396 (a) (k) (10)

- They named a family member as trustee.
- They gave the trustee authority to distribute all or none of the income at the trustee's discretion.
- If one of the donor-beneficiaries needed skilled nursing care and wanted to apply for Medicaid, only the income was available to be spent on him, and only half of it if there were two beneficiaries.

### Issues Created by the Use of Trusts

Few lawyers will discuss the considerable problems created by the use of these trusts:

- A trust cannot hold qualified funds. Funding it with such creates an immediate, lump-sum tax liability.
- The trust is of no value while the person needing care is in the community, because Medicaid pays only for limited, if any, home care.
- Once an applicant is on Medicaid, as previously explained, his or her Community Spouse loses most, if not all, of the applicant's income.

## Trusts after OBRA '93

The **1993 Omnibus Budget Reconciliation Act (OBRA '93)** again attempted to correct the perceived weaknesses of the 1985 law. The act has several provisions, the most important of which are expanding estate recovery and trusts for disabled individuals.

### Expanding Estate Recovery

Undoubtedly, the most far-reaching section of OBRA '93 is the law mandating the states to implement estate recovery on a Medicaid beneficiary's taxable—not just probate—estate. This undermines those who have:

- Income-only trusts drafted after August 11, 1993
  - The entire proceeds of such a trust could be deemed available to repay Medicaid
- Life estates
  - These are created when the owner of real estate conveys it to another person (usually a child or children) but keeps the right to live there and control what happens to it during his life. Legally, the individual has conveyed a remainder interest, keeping a life interest, also called a life estate, which terminates at his death. The entire value of the property is included in the decedent's taxable estate at death, thereby giving the children a step-up of the property's cost basis to fair market value.
  - Life estates are cast into doubt because many states are starting to place a lien on the interest.

### Trusts for Disabled Individuals

Trusts may be particularly useful if your client has a pre-existing medical condition and does not qualify for LTCI. His assets may be placed in trust for a disabled child under age 65, even while he applies for Medicaid, and no disqualifying transfer would

take place. Two types of trusts serve this need: supplemental needs and pooled disability.

### Supplemental Needs Trust (SNT)<sup>14</sup>

OBRA '93 allows a disabled individual under age 65 to be the recipient of a *supplemental needs trust* established for his benefit. The following rules apply:

- The trust must be established for the sole benefit of the disabled person by a parent, grandparent, legal guardian or a court of competent jurisdiction.
- If the trust is funded with a disabled beneficiary's own assets, it must provide that, upon his death, the assets left will be given to the state to repay benefits granted him.<sup>15</sup> This is called a payback trust.
- A trust funded with someone else's assets, such as those of a parent, is not required to contain a payback provision.

### Pooled Disability Trust

Unlike SNTs, a *pooled disability trust* joins the disabled person's assets with others to form a pool of funds. This has a number of advantages, including affordability; the disabled beneficiary does not have to spend money for a trustee to manage the assets. The trust is also useful for those over 65.

## **Summary**

Medicaid planning may be able to protect assets, but never income. Things to consider when the client suggests that his attorney told him Medicaid would pay for his care:

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<sup>14</sup> For more information on SNTs, go to <http://www.special-needs-trusts.org>

<sup>15</sup> 42 U.S.C. §1396 (d) (4) (A)

- Attorneys tend to focus on protecting assets, not income, which is essential to support lifestyle.
- Attorneys tend to focus on shifting assets. Would they do so if those assets were tied up in qualified tax-deferred investments and low-cost-based assets?
- Attorneys tend to focus on Medicaid's paying for nursing-home care, not care in the community, because the program will usually not pay to effectively keep someone at home long-term.
- Attorneys tend to focus on the quality of care the client will receive in a facility, not the impact that providing quality care will have on his family while they try to keep him in the community.

## **Overcoming the Objection**

"My attorney told me Medicaid will pay for my care."

With few exceptions, the objection you are likely to hear, if any, is:

"My lawyer told me Medicaid will pay for my care in a good nursing home."

A simple set of questions can quickly overcome the objection and place the attorney who gave the advice on the defensive:

"Did he tell you that you could get into a good facility?"

"Yes."

"He's correct. But here's the problem: the goal of the plan I put together for you is to have you remain at home. Did the attorney tell you that Medicaid would pay for home care, adult day care, or assisted living?"

"Actually he never mentioned staying at home; it was nursing-home care."

"That's correct. Did he also mention that you would have to gift all your assets and wait five years?"

"He did."

"The problem is that that will create serious tax issues. Gifting qualified funds means an immediate maximum-rate Federal income tax plus your state tax. If you transfer low-cost-based assets, the children will pay a capital gains tax when they sell them. If they are in your estate they receive a free step-up; no taxes are due when they are sold, which is sound estate planning."

"He didn't discuss any of those issues."

"One more thing, did the attorney mention that once you qualify for benefits your wife will lose most if not all of your monthly income?"

"No."

"She will. So here's the bottom line: Medicaid is not a viable funding source for the plan I put together to keep you at home. There is nothing the program can do to alleviate the emotional and physical stress that taking care of you will cause your wife and children. There is nothing the program can do to protect your lifestyle—or your wife's lifestyle, which will be devastated—because income will have to be reallocated. If the illness lasts long enough, it likely will threaten your wife's future financial security."

Again, there is no need to speak disparagingly of Medicaid. In reality, understanding it helps you make the case for LTCI.

# Chapter C5:

## The Ethical Use of Medicaid

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Some in the LTC insurance industry believe Medicaid should never be used if there are any assets or a home. That may be too simplistic a view: a producer in the field may encounter a variety of situations in which this approach may not make sense, and Medicaid benefits may be appropriate. Here are a few examples:

- A married client has pre-existing medical conditions that disqualify him from buying LTCI, and the family faces financial devastation if he requires extended care.
- The client does not have enough income and/or assets to pay the premium on a LTCI policy.
- The client has assets to pay for his care, but also has a disabled child.

In many respects, taking steps to preserve such people's money from Medicaid is not Medicaid planning in its conventional sense, but applying Medicaid regulations to avoid the total impoverishment of people the program was intended to assist. They may be in the beginning stages of a chronic illness, or about to be admitted to a nursing home, or already in one. Here are some options: Transferring business assets,

spousal refusal, divorcing, protecting a disabled child, and protecting a primary residence.

## **Transferring Business Assets**

If a Medicaid applicant owns a business and derives an income from it, generally, all assets associated with the enterprise are non-countable (exempt). The business can be transferred to the healthy spouse, who continues to derive income from it. If the sick spouse needs Medicaid, the program will allow the Community Spouse to keep the business and the income from it. Check with a local elder-law attorney about applying this in your state.

## **Spousal Refusal**

The federal government has mandated that states qualify applicants for benefits even if their Community Spouse fails (or refuses) to participate in the application process. It is referred to as the "spousal refusal" rule because the Community Spouse refuses to divulge any information, financial or otherwise, and refuses to participate in the application process.

Generally, an individual will qualify for Medicaid benefits under spousal refusal if any of the following conditions applies:

- The Community Spouse's whereabouts are unknown.
- The Community Spouse is incapable of providing the required information due to illness or mental incapacity.
- The Community Spouse lived apart from the institutionalized spouse immediately prior to institutionalization.

The state, however, reserves the right to sue the Community Spouse for recovery of money that otherwise would have had to be spent on care. If the state does file suit, it is almost certain to prevail.

Spousal refusal was used extensively in New York because that state did not pursue spouses who refused to cooperate. That stopped in 2006, when Nassau County Executive Thomas Suozzi filed suit in state court against several spouses who had used spousal refusal to shelter millions of dollars. The average net worth of the families he sued was well over \$1 million. The majority of those sued quickly settled. (For an interesting discussion from a Medicaid planner's point of view, see "Another smart reason to have Good & Current Powers of Attorney: Spouses and Medicaid Spousal Refusal Planning" by David R. Okrent.)<sup>1</sup>

## **Divorcing**

Filing for divorce may work, but there are two factors to consider:

- Couples in long-term marriages are extremely reluctant to file for divorce.
- The court of competent jurisdiction is not likely to strip the institutionalized spouse of all the assets. Most states' family courts do not allow for the divorce process to impoverish one spouse, even if he agrees.

The only instance when this will work is if there is a premarital agreement ("pre-nup") that has provisions for dividing the assets. But the couple must proceed with a divorce according to the pre-nup before applying for Medicaid. Remember, a premarital agreement will not work when a still-married spouse applies for Medicaid.

## **Protecting a Disabled Child**

There are times when it makes sense to try to protect assets for use by someone other than the Medicaid applicant. For example, a client who has been denied insurance because of age or a pre-existing medical condition may be the parent of a disabled child. You should consider suggesting a Supplemental Needs Trust (SNT) to hold the assets for the child.

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<sup>1</sup> Okrent, David R. "Another smart reason to have Good & Current Powers of Attorney: Spouses and Medicaid Spousal Refusal Planning." Available at <http://www.davidrokrentlaw.com/wp-content/uploads/SpousalRefusalArticle-copy.pdf>

### **EXAMPLE**

A producer finds out during a visit to a prospective client's home that the client's father is in a nursing home. The father has \$100,000 left, but it is being spent at the rate of \$5,000 per month on his care. The producer also learns that the client's 50-year-old daughter Louise has Down's syndrome and has been living with her father in an apartment for years.

The producer informs the client that with the help of an elder-law attorney, it will be possible to protect all the remaining assets by establishing an SNT for the benefit of Louise.

The law also permits assets to be given directly to a child under 21, or a child of any age who is blind or disabled. This may be preferable to the SNT if, for example, the child receives Social Security Disability Income (SSDI). This program is not based on financial need; therefore, assets given to the child will not disqualify the client from the benefit.

## **Protecting a Primary Residence**

As you have previously learned, the primary home, if valued below the state cap, is a non-countable asset. However, unless a protected party resides in the home, Medicaid has the right in every state to place a lien on it or force its sale. Protected individuals include:

- The applicant's spouse
- The applicant's child who is under 21, or blind, or permanently and totally disabled (SSDI definition)
- The applicant's sibling, who has an equity interest in the home and was residing in the home for at least one year immediately before the date the applicant became institutionalized

- In this case the transfer of the Medicaid applicant's ownership to her sibling is not subject to penalty or estate recovery.
- The applicant's child, who was residing in the applicant's home for at least two years immediately before the date the applicant became institutionalized, and who (as determined by the state) furnished the applicant care that permitted the applicant to reside at home rather than in an institution
  - In this case the gifting or transfer of ownership in the home to the resident child is not subject to penalty or estate recovery.

Knowledge of these exceptions can help you save a client's home in a crisis. As we have emphasized throughout this course, you should develop a working relationship with an elder-law attorney.





# Section C

## Summary

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By taking time to focus on what *does* pay for extended care, meeting all objections about using assets to pay for care, and introducing the idea that it is income that pays for care, you have clearly set out the serious consequences of using a client's own money to pay for care.

By showing that self-funding would disrupt every plan created to secure financial viability moving into the future, and helping the prospective client realize that the consequences of caregiving on his spouse and family would be devastating, you have helped him consider that using LTCI or another designated funding source would be the better decision to protect his family.

Consumers believe that "something else" will pay for long-term care. Medicare is medical insurance; Veterans Affairs limits access to payment for care through strict rules which likely prohibits most veterans from receiving funding for care; Medicaid is a viable resource for people without money.

LTCI protects a family from the consequences of providing care on a constant basis. It provides the roadmap to follow and tax-free benefits to pay for the care.

LTCI products do exactly what life and disability-income insurance does—they protect those the client loves.

- The client tells you who and what is important to him.
- The client is educated on a series of consequences that would happen to those who are important to the client if he ever needed extended care.

- The client allows you to protect his family.
- The protection is in the form of a plan intended to keep the client safe at home while mitigating the two sets of consequences.
- Because it was the client who asked you to put a plan together, you may reasonably ask: “What do you think will fund it?”
- Long-term care funding products are that funding source. They provide a tax-free predictable stream of benefits in the form of a maximum daily (or monthly) benefit. That “income” is used to fund the plan—to pay for care.
- By doing so, a long-term care funding plan mitigates the two sets of consequences providing care would have for the family.

# Key Points C

## Self-Funding (Page #97)

Paying for long-term care when needed should be viewed as just another expense in life. Expenses should be covered by using cash flow (income), not by invading capital. It is fair to presume the following when working with those who have found success:

- They live on most, if not all, of their income.
- There is no such thing as a discretionary expense.

Reallocating income to pay for care raises the question, how can the client pay for care and keep financial commitments at the same time? Asking income to do both is, in effect, double-counting it.

Expecting assets, principal, and capital to both provide an effective income stream for a family's long-term financial security and pay for extended care at the same time is also double-counting the assets.

## Medicare (Page #105)

Medicare doesn't pay for extended care, period. Medicare is an entitlement program that provides a health insurance plan for people age 65 and older and for disabled people and people of any age with End Stage Renal Disease (ESRD), (permanent kidney failure requiring dialysis or a kidney transplant). It is administered by the Centers for Medicare and Medicaid Services (CMS), and consists of four parts:

Parts A and B, also called Original Medicare (Page #106)

Part C, also called Medicare Advantage (Page #106)

Part D, also called the Prescription Drug Program (Page #106)

Prior to 1998, providers who, understanding that the program would not pay directly for custodial care, used confusing definitions and rules to provide and get paid for services that were primarily custodial in nature. For this and other reasons, many consumers believe that Medicare will pay for extended care.

Medicare (and health insurance) does not pay for long-term care (custodial care); it does pay for short-term care when it is skilled and rehabilitative in nature.

### **The Prospective Payment System (PPS) (Page #110)**

Under PPS, hospitals are paid a pre-determined rate based on the *Diagnostic Related Group (DRG)* for inpatient hospital care furnished to Medicare Part A beneficiaries. Hospitals are thus under pressure to keep their actual costs of treating Medicare patients below the program's fixed reimbursement level.

### **Veterans Affairs (Page #127)**

The VA does offer veterans some extended-care services in some locations. Most long-term services are available only to veterans who either have severe service-connected disabilities or pass strict means tests on their and their spouses' income and assets.

### **Aid and Attendance Pension (Page #132)**

For veterans who meet strict service, income and asset criteria, the Aid and Attendance Pension (A&A) program offers modest compensation for veterans or surviving spouses over 65. The income benefit is well below what most planning clients would want and need to support their lifestyles even if they become disabled and require long-term care.

### **TriCare (Page #135)**

Just like Medicare, the TriCare health insurance program for active and retired military offers no benefits for long-term custodial care services.

## Medicaid (Page #139)

Medicare	Medicaid
Is a health insurance program	Is a health insurance program
Pays for skilled and rehabilitative care	Pays for skilled and rehabilitative care
Is an entitlement program	Is means-tested
Is funded by the federal government	Is jointly funded by the state and federal governments
Is managed by the federal government	Is managed by the state government
Does not cover custodial care	Covers custodial care but primarily only in SNFs

While Medicaid does pay for custodial long-term care, it primarily only pays for care in the one place most clients do not want to plan to go: a nursing home.

## The HCBS and PACE Waiver Programs (Page #141)

Medicaid may pay for care in the community, *Home & Community Based Services (HCBS)*—services at home, adult daycare and assisted living—under a federal *waiver* program.

*Program of All Inclusive Care for the Elderly (PACE)* is an example of an effective HCBS waiver program. PACE helps beneficiaries stay home by requiring the use of Adult Day Care for part-time care and delivery of basic medical services.

## Medicaid Eligibility—Assets (Page #142)

Medicaid determines eligibility for long-term care services initially on assets. “Countable” assets must be below the allowable amounts for either an individual or a couple.

**Countable Assets:** Countable assets are any personal financial resources owned or controlled by the applicant for Medicaid benefits. Medicaid considers them available to pay for care:

- All investments
- Deferred annuity cash value
- Cash value in life insurance, if the death benefit exceeds \$1,500
- All cash, CDs, money market, checking, and other liquid funds
- All tax-qualified pension plans if applicant is retired
- Other residences or property
- Assets in a revocable (living) trust

**Non-Countable Assets:** Non-countable assets are those that are not considered (excluded) when assessing Medicaid eligibility:

- A small sum of cash, called the cash allowance, usually about \$2,000
- A prepaid burial account
- Term life insurance
- A car for personal use
- Business assets, if applicant derives livelihood from them.
- Personal items
- A primary residence, if the equity does not exceed a cap, set by the state, of between \$552,000–\$828,000 in 2016, and a spouse or other protected party does not live in it

**Inaccessible Assets:** Assets that would have been countable but to which the applicant cannot get access. Simply, assets become inaccessible by giving them away or placing them in an irrevocable trust.

## **Look-Back Period (Page #144)**

The Look-Back Period is a time span used by Medicaid to review all financial information when an application for long-term care benefits is submitted. The Look-Back Period begins on the state of application. All states now use a five-year (60-month) period. Any gifts or transfers to trust within the Look-Back Period create a period of ineligibility for Medicaid benefits.

## **Ineligibility Period (Page #144)**

Gifts or transfers to trust within the Look-Back Period create a period of ineligibility. The ineligibility begins currently on the date an application is submitted. The larger the gift (or total of all gifts during the look-back), the greater the disqualification period.

The penalty period formula is:

- All gifts made during a five-year period are aggregated.
  - e.g., \$100,000.
- The total amount is divided by what the state considers the average monthly cost of a semiprivate room in a skilled nursing facility.
  - e.g., \$5,000/month.
- The total period of ineligibility would be 20 months
  - $\$100,000 \div \$5,000/\text{month}$ .

## **Community Spouse Resource Allowance (CSRA) (Page #147)**

Designed to prevent the impoverishment of a Community Spouse (the non-Medicaid spouse), the CSRA allows the Community Spouse to keep half of all countable assets—in either or joint names—but no more than a federally set maximum. There is a minimum guaranteed CSRA.

## **Income: Individuals (Page #148)**

All income, regardless of how earned or when received, is considered available to be spent on the Medicaid beneficiary's care, Medicaid only pays the difference between income and the Medicaid payment amount to the SNF. There are three income exceptions:

1. A personal monthly needs allowance, usually between \$30 and \$60 per month
2. The beneficiary's Medicare Part B and Medicare supplement insurance premiums
3. Other small deductions permitted by state law

## **Income: Couples (Page #150)**

The Community Spouse's monthly income ("name on the check" rule) is never used in determining the Medicaid eligibility of her institutionalized spouse. The CS can keep unlimited income in her own name.

## **Minimum Monthly Maintenance Needs Allowance (MMMNA) (Page #150)**

If the Community Spouse's income is below federally-set minimum, the CS's income can be increased to the MMMNA by keeping a portion of the Institutional Spouse's income. There is a federally-set minimum and maximum MMMNA.

Medicaid Planning may be able to protect assets in certain circumstances, but it cannot protect income. Even once a spouse is qualified, the Community Spouse may suffer a severe reduction in income and lifestyle. Effective extended care plans focus on protecting income and lifestyle.

## Section C Quiz

1. Which of the following extended care plans does every client already have in place?
  - A. Medicare
  - B. Medicaid
  - C. Self-funding
  - D. Veterans benefits
  
2. In order to effectively self-insure for long-term care costs a client should first consider:
  - A. How much he has in total net worth
  - B. How much assets he has in marketable securities and savings
  - C. How much he has available in low-risk investments
  - D. How much income he has
  
3. Medicare covers what portion of custodial long-term care costs?
  - A. None
  - B. The first 100 days
  - C. Medically necessary care
  - D. Services under Part B

4. "Original Medicare" is considered to include which parts:
- A. A, B, C, and D
  - B. A and B
  - C. C
  - D. C and D
5. What process limits the amount of money Medicare provides to hospitals, skilled nursing facilities, and home health care agencies?
- A. Benefit periods
  - B. Predetermined payment
  - C. Prospective payment system
  - D. Capitation
6. Some Medicare supplement and Medicare advantage plans provide benefits for custodial extended care:
- True
  - False
7. The Department of Veterans Affairs makes extended care services available to:
- A. All disabled veterans
  - B. Veterans who were honorably discharged
  - C. Veterans with severe, service-connected disabilities
  - D. Those who are dually-eligible for TriCare

8. The VA Aid and Attendance program provides a limited income benefit for veterans who:
- A. Need custodial long-term care services
  - B. Need custodial long-term care services and who served during certain war times
  - C. Need custodial long-term care services, who served during certain war times, and who have assets and income below certain minimums
  - D. Have extended care expenses that exceed their income
9. Countable assets for Medicaid include all of the following EXCEPT:
- A. Term insurance
  - B. Tax qualified funds
  - C. Assets in a revocable trust
  - D. Vacation property
10. All of the following provide protection for a Community Spouse EXCEPT:
- A. Community Spouse Resource Allowance (CSRA)
  - B. The Look-Back Period (LBP)
  - C. Protection of a primary residence
  - D. Minimum Monthly Maintenance Needs Allowance (MMMNA)



**SECTION D:**

**LONG-TERM CARE  
INSURANCE**



# Chapter D1:

## Product Evolution

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To understand today's products, it is necessary to look at how LTCI has evolved over the past 40-plus years. Knowing the origins of LTCI will help you gain a better perspective on where these policies stand today.

Compared to most other types of insurance—such as life, disability, home, auto and health insurance—that have been around for hundreds of years, LTCI is still very young. Although no longer in its infancy, LTCI is certainly still struggling through a late adolescence—at least in insurance years! LTCI turned 42 years old in 2016.

New caregiving options, competition between insurance carriers, consumer complaints and regulatory changes have all had an impact on the development of LTCI, and continue to drive changes today.

### **The Early Years**

Long-term care insurance was born in the early 1970s as "nursing home insurance." As there was no other model to follow, early coverage, all the way up through the mid-1980s, tracked many of Medicare's definitions. Because Medicare is an acute-care medical insurance program, using it as a model for LTCI created a number of negative consequences as custodial care options began to expand beyond skilled nursing facilities.

Before about 1988, most policies had what were considered problematic policy provisions that prevented easy access to many services that are taken for granted today as routine care options.

The development of new options for care including assisted living and private duty home care along with competitive marketing pressure forced larger companies to eliminate these problem provisions voluntarily by the end of the 1980s. The *National Association of Insurance Commissioners (NAIC)* issued its first *LTC Model Acts and Regulations* in 1993 to explicitly prohibit these types of provisions for new policies.

Review the table on the next page that illustrates many of the problematic provisions in early policies and the corresponding changes that have been mandated by law for new policies since 1993. Older policies—that may still be in force—do not typically have all, but may have at least one or more of these provisions that can still cause significant claim limitations for policyholders.

**Table: Early vs. Current LTC Insurance Policies**

Early Policies (pre-1993)	Current Policies
<p>Excluded Alzheimer’s Disease</p> <p>Required care to be “medically necessary”</p> <p>Policy language was unclear and vague</p>	<p>Cover Alzheimer’s and related dementia</p> <p>Require care to be the result of an ADL loss or cognitive impairment (may also have medical necessity)</p> <p>Policy triggers and benefits clearly spelled out</p>
<p>Service “step-downs” common:</p> <ul style="list-style-type: none"> <li>• Required prior hospitalization for benefits to begin</li> <li>• Required skilled care before paying for custodial care</li> <li>• Required prior nursing home stay to pay for home care</li> <li>• Covered home health care, but only at the skilled level</li> </ul>	<p>“Step-downs” not allowed:</p> <ul style="list-style-type: none"> <li>• Cannot require prior hospitalization for benefits to begin</li> <li>• Cannot require prior skilled to pay for custodial care</li> <li>• Cannot require prior nursing home stay to pay for home care</li> <li>• Cover custodial home care</li> </ul>
<p>No state or government standards</p> <p>No clear federal tax guidelines</p> <p>Post-claim underwriting to deny claims</p> <p>Policies could be cancelled</p>	<p>NAIC state model acts and policy regulations</p> <p>Since 1997 (HIPAA), Tax-Qualified policies carry federal consumer protections &amp; clear tax guidance</p> <p>Upfront underwriting; post-claim underwriting prohibited</p> <p>Guaranteed renewable</p>



# Chapter D2:

## Policy Language and Coverage

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### **NAIC Long-Term Care Insurance Model Act and Model Regulation**

The insurance industry is regulated at the state, rather than federal, level. Each state, through its insurance department or division, regulates that state's carriers in accordance with laws known collectively as the state insurance code.

Although each state has the authority to regulate its insurance business in any manner it chooses, state insurance laws and regulations are remarkably consistent, due primarily to the influence of the *National Association of Insurance Commissioners (NAIC)*.

Comprising the insurance commissioners of the 50 states, the NAIC meets regularly to review current and ongoing issues facing the insurance industry. Where appropriate, the NAIC develops model legislative acts and regulations that states may use when crafting their own laws and regulations.

In 1993, the NAIC developed a set of model acts and regulations that established minimum standards for LTC policies—the *1993 NAIC Long-Term Care Insurance Model Act and Model Regulations*. These model acts and regulations are updated

regularly to reflect changes in regulatory needs and priorities and to keep up with changes and innovations from insurance companies.

While state legislatures are not obligated to adopt legislation on the NAIC model, most have used it as the basis for their LTCI legislation. In fact, most of the policy provisions laid out in the *1993 NAIC Long-Term Care Insurance Model Act and Model Regulations* are in HIPAA's tax-qualified policy definition. A few states, most notably California, have crafted regulations that do not follow the NAIC model, but create even more stringent requirements on carriers and their policies.

All LTCI carriers offer the features and benefits currently included in the 1993 NAIC models. Some provisions are required to be included in all LTCI policies, while others are required only to be offered as options.

Since it serves as the basis for tax-qualification standards as well as for most states' minimum standards, the *1993 NAIC Long-Term Care Insurance Model Act and Model Regulations* are an important resource for understanding today's policies. Some of its more significant provisions are summarized next.

## **Key Points of the NAIC Model Regulation**

### Standardized Definition of LTCI

"Long-term care insurance means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months on an expense-incurred, indemnity, prepaid, or other basis; 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."

### Standardized Policy Language

Carriers offer different features and benefits (for example, some pay for Meals on Wheels or informal care). However, all must make those benefits available in the following settings:

- Care received at home
- Adult day care centers
- Assisted-living care, room and board, if benefit triggers are met
- Care provided in non-skilled or skilled nursing facilities
- Specialized units for Alzheimer's disease and other forms of dementia

Here is a general summary of base contract language:

Benefits are payable for a pre-determined period of time or up to a total pool of money, as defined in the policy's Benefit Period clause.

To qualify for benefits, a policyholder must meet certain requirements, called benefit triggers, and, in addition, satisfy an elimination period.

Long-term care insurance policies are contracts of adhesion, which means that the provisions contained within them are not subject to negotiation.

Some of the provisions reviewed below were mandated under the 1993 NAIC Model Act and Model Regulations. Others were introduced as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Length of coverage: Carriers must offer at least a year of coverage. Some states mandate a minimum of two years.
- Non-hospital treatment coverage: Carriers cannot limit coverage to care given in hospitals only.

### Unintentional Lapse

A LTCI policy shall include a provision for reinstatement of coverage if the insurer is provided proof that the policyholder was cognitively impaired at the time of lapse. If this can be shown, the insurer must provide full reinstatement for at least 180 days after the lapse. Carriers can offer a longer reinstatement period, and they can allow

this extended reinstatement for a loss of two or more ADLs, but these are not common.

No individual long-term care policy shall lapse or be terminated for nonpayment of premium unless the insurer has given notice to the policyholder at least 30 days before the effective date of the lapse or termination. And companies must provide a “grace period” of at least 30 days after the premium due date.

#### Prohibition of Post-Claim Underwriting

Post-claim underwriting—a practice in which policies were issued based only on information provided on the application, and which gave insurers the opportunity to contest a claim or cancel a policy because of health conditions that were not disclosed on the application (or even asked about by the insurer)—is not permitted.

#### No “Step-down” (Prior-Hospitalization or Skilled-Care) Requirement

No policy may require a prior hospital stay, nor require a higher level of service (such as skilled care) before qualifying the policyholder for a lower level of covered care (such as custodial care). This practice of requiring a higher level of care before qualifying a policyholder for benefits is known as a “step-down” requirement.

It is important to recognize that many consumer advocates continue to caution against buying coverage with these types of step-down provisions. While older, pre-1993 contracts may still be in force with this limiting language, it has been illegal to write new policies with this language since 1993.

#### Renewability: Guaranteed

Policies must be guaranteed renewable: the insurer may not refuse to renew a policy regardless of claims experience. And the insurer may not reduce or limit contract benefits without the policyholder’s agreement.

Although insurers do have the right to increase the premiums of a guaranteed renewal contract, they may do so only when they raise the premiums of all policies of

that class or form number that have been issued in that state. Insurers may not single out individual policyholders for a premium increase for any reason (e.g., not because of claims experience, age, or health). In practice, most insurers try to maintain a level premium for LTCI policies.

Unlike health, auto or homeowners insurance—which base this year’s premiums on last year’s premiums and actual claims—traditional LTCI is “designed to remain level.” But it is not guaranteed to do so. LTCI is “reserve priced.”

### Time Limit on Denial of Coverage for Pre-existing Conditions

Insurers have a legitimate right to avoid insuring persons with pre-existing (pre-ex) medical conditions. Applicants with known medical issues may be rejected in underwriting.

If an insurer elects to issue a policy to someone with a known pre-existing medical condition, most states limit the time period during which the policy may deny coverage for that condition. The time limit is no more than two years after the policy’s effective date for conditions that existed six-months before the effective date.

LTCI that is fully underwritten does not impose a pre-ex limit. It is more commonly seen in group policies where coverage is offered on a guarantee-issue basis.

### Pre-existing Conditions and Policy Replacement

HIPAA prohibits insurers from imposing any new restrictions on replacement policies because of pre-existing conditions.

Many states, and some carriers, allow only renewal commissions, or first-year commissions just on the enhancement features, to be paid on the sale of a replacement policy.

### 30-Day Free-look Period

Policyholders must be offered a 30-day free-look period, beginning on the date the policy is delivered, during which time it may be returned for a full refund of all

premiums and other fees paid. The policyholder may also make certain benefit changes to the policy during this specified time.

### Coverage of Alzheimer's Disease

Once a policy has become effective, Alzheimer's disease may not be excluded as a covered condition or trigger. While policies must cover Alzheimer's, dementia, and other "organic cognitive disabilities" (disabilities that result from changes to the structure of the brain), they are not required to cover nonorganic "mental and nervous" (psychiatric) disorders such as depression or schizophrenia. Some states, like Massachusetts and Washington, however, require LTCI policies to cover all mental/nervous/psychiatric conditions, regardless of their origin. Some carriers offer this coverage independently of state requirements, and some that fully cover mental and nervous conditions exclude care in dedicated psychiatric facilities.

### Inflation Protection

Policies must offer optional automatic inflation protection, which increases the daily or monthly benefit over time. Inflation options will be covered later.

### Home Health and Community Care

A home health and community care feature must be offered as an option on all plans offered to prospective LTCI buyers. The home health care benefit level may not be less than 50% of the institutional benefit amount.

In addition, a LTCI policy shall not limit or exclude such benefits by:

- Requiring that the policyholder need care in a skilled nursing facility if home health services were not provided
- Requiring that the policyholder first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before custodial home health care services are covered

- Limiting eligible services to those provided by registered nurses or licensed practical nurses
- 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 certification
- Excluding coverage for personal care services provided by a home health aide
- Requiring that the provision of home health services be at a level of certification greater than that required by the eligible service
- Requiring that the policyholder have an acute condition before home health services are covered
- Limiting benefits to services provided by Medicare-certified agencies or providers
- Excluding coverage for adult day care centers

### Nonforfeiture Benefits

Policies must offer an optional nonforfeiture benefit, which preserves some coverage if the policy lapses. This option will be discussed in more detail later.

### Group Policies

If a group policy is to be terminated, group participants who have been covered for at least six months must be given the option to continue the group coverage, or convert their coverage to an individual policy with identical benefits, without having to furnish evidence of insurability. Unlike most other group insurance plans, LTCI is fully portable. This means the employee leaving the employer through termination or retirement may keep the same benefits and same premium.

### Standards for Benefit Triggers

The LTCI policy's benefits become payable when the policyholder submits proof that a benefit trigger has occurred. Today's triggers are standardized and more understandable than they were in the past.

What follows is the standardized language for policies issued after 1993 and before Jan. 1, 1997.

A LTCI policy must include both of these triggers:

- Physical limitations preventing the policyholder from performing one or more (most commonly two) Activities of Daily Living (ADLs)
- Cognitive impairment, a loss of intellectual capacity that results in a need for supervision to protect the policyholder's health or safety

#### PHYSICAL LIMITATIONS (ADL DEFICIENCIES)

The inability to perform activities of daily living (ADLs) is used in long-term care policies as an important step on the path toward, and measure of the need for, receipt of benefits. To help you remember all six, they are listed below in the order we do them each morning in about the first 30 minutes of awakening. LTCI policies typically refer to the following list of six ADLs:

- Transferring (to/from bed or chair, wheelchair, walker, etc.)
- Toileting (including getting to/from and on/off with the associated hygiene)
- Bathing (including getting safely in and out)
- Dressing
- Eating (does not include meal preparation)
- Continence

Some older policies excluded the bathing or dressing ADL, and some required the loss of three ADLs. All tax-qualified policies require the inability to perform at least two ADLs from a list of at least five of these six. Most policies sold and all policies issued today require the loss of two out of six ADLs.

ADL assistance can be defined as either hands-on assistance—sometimes called “direct human assistance,” or stand-by assistance. Stand-by assistance is a better

definition as it recognizes a lower degree of ADL limitation. Most policies include both measures of physical help.

### COGNITIVE IMPAIRMENT

Cognitive impairment is generally defined as deterioration or loss of intellectual capacity as certified by a licensed health care practitioner and verified by clinical evidence and standardized tests that measure impairment in the areas of:

- Short- or long-term memory
- Orientation as to person, place and time
- Deductive or abstract reasoning
- Judgment as it relates to safety awareness

### MEDICAL NECESSITY

HIPAA eliminated the medical-necessity benefit trigger from tax-qualified policies. Some policies issued before 1997 may still have a “*medical necessity*” trigger, which is also called a “third trigger,” as it is in addition to the ADL and cognitive impairment triggers.

After 1993 policies could also include a medical necessity trigger, but it could no longer be the only trigger. A policy issued after HIPAA (1997) that included this “third trigger” is deemed non-tax-qualified. A medical-necessity service is one that is:

- In accordance with accepted standards of medical practice for the diagnosis and treatment of the policyholder’s condition
- Delivered in the least restrictive health care setting required by his condition, when possible
- Not given solely for the patient’s convenience or that of his family or health care provider (in other words, the service must be essential).

## Suitability

HIPAA also adopted the NAIC's guidelines for suitability of purchase and applications for tax-qualified policies. You will find a *Personal Worksheet* in the required application forms that must be completed. To complete this form, you have to ask applicants to indicate their assets and income ranges.

Applicants with low incomes (of less than \$20,000 per year) and/or assets (of less than \$30,000, not counting a residence) can still purchase LTCI, but to do so they must sign a form attesting that they want the coverage even though regulatory standards deem it inappropriate for them. If it is difficult for such clients to afford a policy, you may suggest to them that their children contribute to its cost. The *Personal Worksheet* form allows for a statement that someone else will be paying the premium.

NAIC guidelines state that every insurer, health care service plan, or other entity marketing LTCI shall:

- Develop and use suitability standards to determine whether LTC insurance is appropriate to the needs of the applicant
- Train its agents in the use of its suitability standards
- Determine whether an applicant meets the standards, the agent and insurer shall develop procedures that consider the following:
  - The applicant's 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 extended care and the advantages and disadvantages of insurance as a means to meet them
  - The values, benefits and costs of existing insurance, if any, when compared to those of the recommended replacement policy

### Coverage Must be Outlined

To encourage consumer awareness, the NAIC regulations also require insurers, through their representatives, to furnish prospective buyers with an *Outline of Coverage* before they apply for the insurance. These outlines typically summarize key policy provisions, including those pertaining to benefit levels, restrictions, exclusions, policy renewal, and pre-existing conditions. Most states require these outlines to be written in language that is easily understood by the average consumer.

The Outline of Coverage must be delivered to a client no later than the date when an application is signed.

### **Policy Designs**

The field of LTCI is in transition. There are many more products available today that are based on innovative designs, all of which have the same purpose: to fund a plan to protect those who the client cares about. We will refer to these products, as well as to LTCI, as extended-care solutions.

Generally, LTC insurance policies come in three designs:

- Individual or “traditional” LTC insurance policy
- Linked-benefit policies (also called hybrid, combo, or asset-based)
- Life insurance that accelerates the death benefit to pay for extended care

### Individual Long-Term Care Policy

As the name suggests, an Individual Long-Term Care Policy covers only one person.

Many policies offer a sharing provision. This is not a policy design, but rather an option that allows two individual policies to share benefits, typically through a rider. At least one carrier offers a third pool of shared funds that an insured who exhausts his own pool can then use; a third pool protects the spouse’s or partner’s own pool of money being used by the first to need care.

### Linked Benefit Policies (Hybrid, Combo, or Asset-Based Policies)

As their name implies, in linked-benefit policies, extended-care benefits are linked to another underlying product. That other product can be either an annuity or life insurance. Regardless of the type of product, the underlying benefit (e.g., the life death benefit) must first be spent on compensable services (care that the carrier specifically states it will pay for).<sup>1</sup> See Section E for situations in which these products may be attractive.

### Linked Life Insurance (Whole-Life or Universal Life Chassis):

**LINKED BENEFIT LTC—ALSO REFERRED TO AS ASSET BASED OR HYBRID:**

How it generally works:

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<sup>1</sup> The Pension Protection Act, Section 844 allows, as of Jan. 1, 2010, the payment, free of income tax, of extended care benefits from non-qualified annuity and life insurance contracts as long as they meet tax-qualified LTC insurance policy design standards; the 1035 exchange of an annuity that does not have a LTC insurance rider to one that does; and the 1035 exchange of a life insurance policy or annuity to a stand-alone LTC insurance policy.

### **EXAMPLE**

- Base premium: \$105,000 paid lump sum or over period of time
- Death benefit if not used: \$150,000
- LTC benefit for 2 years: \$150,000 from acceleration of death benefit
- Extension of benefits (EOB) rider for 4 years: \$300,000 (LTCI benefits only)
- The EOB rider can either be a separate benefit or integrated with the base life/LTCL policy.
- Total LTCL benefits if EOB rider added is 6 years: \$450,000
- Residual death benefit: Varies by carrier

#### Market:

- Clients with high net worth generally \$500,000 +
- Traditionally marketed as leveraging under producing (i.e., liquid) assets and leveraging death benefit if care is needed. If care is not necessary family receives death benefit.
- Currently policy is marketed as LTC protection not insurance to offset future increase in interest rates on liquid funds and objection that client may not need more insurance.

Underwriting is either full (usually six weeks) or simplified (ten days).

### LIFE INSURANCE WITH RIDER FOR LTC

Generally, either a universal or whole life policy with a tax-qualified LTCL rider that derives its funding from the death benefit. This is often referred to as an *Accelerated Death Benefit for LTC*.

How it works:

**EXAMPLE**

- Rider added to insurance contract.
- Death benefit accelerated to provide tax-free LTC benefits.
- Favorable treatment under both IRC 101 G and IRC 7702 B
- What is not used (or entire death benefit) paid to heirs.
- Usually a minimum benefit if all death benefit used for care.

## Market:

- Client has additional need for life insurance
- Client has decent income (pensions etc.) but modest assets.
- Client wants to find charity, college for grandchildren, etc.

**LTC RIDERS ON ANNUITIES**

How it works:

### **EXAMPLE**

- Non-qualified annuity worth \$120,000 with \$60,000 cost basis using 1035 benefit is transferred to an annuity product with 2X or 3X LTC benefit.
- Contract continues to grow tax deferred.
- If claim is submitted, insured uses annuity first but pays no tax on drawdowns because of the Pension Protection Act.
- If annuity exhausted 2X option yields  $\$240,000 \div 72 = \$3,332$  per month.
- If annuity exhausted 3X option yields  $\$360,000 \div 72 = \$5,000$  per month.
- Premiums for riders are tax-free withdrawals from annuity.

#### Market:

- Clients with appreciated non-qualified annuities who want LTC benefits
- Limited because of low interest rate environment; clients are not likely to give up current yield.
- Clients with modest health issues because of limited underwriting.

### **LIFE INSURANCE WITH CHRONIC ILLNESS RIDERS**

#### How they work:

- Same structure as life insurance with LTC benefit but insured must present doctor certification that condition will last for remainder of life.
- Qualifies for IRC 101(g) status: death benefit not taxed.
- They cannot be marketed as payment for LTC.

Benefit specification: This applies to what amount of benefits the insured receives based on underwriting, rider charges, whether benefits are known at underwriting, and the amount of the final death benefit.

There are three options: dollar-for-dollar, discounted, and lien.

Dollar for dollar method:

- Separate LTC rider underwriting
- Additional rider charge on policy
- LTC benefits reduce death benefit dollar for dollar
- LTC benefit determined at issue
- LTC benefits remain constant regardless of when claim occurs
- 100% of policy benefits are paid

Discounted method:

- Limited or no underwriting
- No charge until rider is invoked: the LTC benefit is never free
- Benefit determined at claim, reduced by back end charge
- Charge paid by reducing total benefit making amount available unpredictable
- Remaining death benefit unpredictable

Lien method:

- No underwriting—but only on standard or better
- No charge until rider is invoked: the LTC benefit is never free.
- Only a portion of death benefit can be accelerated, generally the lesser of \$250K or 50% of death benefit
- Charge in form of interest on death benefit that has been accelerated, with a lien on remaining death benefit that covers interest due
- Not a policy loan, and final reduced death benefit not known until death

## **Alternatives for Those Who Do Not Qualify for Standard Issue**

There are four options to consider if the client cannot qualify under traditional criteria:

- Rated Underwriting Policy
- Life With Accelerated Benefit Rider
- Home Equity Conversion Mortgage (HECM), also known as reverse mortgage
- Impaired-risk Single-Premium Immediate Annuity (SPIA)

### Rated Underwriting Policy

A rated policy means that the applicant may be approved for coverage but with a higher premium based on health.

### Life with Accelerated Benefit Rider

This product can be very effective for those with underwriting issues; keep in mind however, that the chronic illness rider as set forth above is not “free.”

### Home Equity Conversion Mortgage (Reverse Mortgage)

While not a form of insurance, reverse mortgages should be understood in terms of resources available to fund extended care or even LTC insurance premiums.

Formally called a *Home Equity Conversion Mortgage (HECM)*, HECMs were created and are administered by the federal Department of Housing and Urban Development (HUD).

Also known as “reverse mortgages,” HECMs can be an effective tool to finance a post-retirement lifestyle or to pay the expenses of a long illness. The lender agrees to advance a sum of money, either in a lump sum or on a periodic basis. The loan is secured with a mortgage on the borrower’s house. There are no monthly payments. Rather, the lender has an increasing claim against the equity in the home as interest

accrues. A HECM is a “non-recourse” loan, meaning that even if the eventual loan exceeds the then-value of the house, the bank cannot collect more than the home’s equity. Reverse mortgages have become more popular with older Americans who have modest incomes or minimal assets and seek to remain at home.

To qualify, the homeowner must:

- Be over 62
- Live in a single-use dwelling such as a home, condominium or townhouse that meets Federal Housing Administration (FHA) guidelines (multi-unit properties may qualify, but the applicant must be a resident of one)
- Purchase a type of mortgage insurance to cover any exposure that the lending institution may have, because the accrued balance may exceed the value of the house; the insurance guarantees that the heirs of the borrower will not be liable for any shortfall

The monies available are tax-free—it is a loan—and do not count as income for Social Security eligibility purposes. The funds can be taken in several ways:

- Lump sum
- Monthly payments over a period of years
- Line of credit to be drawn on as needed
- Combination of lump sum, monthly payments, and/or line of credit

HECMs have come under intense scrutiny primarily because of misleading marketing tactics, confusing language, and high fees. For example, homeowners may not be able to pay the real estate taxes, putting the house in danger of foreclosure, or if a house is in the name of only the spouse who receives the money, at her death the surviving spouse must repay the outstanding loan or lose the house.

New regulations now require a degree of “financial underwriting” on the part of the lender to ensure the homeowner can pay taxes, insurance, and upkeep on the home. It is not as onerous as qualifying for a typical first mortgage or home equity line.

### Impaired-Risk Single-Premium Immediate Annuity (SPIA)

Underwriting based on health, not age at issue.

#### **Traditional SPIA vs. Impaired-Risk SPIA:**

	<b>Traditional SPIA</b>	<b>Traditional SPIA</b>
<b>Sex and Age</b>	Male, 80	Male, 80
<b>Health</b>	Moderate Alzheimer's	Moderate Alzheimer's
<b>Desired Monthly Income</b>	\$3,000	\$3,000
<b>Income Duration</b>	Lifetime	Lifetime
<b>Premium Required</b>	\$255,890 (85 months)	\$118,000 (39 months)
<b>Difference</b>	\$137,890	

### **Scope of Coverage**

HIPAA permits several different forms of coverage. In general, tax-qualified policies may adopt one of three possible forms:

- Facility care only
- Home health care only
- Comprehensive care

#### Facility Care Only

Some policies cover only extended care provided in licensed facilities, such as nursing homes and assisted-living facilities. Policy applicants should understand that home care, although it represents a significant share of all extended care, is never covered

by this type of policy. If a facility care only offered, insurers must provide an option to include an extra-cost rider that covers home care.

Since a 40% premium savings is not uncommon, purchasers of facility care only policies tend to be older buyers for affordability reasons. Single people may also find the premium savings valuable while considering that it is hard to effectively stay at home without an available informal caregiver.

### Home Health Care Only

Recognizing that most extended care is provided in the home, some insurers offer policies that cover only home health care services. Such limited coverage is ideal for people who want to stay at home and will self-pay for facility care or look to qualify for Medicaid benefits.

A home health care only policy typically covers:

- Adult day care centers
- Home care aides who assist the care recipient with ADLs or supervise because of a cognitive impairment
- Homemaker services like cooking, cleaning, transportation and telephoning
- Respite care for caregivers—temporary (typically 14–30 days/year) home care provided to a recipient while an informal caregiver takes vacation time

Home health care coverage is not typically designed to provide round-the-clock care, which is far more expensive than nursing-home care.<sup>2</sup> However, when combined with

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<sup>2</sup> The *Genworth 2016 Cost of Care Survey* reported the cost of a home health aide as: \$20.25 per hour, and that of a homemaker or companion as \$20 per hour. The round-the-clock cost would be \$486 and \$456, respectively, far higher than nursing-home care at \$253 for a private room or \$225 for a semiprivate room.

an informal primary caregiver—a family member or friend—the home health care benefit may be the only thing that keeps a policyholder out of a nursing home.

Be careful when selling a home care-only policy to people who assure you they will never go to a nursing home. Very few insurance companies offer them, because it is difficult to guarantee that any particular person will never go to a nursing home. If that happens as a last resort, a lack of insurance may force the client onto Medicaid, contrary to his wishes, or best interest.

### Comprehensive Coverage

The most common policies are those that cover a full range of care services, whether provided in the home, a nursing or assisted-living facility, or even through other forms of community-based care. If these services outside of a nursing home are included and not optional, the policy is known as a comprehensive benefit plan.

Some older comprehensive policies stipulated different elimination periods, benefit periods, and benefit amounts, for each of the four principal types of care—home care, assisted living, adult day care centers and nursing-home care.

Current comprehensive policy offerings have a single Benefit Period/pool of money for all forms of care. However, there are still options to have a home care benefit that is lower than the nursing home or facility benefit. For example, home care and adult day care center benefits may range from 50% to 100% of the nursing home/facility benefit.

## **Flexible Benefit Choices**

While most policy provisions are fixed—they must be included in the contract unaltered—there are four major opportunities to tailor a policy, giving applicants control of designing a policy that best fits their needs. A few other benefit features (riders) are flexible and will be discussed later in this section.

The four most significant flexible provisions are:

1. Benefit Amount
2. Benefit Period
3. Elimination Period
4. Inflation Benefit

### 1. Benefit Amount (or benefit level)

This provision defines the daily or monthly reimbursement or indemnity benefit payable when the policyholder qualifies for benefits. Benefit levels generally range from \$50 to \$500 per day—\$1,500 to \$15,000 per month.

#### **BENEFIT PAYMENT**

Policies pay benefits in one of two ways: reimbursement or indemnity (called “per diem” by HIPAA).

#### **REIMBURSEMENT**

A reimbursement policy only pays based on covered, compensable expenses on extended care up to the daily benefit. The operative word is compensable. You should carefully review what services the carrier actually pays for. For example, one carrier will pay for an independent aide while another requires services be provided through a professional agency.

Reimbursement policies are the most common type of benefit payment in traditional and linked-benefit LTCL policies.

#### **INDEMNITY**

An indemnity (or per diem) policy pays the full contract benefit regardless of the actual expenses incurred. There are two types of indemnity benefits:

*Cash benefit indemnity* pays the full benefit, in cash, monthly regardless of expenses, who takes care of you, where, or how often. The client must be benefit eligible and have a written plan of care that is appropriate for her care needs. This is the most

flexible type of benefit available. It is also more expensive than daily indemnity or reimbursement.

*Daily or "professional" indemnity* pays the full daily benefit regardless of actual expenses incurred upon showing at least one covered, compensable event per day (that for which the carrier will pay), such as a home care visit or a visit to an adult day center. For example a policy with a \$100/day benefit will pay the full \$100 even if only \$60 is spent on Adult Day Care. Daily indemnity pays no benefit if receiving only informal care in a day.

Very few companies offer any type of indemnity benefit today.

## 2. Benefit Period

This is the period of time the benefit payments last after payment has started. Common provisions range from one year to 10, although some states require at least a two-year benefit period to be offered. Many older policies offered "lifetime or unlimited" benefits with no finite pool of money; no longer available on traditional LTCI, lifetime benefits are still offered in some linked-benefit plans.

Most policies today employ a pool-of-benefits (also called pool-of-funds) approach to determining total plan benefits. The benefit period is not a time limit, but rather it is a multiplier. The pool is determined simply by multiplying the daily benefit by 365 (or the monthly by 12) and the number of years selected in the policy. The pool is available to be spent on a variety of care services.

Unused benefits in a day or month are not lost but stay in the pool, effectively stretching out the total "Benefit Period."

## 3. Elimination Period (EP)

Sometimes called a waiting period, it is the period of time that must elapse after a benefit-triggering event has occurred, before coverage starts. Conceptually similar to a deductible, Elimination Periods are a means of controlling premium costs; the

longer the elimination period, the lower the policy's premium, all other factors being equal.

Elimination Periods generally range from none to one year (some states will not permit more than 180 days). Elimination Periods are usually expressed in a number of days.

Some policies may have separate elimination periods for facility vs. home care. A 90-day Elimination Period that must run before nursing-home benefits are payable is different from a 90-day period that must pass before home-care benefits begin; home-care Elimination Periods may count only days on which covered care is administered, and therefore could take a much longer time to be met, if home care is not needed every day.

#### **DIFFERENCES IN DETERMINING ELIMINATION PERIODS**

Most policies require that the Elimination Period run only once in the insured's lifetime. Older policies may require that a new Elimination Period run after a certain period of time during which benefits are not paid.

Three methods are currently used:

1. **Calendar Day:** The insured need not show that any care was received, only that he is benefit eligible. This is the simplest way to go through an elimination period. Calendar Day is the only type of EP that can be fairly called a "waiting period". It is the least-common type of EP. It may either be built-in or offered as an extra-cost rider.
2. **Service Days:** Credit is given only when the insured receives at least one covered, compensable service in a day. Compensable services are services the carrier will pay for. Make sure you understand what these are and explain them carefully to the client. If a policyholder only receives covered home care services 3 days a week during the EP, it will take more than 8 months to accumulate 90 days to satisfy the EP. This is the most-common type of EP and

can be devastating for families who do not understand that they need at least an hour of paid service every day for every day to count toward the EP.

3. Hybrid EP: There are generally two types of hybrids:
  - Service Day with a Credit. The carrier credits the insured with seven days towards the elimination period as long as he receives at least one compensable service per week (a "7 for 1" elimination period). A variant credits seven days towards the elimination period if the insured receives three days of compensable services during the week (a "7 for 3" elimination period). This used to be very common, but is not seen much in new policies.
  - Zero Day Home Care EP (or "Waiver of EP for Home Care"). The carrier has a zero day elimination period for home care and a days-measured elimination period for facility care. This is either built-in or offered as an extra-cost rider.

#### **WARNING ABOUT RELYING ON MEDICARE TO COVER THE ELIMINATION PERIOD**

Many producers and clients believe that Medicare will always pay for 100 days of care. This is not true. First, the coverage is for "up to" 100 days, not at home but in a skilled nursing home, and only if:

- The recipient was first in a hospital for at least three nights.
- The recipient was transferred to a skilled nursing facility within 30 days of leaving the hospital.
- The recipient requires skilled, rehabilitative services.

Even then, as you've seen starting in 1986, Congress has severely limited coverage by switching Medicare to a flat-fee compensation system. This gives providers, such as skilled nursing facilities and home health care agencies, a strong incentive to end services as quickly as possible.

## THE ELIMINATION PERIOD AND “STACKING” POLICIES

Notwithstanding the case against long elimination periods, you may wish to consider a one-year EP if the client has an older policy with limited benefits. For example if the individual has a two-year benefit for \$100 per day, “stacking” it with a policy worth \$150 (or whatever is appropriate for your community) for three years with a one-year elimination may make sense. The elimination period of the second policy can start to run when you put the first claim in.

### 4. Inflation Benefits

Inflation protection is so critical that the *1993 NAIC Long-Term Care Insurance Model Act and Model Regulations* mandated that it be offered as an option. The thinking is that, because policies are unlikely to be used until many years after purchase, the increase in the cost of care could render the daily benefit inadequate.

HIPAA and many states’ regulations require insurers to offer the option of automatic inflation protection to all buyers, though it can be declined. It is important to note that insurers are not required to make inflation protection a fixed part of a policy, but only to offer it as an option.

There are currently six types of inflation protection, all offered as riders:

- A *Guaranteed Purchase Option (GPO)*, which some carriers call a *Guaranteed Insurability Option (GIO)*, or *Future Purchase Option (FPO)* or periodic inflation, permitting the policyholder to buy additional daily benefit in a fixed percentage (such as 5%) at specific points in the future without having to furnish the insurer with evidence of insurability
  - The logic is that the premium is reduced at purchase, therefore making the policy more affordable during working years. However, there are two considerations:
    - Generally, if the option is not exercised during a period or periods set by the carrier, the policyholder may forfeit future offers.

- Generally, if the option is exercised, the premium is based on age attained, and not the date of issue, potentially making the policy unaffordable.<sup>3</sup>
- Inflation protection based on the *Consumer Price Urban Index (CPU)*
  - The thought is that it better reflects the cost of care at home.
- Benefit based on return of investment pool. One carrier offers the option of having the policyholder share in the return of the investment portfolio. The benefit includes a future purchase option that allows the policyholder to increase the benefit regardless of the return.
- Automatic additional daily benefit purchase
  - One carrier offers the option of automatically increasing the daily benefit each year.
- Simple inflation, which annually increases the daily benefit and maximum lifetime benefit by a fixed percentage (typically 5%) of the first year's daily benefit
- Compound inflation, which annually increases the daily benefit and maximum lifetime benefit by a fixed percentage (typically 3 to 5%) of the previous year's benefits

The table below shows the effect an inflation rider can have on a policy's benefit. While compound interest increases the benefit more rapidly, it also increases the premium.

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<sup>3</sup> One carrier does not cause the forfeiture of the option at all during the life of the policy and, if it is exercised, bases the premium on the date of issue.

### Daily Benefit of \$200 x 6 Years:

Year	5% Simple: Doubling in 20 years	5% Compound:* Doubling in 15 years
5	\$250=\$547,500	\$255=\$558,400
10	\$300=\$657,000	\$326=\$713,940
15	\$340=\$744,600	\$402=\$880,380
20	\$400=\$876,000	\$696=\$1,524,240

\* Compound benefits rounded to the dollar

The only good policy is one that stays in force. Some policyholders end up dropping coverage because they feel the premium is too high. We therefore suggest that you spend extra time with your prospective clients to explain compound versus simple interest, and that you ensure they understand that choosing the latter means coinsuring the risk to a greater degree.

## Suggestions

The average claim is filed between the ages of 78 and 84. In the following illustrations, we assume age 84.

### Traditional Thinking Based on Claim being Filed on Average at Age 84

- For clients up to age 65: Compound.
  - The need for care is in the more distant future, when its cost is likely to be greater. The passage of time allows the compound factor to increase the benefit substantially.
- For clients of ages 65–75: Simple.

- Compounding does not start to pull away significantly from simple inflation until the 13th year (see Table on previous page), which puts the insured close to a claim. You may wish to reconsider if his age at issue is under 68.
- For clients older than 75:
  - A higher daily benefit may make more sense, because of the substantial cost of any inflation protection and the proximity to a claim.

### Thinking Differently about Inflation in the New World of Higher Premiums

The problem with offering inflation protection is that, based on the following factors, carriers now price this option very conservatively:

- Extremely low lapse rate, which increases the likelihood that the policy will be used
- Very low rates of return in the market
- Increased longevity (decreased mortality)

Here are some options if you live in a state where you would recommend a \$200 per day benefit to a male at age 60<sup>4</sup>, with a 90-day elimination period based on days-of-service:

#### **OPTION 1 (Traditional)**

\$200 daily (\$6,000 monthly), 5% compound, six-year benefit period, in the 24th year:

- A daily benefit of \$645
- A pool of \$1,412,550
- Premium in 2015: \$6,500–\$8,000 per year

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<sup>4</sup> Keeping in mind that the average claim is filed at age 82

### *ADVANTAGES*

- Higher daily benefit
- Longer benefit period
- Larger pool of funds
- May continue to compound if on claim

However:

- The daily benefit may be too high. Historically, maximum daily benefit (MDB) is rarely used if the proper benefit is suggested.
- The benefit period may be too long. The average claim settles in under three years. Not maximizing the daily or monthly benefit further extends an already long benefit period.
- The benefit pool may be too high. The average claim settles for \$200,000–\$450,000.
- It limits the pool of eligible buyers because income has to be substantial.

### **OPTION 2**

\$200 daily (\$6,000 monthly), 3% compound, four-year benefit period, in the 24th year:

- A daily benefit of \$407
- A pool of \$594,220, payable over four years
- Premium in 2015: \$6,500 to \$8,000

### *ADVANTAGES*

- Solid coverage based on average claim.
- May continue to compound if on claim.

However:

- The daily benefit does not double until 24 years. The insured may be at a disadvantage during this period if care is needed.

### **OPTION 3**

\$400 daily (\$12,000 monthly), three-year benefit, without automatic inflation protection, in the 24th year:

- A daily benefit of \$400
- A pool of \$438,000, payable over three years
- Premium in 2014 of \$3,000–\$4,500

#### ***ADVANTAGES***

- Higher daily benefit upfront. The assumption that the client is likely to need care only in the distant future may be unwise. If care is required during the first 15 years, the higher daily benefit would probably not be exhausted and would thus extend the benefit period.
- Coinsurance would probably be unnecessary unless the policyholder wished to extend the benefit period.

However:

- If the cost of care grows at a faster inflation rate than 3% per year, the client may have to co-insure more of the cost than planned.
- The benefit pool may be too low.

The following thoughts may be helpful in deciding which benefit to recommend:

- The cost of a traditional policy (Option 1) effectively excludes clients with modest incomes (\$50,000–\$75,000). The problem becomes more acute if you are trying to cover both spouses.
- The premiums on Option 3 (\$3,000 to \$4,500 per year) over 24 years are around \$84,000 cheaper than those of Option 1 (\$6,500–\$8,000). A less

expensive option than the traditional Option 1 could be very helpful if a client's advisor suggests that the policy is too expensive.

A thought about Option 3: If you choose Option 3 and are concerned about running out of benefits, you may want to consider a modest (\$100,000?) UL/whole life policy with an ABR that could be used as back-up.

## **Other Policy Provisions**

These features are built into all of today's policies: Bed reservation, alternate plan of care, care coordination, caregiver training, waiver of premium, and respite care.

### Bed Reservation

If a resident of a nursing home or an assisted-living facility requires hospitalization, his bed or room normally becomes available to other patients. If the nursing home or assisted-living facility has a waiting list, as many now do, the former resident may find that she no longer has a bed or room there upon her release from the hospital.

The bed reservation feature continues paying the daily benefit for a skilled nursing home or an assisted-living facility if the policyholder needs to be hospitalized or away, thus reserving his space. Benefits usually range between 14 and 30 days per year, and are sufficient to cover most hospital stays. Many policies also pay while the resident goes to a relative's home for a visit.

### Alternate Plan of Care, including Home Modification Feature

The claim departments of early LTCL carriers used to experiment with benefit utilization by offering alternatives to nursing home confinement to those filing claims. This feature allows the family and the carrier's claim department to negotiate the level of care needed and coverage available.

This process is intended to be mutually beneficial to both the insurer and the policyholder. Done properly, it can save insurers thousands of dollars per claim and provide the policyholder with more comfortable care. It relies on compromise: by authorizing benefit payments for sources of services that are not usually covered,

insurers try to save claim dollars while at the same time helping policyholders obtain care and services that better meet their needs.

Today, most LTCI policies include a provision that permits either the insurer or the insured to propose an alternate plan of care when the final result is at least as favorable to the insured as the policy would normally permit. This option is also valuable because it provides a way for a policy to pay for new services that aren't specifically written in the policy language.

Facility-only policies will never cover home care under an alternate plan of care, but may consider alternate types of facilities or residential care settings.

The insurer does not have the right to demand implementation of an alternate plan of care. Also the insurer does not have to agree to any alternate plan of care; it can essentially "veto" any alternate care request.

### Care Coordination

Care coordination calls for the carrier to pay for a third party to establish and manage the policyholder's care. The coordinator, usually a nurse, licensed social worker, or "geriatric care manager," would, among other responsibilities:

- Help choose where the care is best delivered (home, assisted living, adult day care centers, nursing home or even hospice)
- Help negotiate prices and coordinate schedules
- Provide constant monitoring of the insured's status and report it to family members who might not live nearby

Some companies consider this benefit so important that its use does not deplete the overall benefit maximum for their policies. Some provide unlimited benefits for carrier-appointed care coordinators, a specific benefit for a private care coordinator of the policyholder's own choosing, or both.

When you deal with the affluent, you should focus on this provision because it provides a benefit that is truly priceless: assisting those the insured loves through the emotional and complex world of simply choosing what type of care is best at any given time.

### Caregiver Training

Many carriers will pay a modest amount (usually between three and five times the maximum daily benefit) to train an informal caregiver to lift, move, feed, bathe, give medicines, and the like.

### Waiver of Premium

This provision, common in life and disability insurance, waives—or forgives—the premium requirement for policyholders who go on claim. Carriers who issue a shared policy may waive the premium for both insureds when one goes on claim; this is called a “joint waiver,” and also may be offered as a rider.

Waiver of premium for the claimant is built into most policies, but some are now eliminating this feature to keep premiums down.

### Respite Care

Respite care is generally defined as temporary institutional or home care provided to a recipient while the informal caregiver takes vacation time or other time off. Respite care benefits typically provide 14 to 30 days of benefits per year. Some policies pay respite care only in the home, but the ideal respite care benefit pays for facility care as well to cover the round-the-clock care that will be needed if the informal caregiver goes away for several days.

The question is sometimes asked, “Why is this different from the daily benefit?” The answer depends on the carrier, but generally:

- Respite care will pay to bring someone in during the elimination period; however, the care provided does not satisfy the elimination period.

- Some carriers will pay for respite care even though it exceeds the maximum daily benefit.

## **Optional Policy Provisions (Riders)**

The following optional features, which some carriers call riders, are available at extra cost in some LTCI policies: Restoration of benefits, survivorship, and accelerated payment.

### Restoration of Benefits

The restoration of benefits provision restores the full benefit maximum after some benefits have already been paid. To qualify, the policyholder must have fully recuperated and may not suffer a relapse for a minimum period (usually six months). If the policyholder requires extended care within six months of recovering from a prior period of care, some policies will restore full benefits if the cause is different from the first illness or injury, but most won't restore benefits for any reason until the policyholder has, for at least six months, regained the ADL or cognitive capacity he was lacking.

This provision will most likely be used by a younger person, who stands a better chance of recovering from a chronic illness. The caution here is that, after extended periods of care of perhaps more than a year, older extended care patients typically do not get better.

### Survivorship

Offered by most carriers either as a built-in or an extra-cost option (rider), the survivorship benefit applies to couples purchasing policies together. This benefit varies from one carrier to another. Typically, if a policy premium has been paid for a period of time, usually ten years, and one of the spouses dies, the surviving spouse's policy is deemed paid-up with no further premiums required.

Many carriers will cap the allowable age difference at 15 years.

### Accelerated Payment (Limited-Pay)

Most carriers have eliminated this option to accelerate the payment of premiums. Traditionally, the insured was offered a ten-pay, twenty-pay, or paid-up at 65 option. These options are called accelerated-payment or limited-pay. They are of little value to consumers for the following reasons:

- No discount is given for paying over a shorter period of time.
- All payments are lost if the owner dies during the payment period.
- The premium could be increased during the payment period.
- There is no tax benefit because deductibility is capped by age.

Practically, the only advantage may be to those who have just sold a business or have substantial resources and want to get the payments out of the way quickly, while at the same time guaranteeing no premium increases by paying up early.

Don't confuse an accelerated payment schedule for LTCI with accelerated benefits of a life insurance policy.

## **Nonforfeiture Options**

Tax-qualified LTCI policies must offer the option of nonforfeiture. One of these two nonforfeiture options must be offered, but as an option: Return of premium, and shortened benefit period

### Return of Premium

The estate or beneficiary with this option is refunded some or the entire premium upon the death of the insured. If it is offered, it takes one of two forms:

- Return of premium less claims paid
- Full nonforfeiture: return of all premium, unaffected by claims

### Shortened Benefit Period

Also known as a premium bank account, the shortened benefit period is the most common form of nonforfeiture in tax-qualified policies because it is the recommended option in recent revisions to the *NAIC Long-Term Care Model Act and Model Regulation*. The shortened benefit period method entitles policyholders to a paid-up benefit equal to the greater of all premiums paid or 30 days of benefits when the policy has been in force for three years or more. (In California, the benefit is the greater of premium paid or 90 days, and the policy has to be in force for at least ten years, not three.)

### **Community Living Assistance Services and Supports Act (CLASS)**

The *Community Living Assistance Services and Supports Act* (or CLASS Act) was a U.S. federal law, enacted as Title VIII of the *Patient Protection and Affordable Care Act (ACA)*. The CLASS Act would have created a voluntary and public LTCI option for employees, but in October 2011 the Obama administration announced it was unworkable as the legislated policy provisions could not be actuarially sustained and would be dropped.

After the CLASS Act ended Congress created the LTC Commission to address the country's surging need for long-term health care. When the panel released its recommendations in September 2013, they failed to offer a plan to help pay for the often expensive services. Public funding for extended care services (what bureaucrats now call "Long Term Services and Supports" [LTSS]) continues to run into funding limitations and a divided group of advocates that push and pull their own agendas from either side of the private versus public funding priority.



# Chapter D3:

## Health Insurance Portability and Accountability Act (HIPAA)

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### **Background: HIPAA**

While the 1993 NAIC Models initiated the definition of “modern” LTCI policies, it is the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* that deserves the credit for further standardizing the product and focusing consumers’ minds on its value. Passage of this federal bill demonstrated a clear consensus that insurance would, and should, become a key means of financing extended care.

### **Tax-qualified policies**

Tax-qualified LTCI policies offer their holders certain tax benefits, including deductibility of premiums, tax-free benefits and preferential treatment by many states. Such policies must meet certain standards, many of which were originally

outlined in the *1993 NAIC Long-Term Care Insurance Model Act and Model Regulation*.

### Requirements for Tax-Qualified Policies

The Internal Revenue Code defines a qualified LTCI contract as one that:<sup>1</sup>

- Does not have a medical-necessity trigger
- Covers only qualified long-term care services
- Does not pay or reimburse expenses that are reimbursable by Medicare, except when Medicare is a secondary payor or the policy pays on an indemnity or cash-benefit basis<sup>2</sup>
- Is guaranteed renewable
- Does not provide a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan or borrowed, except any refund on the death of the insured or on a complete surrender or cancellation of the contract
  - Such a refund cannot exceed the aggregate premiums paid for the contract.
- Includes any refund on a complete surrender or cancellation in gross income to the extent that premiums had been deducted or excluded from taxable income<sup>3</sup>
- Applies all refunds of premiums, and all policyholder dividends or similar amounts, as reductions in future premiums or to increase future benefits

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<sup>1</sup> Internal Revenue Code §7702B(b)(1)

<sup>2</sup> Internal Revenue Code §7702B(b)(2)(A) and (B)

<sup>3</sup> Internal Revenue Code §7702B(b)(2)(C)

## Definitions Applicable to Tax-qualified Policies

The following definitions apply.

Qualified long-term care services: 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.<sup>4</sup>

Chronically ill individual: Any individual who has, in the preceding twelve months, been certified by a licensed health care practitioner as:

- Being unable to perform, without substantial assistance<sup>5</sup> 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
- Having a similar level of disability
- Requiring supervision to protect him or her from threats to health and safety due to severe cognitive impairment

Activities of daily living (ADLs):<sup>6</sup>

- Transferring
- Toileting
- Bathing
- Dressing
- Eating

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<sup>4</sup> Internal Revenue Code §7702B(c)(1)

<sup>5</sup> Substantial assistance may be either hands-on or standby

<sup>6</sup> Internal Revenue Code §7702B(c)(2)(B)

- Contenance

To be tax-qualified, a LTCI contract must use at least five of these six ADLs in determining whether the insured is chronically ill.

Licensed health care practitioner: A licensed health care practitioner is any physician<sup>7</sup> and any registered professional nurse, licensed social worker, or other individual who meets such requirements as prescribed by the Treasury.<sup>8</sup>

### Consumer Protection Standards for Tax-Qualified Policies

Tax-qualified contracts must satisfy all of the following standards. Non-qualified contracts may or may not satisfy them.

- Policies must be guaranteed renewable (as long as the policyholder pays the required premium). Insurers may not cancel or refuse to renew a policy because of the insured's age, his health deterioration, or its claims history. They may raise premiums, but only on all policies of that class, regardless of individual claims experience.
- Policies must offer an inflation protection option. Producers who sell tax-qualified policies must also offer and explain this option in their sales presentation.
- Policies must be offered with an optional non-forfeiture benefit, but it may not be a cash surrender value. A premium refund benefit in the form of reduction of future premiums is permitted.

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<sup>7</sup> Physician as defined in Section 1861(r)(1) of the Social Security Act

<sup>8</sup> Internal Revenue Code §7702B(c)(4)

- Policies must include an unintentional-lapse provision, permitting a policyholder who misses a premium payment because of his cognitive or physical impairment to reinstate the policy up to five months later.
- Policies sold to replace existing LTCI policies (qualified or otherwise) may not impose any pre-existing-condition restrictions or probationary periods that existed in the original policy and were satisfied.

Furthermore, tax-qualified LTCI contracts may not impose unreasonable benefit limits or exclusions. The law specifically requires them to comply with certain provisions of the *NAIC Long-Term Care Insurance Model Act and Model Regulation* pertaining to prohibitions on limitations and exclusions, extension of benefits, disclosure and other standards. Especially noteworthy are these provisions:

- Policies may not condition coverage of a level of care upon prior need for a higher level of care or hospitalization.
- Insurers may not practice post-claim underwriting. They must conduct proper and complete underwriting, including the use of medical questions, prior to issuing the policy. Post-claim underwriting is the practice of “underwriting” a policy after a claim is submitted. This method’s rationale was to cut down on underwriting costs by underwriting only those policies on which claims were submitted, but policyholders are generally disconcerted by the uncertainty that their claims will be honored.

### Hands-on Versus Stand-by Assistance

Rarely mentioned in discussions of HIPAA, but very important nonetheless, is the virtual elimination of a hands-on-only assistance requirement to receive benefits, which was prevalent in earlier policies. Such language meant that a claim would not be paid unless the insured needed assistance involving direct physical contact.

The new term used is stand-by assistance; this might be, for example, someone’s presence nearby to provide help with balance when necessary. Other terms associated with stand-by assistance are directional and verbal cuing. A majority of

policies employ stand-by assistance as the criterion for payment under the ADL trigger.

### Pre-1997 Policies Grandfathered

All LTCI policies that were issued before HIPAA took effect on Jan. 1, 1997, are grandfathered and are considered tax-qualified as long as there are no “material” benefit changes.

Non-tax-qualified policies. Currently, no carrier offers non-tax-qualified LTCI.

## **Tax Benefits of Tax-qualified Policies**

### Benefit Taxability

The Internal Revenue Code regards tax-qualified policy benefits as payments received in accordance with a health insurance contract in reimbursement for actual expenses on medical care.<sup>9</sup> Benefits are therefore tax-free up to these limits as follows:

- All benefits from a policy that reimburses actual expenses are tax-free.<sup>10</sup>
- All benefits from a policy that pays a set dollar amount (per diem) when the patient is terminally ill are tax-free.
- All benefits from a policy that pays a set dollar amount (per diem) when the patient is chronically ill are tax-free only up to \$340 per day in 2016.<sup>11</sup> If the per diem amounts exceed the limitations, benefits are taxable only to the extent the benefits exceed the actual expenses.<sup>12</sup>

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<sup>9</sup> Internal Revenue Code §105(b)

<sup>10</sup> Internal Revenue Code §101(g), 7702B(d)(1)

<sup>11</sup> Internal Revenue Code §7702B(d); IRS Revenue Procedure 2007-66

<sup>12</sup> Internal Revenue Code §7702B(d)

## Benefits of Long-term Care Riders on Life Insurance Policies

A long-term care rider on a life insurance policy is treated as a qualified long-term care insurance contract. All carriers who offer this vehicle issue only tax-qualified LTCI contracts. Therefore, the taxability of benefit payments received under these policies is treated similarly to benefits received under other tax-qualified LTCI contracts.

## Deductibility of Premiums

### BASICS

As has been discussed, tax-qualified LTCI contracts are treated as health and accident plans.<sup>13</sup> Deductibility of the premium payment depends on which type of taxpayer, an individual or an entity, is claiming the deduction. Furthermore, the taxpayer's method of accounting—cash or accrual—determines the timing of the deduction.<sup>14</sup>

Premium deductions for the following taxpayers are limited and are based on age:<sup>15</sup>

- Non-self-employed individuals
- Self-employed individuals
- Partners in a partnership
- Owners of more than 2% of the shares in S corporations
- C corporations

The deductible amount for these taxpayers, in 2016, listed in the table below is called the eligible long-term care premium and is included among eligible medical expenses for deduction.<sup>16</sup>

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<sup>13</sup> Internal Revenue Code §7702B(a)(1)

<sup>14</sup> Regulation 1.461-1(a)(1), (a)(2)

<sup>15</sup> Internal Revenue Code §213(d)(10)

<sup>16</sup> Internal Revenue Code §213(d)(10)

<b>Age</b>	<b>Eligible Premium</b>
40 or less	\$390
41-50	\$730
51-60	\$1,460
61-70	\$3,900
71 and over	\$4,870

Individual Taxpayer (not a business owner)

An individual taxpayer claiming a deduction of the eligible premium must:

- File an itemized return (Form 1040, Schedule A).
- The portion of LTCI premium that is eligible for deduction depends on age as set forth in the table.
- The aggregate of the eligible portion of all medical insurance premiums (including the eligible portion of the LTCI premium) and unreimbursed medical expenses must exceed 10% of adjusted gross income (AGI).
- There is a temporary exemption for individuals age 65 and older until Dec. 31, 2016. If you are 65 years or older, you may continue to deduct total medical expenses that exceed 7.5% of your adjusted gross income through 2016. If you are married and only one of you is age 65 or older, you may still deduct total medical expenses that exceed 7.5% of your adjusted gross income.
- This exemption is temporary. Beginning Jan. 1, 2017, the 10% threshold will apply to all taxpayers, including those over 65.

- The amount in excess of 10% of AGI is deductible from gross income on Schedule A.<sup>17</sup>

### Employees

- Employer-paid premiums on tax-qualified LTCI contracts are excluded from an employee's income.
- The eligible premium may be reimbursed from a Health Savings Account (HSA), a Health Reimbursement Account (HRA) or an Archer Medical Savings Account (Archer MSA)<sup>18</sup> without the need to itemize, and without being reduced by the 10% AGI exclusion.
- The eligible premium is not deductible from a flexible spending account (FSA).<sup>19</sup>
- An employee may not pay LTCI premiums with pre-tax funds in a Section 125 cafeteria plan, as LTCI is excluded from the qualified benefits such plans may provide.<sup>20</sup>
- A premium payment made from the cash value of an annuity contract or the cash surrender value of a life insurance contract is not deductible as a medical expense.
- A couple (married or not) who own a joint policy with only one owner and two insureds are still allowed to claim an eligible premium deduction for each insured.

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<sup>17</sup> Internal Revenue Code §213(d)

<sup>18</sup> Internal Revenue Code §220(d)(2)(B), 223(d)(2); IRS Notices 2002-45, 2004-2, 2004-50

<sup>19</sup> Internal Revenue Code §106(c)

<sup>20</sup> Internal Revenue Code §125(f)

## Self-Employed Individuals (Sole Proprietors)

The tax code treats self-employed individuals more favorably than non-owner employees. The sole proprietor:

- Pays for the actual premium from gross revenue (similar to health insurance<sup>21</sup>; then...
- Deducts his or her eligible premium on Form 1040, line 2922 and pays self-employment tax on the premium (similar to health insurance).<sup>23</sup>
- The balance (the difference between the actual premium claimed on line <sup>29</sup> and the eligible premium deducted) is subject to full taxation.

The owner can also:

- Deduct the eligible premiums the business paid for his or her spouse and tax dependents, such as parents<sup>24</sup>
- Deduct the entire premiums paid for employees from business income on Schedule C, E or F, as applicable. <sup>25</sup>These premiums are excluded from the employees' incomes, and benefits are tax-free.<sup>26</sup>
- Discriminate by class, offering LTCI to some employee classes but not others, because, in general, group long-term care insurance plans are not subject to nondiscrimination rules like other plans, since they are fully insured plans.<sup>27</sup>

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<sup>21</sup> Revenue Code §162(1)(2)(C)

<sup>22</sup> Internal Revenue Code §162(l), §162(l)(2)(C) and §213(d)

<sup>23</sup> Internal Revenue Code §162(l)(4)

<sup>24</sup> Internal Revenue Code §162(l)(4)

<sup>25</sup> Internal Revenue Code §162(a)(1)

<sup>26</sup> Treasury Regulations 1.106-1

Consider: If the sole proprietor's spouse is on the payroll and meets the criteria of a bona fide employee, the entire premium is deductible on the sole proprietor's Schedule C28. In this case, the insurance policy should be in the name of the business or the employee spouse.

### Partnerships

Partners file as individuals. Partnerships may treat the payment of LCTI premiums made on behalf of their partners, their spouses and their tax dependents in one of two ways:

1. As a guaranteed payment
2. As a distribution

Normally, the payment would be treated as a guaranteed payment.<sup>28</sup>

Partners may deduct eligible premiums as self-employment health-insurance premiums on Form 1040, line 29 as follows:

- The premium, treated as a guaranteed payment on the partnership's tax return, is reported in Box 4 of the partner's Form K-1 and is subject to income and self-employment taxes.
- The premium, treated as a distribution on the partnership's tax return, is reported in Box 19 of the partner's Form K-1 and is not subject to income tax or self-employment tax. However, it may be subject to capital gains tax if the distribution is in excess of the partner's tax basis in the partnership.<sup>29</sup>
- Under either alternative, the partner deducts the amount of eligible premiums as self-employed health insurance premium on Form 1040, line

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<sup>27</sup> Treasury Regulations 1.105-5, 1.106-1

<sup>28</sup> Internal Revenue Code §61

<sup>29</sup> Internal Revenue Code §731(a)(1)

29.<sup>30</sup> The balance (the difference between the actual premium and the age-based eligible premium deducted on line 29) is subject to full taxation.

- The partnership can deduct the entire premiums paid for other employees from business income.<sup>31</sup> The premium is excluded from employee income, and benefits are tax-free.<sup>32</sup>
- The partnership is not subject to anti-discrimination rules. It can discriminate by class, offering the insurance to some employee classes but not others.<sup>33</sup>

### Subchapter S Corporations

Shareholders in *S Corporations* file as individuals. With respect to benefits, *S Corporations* are treated like partnerships, and shareholders who own more than 2% of an *S Corporation* are treated like partners rather than employees.<sup>34</sup> Those greater-than-2% shareholders can deduct eligible premium payments as self-employment health insurance premium on Form 1040, line 29, as follows<sup>35</sup>:

- The corporation may pay the entire premium and deduct it,<sup>36</sup> if the LTCI contract is in the name of the greater-than-2% shareholder and he pays the premium from personal funds, the corporation may reimburse the

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<sup>30</sup> Internal Revenue Code §162(l), §213(d)(1)(D) and §213(d)(10)

<sup>31</sup> Internal Revenue Code §162(a)

<sup>32</sup> Treasury Regulation 1.106-1

<sup>33</sup> Treasury Regulations 1.105-5

<sup>34</sup> Internal Revenue Code §1372(b)

<sup>35</sup> Revenue Ruling 91-26

<sup>36</sup> Internal Revenue Code §162 (a)

shareholder, if he provides the company with adequate proof of the premium payment.<sup>37</sup>

- The entire premium paid, whether paid by the corporation directly or through substantiated reimbursement, is treated in a manner similar to the way in which a guaranteed payment is reported and taxed to a partner. It is considered part of the shareholder's salary and is reported to him on his Form W-2, as well as to the IRS on the S Corporation's return, Form 1120S.<sup>38</sup>
- Payment or reimbursement of actual premium is considered part of the shareholder's salary and is reported on Form W-2, as well as to the IRS on the S Corporation's return, Form 1120S. Generally, such income would be subject to income tax but excluded from employment taxes.<sup>39</sup>

For the greater-than-2% shareholder to be allowed any deduction on his or her Form 1040, all of the following conditions must be true:

- The premium must be paid directly by the company or the shareholder must substantiate the premiums he paid to the company and be reimbursed by it.
- The premium paid or reimbursed must be reported by the company on the shareholder's Form W-2 for that year.
- The shareholder must report the premium paid or reimbursed by the S corporation as gross income on his Form 1040.

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<sup>37</sup> Internal Revenue Service Notice 2008-1, 2008-2 IRB 251

<sup>38</sup> Revenue Ruling 91-26

<sup>39</sup> Revenue Code §3121 (a)(2)(b)

If any of these conditions are not true, the greater-than-2% shareholder is not allowed a deduction for any premiums paid or reimbursed.<sup>40</sup>

If the above events have occurred, the greater-than-2% shareholder may deduct the eligible premium payments as self-employment health insurance premium on Form 1040.<sup>41</sup>

#### The Shareholder:

- Pays for the actual premium from gross revenue (similar to health insurance)<sup>42</sup>
- Deducts his eligible premium on Form 1040, line 29<sup>43</sup> and pays self-employment tax on the premium (similar to health insurance)<sup>44</sup>
- Is limited to deducting only the eligible premium (unlike in deducting health insurance)
  - The balance (the difference between the actual premium and the age-based eligible premium deducted) is subject to full taxation.

#### The Corporation:

- Can deduct the entire premium paid for other employees from business income<sup>45</sup>

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<sup>40</sup> Revenue Service Notice 2008-1, 2008-2 IRB 251

<sup>41</sup> Revenue Code §162(l), 213(d)(1)(D), 213(d)(10)

<sup>42</sup> Internal Revenue Code §162(1)(2)(C)

<sup>43</sup> Internal Revenue Code §162(l), §162(l)(2)(C) and §213(d)

<sup>44</sup> Internal Revenue Code §162(l)(4)

<sup>45</sup> Internal Revenue Code §162(a)

- The premium is excluded from employee income, and benefits are tax-free.<sup>46</sup>
- Deduct the eligible premiums it paid for a shareholder's spouse and tax dependents, such as parents.<sup>47</sup>
- Is not subject to anti-discrimination rules; it can discriminate by class, offering the insurance to some employee classes but not to others<sup>48</sup>

Consider: Employment of a spouse or dependent parents yields no additional tax benefit, because of the rule of attribution; the spouse's premium deduction is still capped at the eligible premium.<sup>49</sup> Premiums paid by the company for such family members must be included as wages on their Form W-2, and the family members can deduct the amount, if they meet the other requirements of Internal Revenue Code §162(l).

### Limited-Liability Companies (LLCs)

A *Limited-Liability Company* (LLC) is a state-defined business structure that protects owners from the liabilities of their companies. By default, an LLC with one owner is treated for tax purposes as a sole proprietorship.

An LLC with more than one owner is treated as a partnership.

An LLC may even elect another tax status, including that of a C Corporation or an S Corporation.

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<sup>46</sup> Treasury Regulation 1.106-1

<sup>47</sup> Internal Revenue Code §162(l), §162(l)(2)(C) and §213(d)

<sup>48</sup> Treasury Regulations 1.105-5

<sup>49</sup> Internal Revenue Code §318 and §1372

## Professional Corporations (PCs)

*Professional Corporations* are generally taxed similarly to *C Corporations*; check with your state.

## C Corporations

- The company can deduct the entire premium paid for an employee, regardless of whether he is a greater-than-2% shareholder in the company.
- The employer's method of accounting—cash or accrual—determines the timing of the deduction.

When the employer pays the premium on a tax-qualified LTCI contract covering an employee, the premium is excluded from the employee's income and, therefore, is also not subject to federal income tax withholding, Social Security, Medicare and federal unemployment taxes.<sup>50</sup> However, if the employee pays for such coverage through an after-tax payroll deduction, all such taxes do apply, as tax-qualified LTCI contracts are not eligible for payment from cafeteria plans.<sup>51</sup>

The company...

- Can also deduct the entire premium paid for an employee's spouse or tax dependents, such as parents<sup>52</sup>
- Is not subject to anti-discrimination rules
  - It can discriminate by class, offering the insurance to some employee classes but not others.<sup>53</sup>

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<sup>50</sup> Internal Revenue Code §106, §3121(a)(2)(B), § 3306(b)(2)(B); Treasury Regulation 1.106-1

<sup>51</sup> Internal Revenue Code §125(f)

<sup>52</sup> Internal Revenue Code §162(l), §162(l)(2)(C) and §213(d)

<sup>53</sup> Treasury Regulations 1.105-5

Premium paid for a shareholder who is not an employee is not tax-deductible to the company.

### Premiums of Long-term Care Riders on Linked Benefit Policies

For tax purposes, a long-term care rider on a life insurance policy or, beginning in 2010, on an annuity contract is treated like a tax-qualified LCTI policy if its coverage conforms to the tax-qualified policy definition. However, only the amount of the deposit and premium that is considered payment for the long-term care benefit (not the base life or annuity contract) may be deducted as a medical expense.

## **Other Taxability Considerations**

### Effect of the Pension Protection Act

Effective Jan. 1, 2010, Section 844 of the *Pension Protection Act* provides for tax-free:

- Withdrawals from non-qualified annuities for payment of extended care...if the annuity has tax-qualified LTCL language
- 1035 exchanges of life-insurance cash value into life/long-term care hybrid contracts
- 1035 exchanges of life-insurance cash value into annuity/long-term care hybrid contracts
- 1035 exchanges of annuity value into annuity/long-term care hybrid contracts
- 1035 exchanges of life-insurance or annuity value into single-pay LCTI contracts (which no carriers offer)

### State Tax Incentives

Many states now offer tax deductions or credits for long-term care policies. See Appendix 3.

### Premiums Paid for Parents' Policies

LTCI policy premiums paid for a parent are deductible as qualifying medical expenses for income tax purposes if the parent is a dependent of the child by IRS definition.

Premiums of tax-qualified LTCI policies represent qualifying medical expenses for the purposes of the annual gift tax exclusion, if they are paid directly to the insurance carrier.<sup>54</sup>

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<sup>54</sup> Internal Revenue Code §2503(e)(2)(B)

# Chapter D4:

## Rate Stabilization and Nonforfeiture

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Long-term care insurance carriers faced a host of challenges in bringing affordable and competitive products to the marketplace. Their competition to buy market share revolved around key decisions that included, among other factors:

- Attractive commissions
- Liberal underwriting
- Ease of claiming, particularly by adding a medical trigger

The situation was exacerbated by pricing based on actuarial assumptions that turned out to be inaccurate, including:

- Unrealistic lapse rate assumptions
  - Insurers underwriting LTC insurance in the 1980s and 1990s assumed that 5-10% of policyholders would ultimately lapse their policies, that is, voluntarily. In reality, industry lapse rates have been less than 2%, with many major carriers seeing lapse rates of less than 1%.
- Increases in morbidity (number of claims)
- Length of claims

- Interest earned on long-term reserve investments

The above factors have resulted in increased premiums many of which occurred when policyholders were older and on fixed incomes creating a great amount of ill will toward LTC insurance. Interestingly, in-force premium rate increases on LTC insurance have not increased the voluntary lapse ratios. Even with the increases, policyholders keep their coverage. They may reduce some of the benefit options to dial back down the increased premium, but policies for the most part have stayed in-force even with substantial and repeated increases. There is not a “death spiral” occurring in LTC insurance.

## **Contingent Nonforfeiture**

After much discussion, the National Association of Insurance Commissioners (NAIC) and the insurance industry negotiated a set of regulations known as the contingent nonforfeiture system, which strongly encourages companies to price products realistically. If a carrier raises rates above a specified percentage (whether in a single increase or over several increases), depending on the insured’s age at policy issue, it must both:

- Offer the policyholder a reduced benefit that would eliminate future rate increase
- Make available a nonforfeiture benefit that the policyholder could accept in place of the rate increase
  - The nonforfeiture benefit made available would conform to the tax-qualified definition under HIPAA; the policy would be deemed paid up and the carrier would pay a total of future benefits equal to the amount of premiums paid.

**EXAMPLE**

Mr. Smith buys a policy at age 60 and pays an initial premium of \$1,000. If the premium increased to more than \$1,700 (by more than 70%), contingent nonforfeiture provisions, described previously, would take effect.

Contingent nonforfeiture deters carriers from rate increases that would trigger it, and from policy underpricing that would entail rate increases. The carriers also know that their failure to ensure rate stability may lead to pressure on state governments to enact mandatory nonforfeiture.

Contingent nonforfeiture was made part of the NAIC Model Act in June 1998. The majority of states have now adopted it, and every carrier now builds this feature into its policies.

Premium increases triggering contingent nonforfeiture

<b>AGE AT POLICY ISSUE</b>	<b>INCREASE TRIGGERING NONFORFEITURE</b>	<b>AGE AT POLICY ISSUE</b>	<b>INCREASE TRIGGERING NONFORFEITURE</b>
29 and under	200%	72	36%
30–34	190%	73	34%
35–39	170%	74	32%
40–44	150%	75	30%
45–49	130%	76	28%
50–54	110%	77	26%
55–59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%

AGE AT POLICY ISSUE	INCREASE TRIGGERING NONFORFEITURE	AGE AT POLICY ISSUE	INCREASE TRIGGERING NONFORFEITURE
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

## NAIC Long-Term Care Model Acts and Regulations since 2000

Contingent nonforfeiture is viewed as an important tool in stabilizing rates. However, the NAIC was concerned that the rate of adoption was not fast enough, and in September 2000, passed the first of several new model acts and regulations which have been substantially adopted by the states. These more recent NAIC efforts are generally referred to as *Rate Stability Regulation*.

To help prevent long-term care insurance premium increases, 41 states have now enacted strict, new regulations on how LTC insurance policies must be priced. Many companies are also pricing new business according to the new regulations even in states that do not yet mandate it.

Preliminary evidence shows that these regulations are working very well in most states.

To understand why these new rate stability regulations are working, you must first understand why the old pricing methodology did not work.

Under the old system, the insurer was required to price their policies according to the projected amount of claims. For example, for every \$3 of claims they projected to

pay, they could charge \$5 in premium, leaving \$2 to go towards administrative costs, distribution expenses, and profit.

At the time, the regulators felt that this was the best way to price LTC insurance. It was similar to the pricing models for other "health-based" insurance products.

There were some major flaws in this old pricing method:

- 1) If a rate increase was needed, the insurers were allowed to price the same level of profit in the rate increase as they had priced into the original pricing method. This meant that a 50% rate increase could also mean a 50% increase in profit.
- 2) The insurers were not allowed to price in any margin for error. Using our example, for every \$3 in projected claims they could only charge \$5 in premium. There was no cushion priced into the policy to avoid future rate increases. The regulators, at the time, thought this was a good idea because it helped keep initial premiums low.
- 3) The insurers did not have to certify the accuracy of their actuarial assumptions. If their assumptions were off, then they could just request a rate increase.
- 4) It was very easy to get a rate increase. Since premiums were tied directly to projected claims, if claims were higher than expected, then premiums could be increased.
- 5) There was no cap on a rate increase. Since premiums were tied directly to projected claims, premiums could be raised as high as necessary.

The *NAIC Model Acts and Regulations* developed since 2000 and the states' implementation of these evolving rate stability regulations have corrected these problems as follows:

- 1) Under rate stability regulation, insurers cannot price the same profit levels into the rate increase as they do on their initial pricing. The regulation requires that only 15% of the rate increase go towards administrative and overhead expenses with 85% of

the rate increased premiums dedicated to pay claims. Also, if an insurer requests a rate increase, the insurer must decrease the profit levels in the initial pricing schedule. For example, if the insurer had initially priced for 50% of the premium to go towards administrative expenses, distribution costs, and profit, the insurer must reduce that to no more than 42% before calculating the rate increase.

2) Insurers are required to include a "cushion" in their initial pricing. They must include a "margin for error" in the initial pricing.

3) Insurers are required to have a qualified actuary certify that no premium increases are anticipated over the life of the policy form, including the provision for assuming a "moderately adverse" situation—the "margin for error."

4) If a rate increase is requested and approved, the insurer has to have an "annual review" with the regulators, for up to five years, to make sure the rate increase was justified and that it was not too high. If the rate increase turns out to have been too much, the insurer has to amend or reduce the increase.

5) Rate stability regulation puts a cap on the amount of a rate increase. The insurer is not allowed to have a rate increase that would be higher than their current pricing levels for new applicants.

- In addition, recent rate stability regulations require:
- That applicants confirm by their signature that they understand rates may increase
- That carriers disclose to consumers their rate increase history on similar policies for the past ten years
- An insurance commissioner receive authority to bar from the state for five years a carrier that exhibits a pattern of inappropriate rates

Although rate stability regulations are proving to be very effective in most states, it only applies to policies purchased after the rate stability regulation became effective in that particular state. For example, California's Rate Stability Regulation became

effective July 1, 2002. All policies purchased before July 1, 2002, are not protected by the California Rate Stability Regulation.

### Is it Working?

The Rate Stability Regulation is working very well in most states.

For example, after California's Rate Stability Regulation became effective July 1, 2002, protecting everyone who has purchased an approved LTCI policy in California on or after that date, 16 LTCI companies control about 85% of the market. Based upon data published in December 2015, of those 16 companies, 93.64% of their rate increases in California have been on policy forms that are not protected by the Rate Stability Regulation. Only 6.36% of the rate increases in California have been on policy forms protected by the Rate Stability Regulation. In fact, 12 of the top 16 companies have not had any increases on any of the policy forms they've sold in California since July 1, 2002.

CalPERS, the California Public Employee Retirement System, has had very large and frequent rate increases on their self-insured, group LTCI policyholders. However, CalPERS is not an insurance company and is not regulated by the California Department of Insurance. Anyone who purchases LTC coverage from CalPERS is not protected by California's Rate Stability Regulation.

Florida's track record with the Rate Stability Regulation is similar to California's. Florida's Rate Stability Regulation became effective Feb. 1, 2003. Based upon data published in December 2015, of the top 16 companies, 93.50% of the rate increases in Florida have been on policy forms not protected by the Rate Stability Regulation. Only 6.50% of the rate increases have been on policy forms protected by the Rate Stability Regulation. In fact, 11 of the top 16 companies have not had any increases on any of the policy forms they've sold in Florida since Feb. 1, 2003.

As with all *NAIC Model Acts and Regulations*, states are not required to adopt the new models, but overwhelming majorities have enacted it or similar legislation.

(The editors would like to thank Scott Olson for his significant contributions to updating and improving this chapter.)

# Chapter D5:

# Group Plans

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## Group Insurance

Two thoughts before we begin:

1. The CLTC program is primarily focused on individual sales. The group (also known as the multi-life or worksite) market employs a different set of dynamics. The purpose of this chapter is to give you a frame of reference on that market.
2. No carrier currently writes true group LTC insurance in the traditional sense defined as employer-owned, with employees covered by certificates of coverage and issued on a guaranteed-issue basis.

Depending on the state, size of the employer, the carrier and how the product is filed when you execute LTC Insurance in a business or corporate setting, you can generally do so in the following ways:

- Full underwriting, where participants could potentially have a chance of securing a preferred underwriting rate depending on the carrier chosen and the state that the product is filed in
- Multi-life format where there could be simplified or “abbreviated” underwriting and a premium discount, where enrollees all can receive a “standard” underwriting class in exchange for the premium discount and abbreviated or “simplified” underwriting

- These types of arrangements are currently very limited.
- Association/affiliation type approach, where there may be a premium discount to the participants with full underwriting
- True group, where there can be limited or no underwriting, and is based on a census submitted to the carrier
  - These plans historically generally have had no financial participation from the employer, being wholly voluntary in nature, though a small employer contribution is possible.

## **Employer Group Plans**

Employer plans are generally divided into three markets: large, affinity and group trust.

### **Large Group Plans**

Large groups are usually those of at least 1,000 employees, but can be far less. They offer LCTI as an employee benefit, typically offering it to persons employed at least 30 hours per week. Eligible employees' family members—parents, grandparents, siblings, children of age 18 and higher, even aunts and uncles—are also eligible; in some plans, relatives of a group member may apply even if the group member himself does not.

### **Affinity Group Plans**

Affinity groups usually include 10–15 lives. Quite frequently, associations will contract with an insurance company to provide LTCL to their members. Often, such plans are supported by individual policies that are usually issued with family discounts. While these are not traditional group plans covering employees of a single employer or members of a labor union, associations meet the definition of a group for insurance purposes and offer discounts to their members.

Many producers work the affinity market for the chance to sell so-called carve-out benefits to key executives. The ability to carve out (to discriminate in favor of some employees only) offers substantial opportunities for individual selling. You can carve out based on employee's title, tenure and/or income.

## **Group Trust Plans**

Similar to multiple-employer trusts (METs) used to provide group medical coverage to small groups, a group trust plan establishes a trust as the master policyholder. Once it is established, it accepts for group coverage employer groups that are too small to be eligible for their own policies. Like METs, these plans are usually established for the benefit of specific industry groups, such as medical care providers or law firms.

### Advantages of Employer Group Plans

- Opportunity to help more people with your area of expertise (employee, spouses/domestic partners, in-laws, grandparents, aunts, uncles, children, siblings, etc.)
- Many times, can be the difference between a person securing coverage or not because the plans have abbreviated or no underwriting as a result of the underwriting strategy
- The potential for premium discounts, which can be positioned as a gesture of goodwill on the part of the employer toward the employee
- Abbreviated underwriting
- Streamlined application
- Opportunity for you as a producer to help more people in a shorter time frame
- Opportunity for you to help people on an ongoing basis (i.e., new hires)

## Marketing to Employer Groups

You will want to consider having the LTC enrollment as its own stand-alone enrollment. The risk is that this LTC planning benefit will get “lost in the shuffle” if you include it in with open enrollment with 401K, health insurance, etc.

Successful LTC enrollments use a combination of web-based, paper-based, and people-based tools including:

- Payroll staffers
- One on one education consults at the employers premises
- Large group meetings
- E-marketing
- Webinars

### **WARNING ON PRE-1997 GROUP PLANS:**

Any type of group or association plan issued before Jan. 1, 1997, that increases policy coverage may jeopardize its tax benefits because of HIPAA rules. However, new members may join the group after that date without jeopardizing its grandfathered status.

### **GROUP PLANS OFFER SEVERAL ADVANTAGES:**

- Portability—Most, if not all, states require group long-term care policies to allow group members to convert their certificates of coverage to individual long-term care policies, without having to provide evidence of insurability, if the group policy is cancelled by either the insurer or the group policyholder.
- Many plans offer coverage to parents. In many instances, this extends to spouses, in-laws and even grandparents. These other family members have to complete full underwriting.
- Premiums may be deducted directly from the employee’s paycheck.

- If the employee is paying the premium for a parent’s tax-qualified policy, the individual may deduct it as a medical expense as long as the parent is a dependent.

## **The Federal Long-Term Care Insurance Program**

The *Federal Long-Term Care Insurance Program (FLTCIP)*<sup>1</sup> is an employer group insurance plan for current and retired federal government employees, including military personnel and their families—a total population of approximately 20 million.

The contract was awarded in late 2001 to John Hancock and MetLife, which created a new entity, Long Term Care Partners, LLC, to administer the program. MetLife declined to bid the contract when it came up for renewal in 2007, and John Hancock now operates the program.

Several groups are eligible to apply for FLTCIP coverage. They include federal employees and annuitants, including members and retired members of the uniformed services, and qualified relatives. Specifically, the following groups are eligible to apply for coverage:

- Federal employees in positions eligible for the Federal Employees Health Benefits Program (FEHB), whether or not they are actually enrolled in it.
- U.S. Postal Service employees in positions eligible for the Federal Employees Health Benefits Program (FEHB), whether or not they are actually enrolled in it
- Active members of the uniformed services who are on active duty or full-time National Guard duty for more than 30 days
- Active members of the Selected Reserve (members of the Individual Ready Reserve are not eligible)

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<sup>1</sup> The Federal Long Term Care Insurance Program Web Page. <http://www.ltcfeds.com>

- Tennessee Valley Authority employees (even if not eligible for FEHB)
- D.C. Government employees first employed by the D.C. Government before Oct. 1, 1987
- D.C. Courts employees
- Navy Personnel Command (BUPERS) NAF employees

Sales are handled by enrollers, who answer questions and take orders, rather than agents and brokers. These are not guaranteed-issue policies. Having knowledge of this plan gives us the opportunity to do what we do best—and that is educate. For some folks, the federal plan may be the best option. For others, it may not. It is another way for us to help our clients, and if you run into an employer where some of the enrollees have access to the federal plan, be sure to consider taking the time to review the Federal Plan option so you can further forge your relationship. After all, the Federal Plan may be the best course of action for them given their circumstances. Learn the Federal Plan and become familiar with the range of policy provisions available and be prepared to compare it to whatever product you may be advising the client on from the open LTC market.

## **Self-Funded Plans**

A relatively new concept in LTCI is self-funded plans, similar to self-funded health insurance programs that large corporations use to reduce costs.

The largest self-funded plan has been instituted by the California Public Employees' Retirement System (CalPERS).<sup>2</sup> This nonprofit venture reserves all income in trust for the benefit of its participants. It offers three basic plan types:

- Nursing Home, Assisted Living Only

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<sup>2</sup> CalPERS. <http://www.calpers.ca.gov>.

- Comprehensive
- Partnership

Members may choose inflation protection of 5% per year, compounded annually, for life. If they do not elect this option, members may periodically (every three years, until they file a claim) choose to increase coverage, without providing evidence of insurability. The Partnership version of CalPERS requires the 5% compound inflation benefit and has different benefit maximums.

All plans offer the standard coverage often found in individual plans. The premiums are level (they may be raised only for the entire group) and approximately 70% to 80% of the applicants are accepted. There is no additional waiting period for pre-existing conditions.



# Chapter D6:

## Partnership Programs

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In 1986, the Robert Wood Johnson Foundation gave grants to four states to study the problem of extended care financing and develop programs that used a combination of public and private dollars to pay extended care costs. Known as *Partnership Programs*, these plans involve the purchase of specially-approved LTCI policies.

The stated objectives of Partnership Programs are to:

- Improve consumers' understanding of the challenges of financing extended care
- Make LTC insurance more readily available to consumers
- Reduce consumers' fears of impoverishment due to extended care
- Cap the use of public expenditures (primarily through Medicaid) in financing extended care

Although these objectives are worthy, the real attraction for the states in offering Partnership programs is that very, very few policyholders go on Medicaid.

A 2006 report by the Congressional Research Service (a division of the Library of Congress) reported that the four original states had issued approximately 181,600 Partnership-eligible policies, of which only 88 policyholders, or .00005%, had exhausted benefits and qualified for Medicaid while protecting assets.

*The Deficit Reduction Act of 2005 (DRA '05)* encourages states to apply to the Centers for Medicaid and Medicare Services (CMS) for waivers to offer Partnership Programs. Prior to the act, CMS mandated the states to practice estate recovery. It obviously makes no sense to protect a person's assets from Medicaid only to have them recaptured by an estate recovery effort at death. Waivers of states' recovery obligations are now routinely granted.

Under DRA '05, future Partnership states will be allowed to offer only dollar-for-dollar protection (see below).

## **How the Partnership Programs Work**

Partnership Programs make LTCI more valuable by offering asset protection to those who purchase their approved policies. Policyholders qualify for Medicaid and still protect, depending on the plan, all or some of their assets.

Policies must meet the following criteria:

- Policies must include an inflation protection provision.
- Policies must be sold only by Partnership-certified insurance producers. The certification of producers assures that Partnership enrollees will have received proper advice on purchasing coverage.

As of 2007, NAIC, under its *Long-Term Care Model Act of 2006*, mandates proficiency in selling not only Partnership products, but any LTCI product. Producers will be required to take eight hours of training, which will be offered through several distribution channels.

Most states' Partnership Programs must include a care management benefit or must have at claim time a plan of care designed by access agencies. Since the benefits paid directly affect any asset protection, the state must ensure that the care given has been prescribed and managed by professionals.

Partnership Program approval of a policy means that it is included on a select list of policies approved by the participating states.

## **Methods of Asset Protection**

### California: Dollar-for-Dollar Asset Protection<sup>3</sup>

California Partnership for Long-Term Care policyholders protect one dollar of assets for every dollar in the benefit pool. Policies must have the following minimum coverage:

- Nursing-Home Care Benefit: \$180 + 5% compound inflation
- Residential Care Benefit: \$126 (assisted living)
- Home and Community Based Care Benefit: \$2700 nursing-home benefit.

### Connecticut: Dollar-for-Dollar Asset Protection<sup>4</sup>

Connecticut Partnership for Long-Term Care policyholders protect one dollar of assets for every dollar in the benefit pool. Policies must have a minimum daily nursing-home benefit of \$247 in 2015 increasing 5% annually) and home care benefit of \$123.50 in 2015 and also include 5% compound inflation protection.

The policy must guarantee the right to periodically increase benefit levels without providing evidence of insurability or health status, so long as the option for the previous period has not been declined. The amount of the additional benefit can be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of 5% from the year of purchase to the year of benefit increase. However, policyholders may opt out of inflation coverage if they are 65 or older by signing a state-approved waiver.

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<sup>3</sup> California Partnership for Long-Term Care. <http://www.dhcs.ca.gov/services/ltc/Pages/CPLTC.aspx>

<sup>4</sup> State of Connecticut Office of Policy and Management. Partnership Information. [http://www.ct.gov/opm/cwp/view.asp?a=2995&Q=383408&opmNav\\_GID=1814&opmNav=|#Connecticut](http://www.ct.gov/opm/cwp/view.asp?a=2995&Q=383408&opmNav_GID=1814&opmNav=|#Connecticut)

Nursing facilities must offer Partnership policyholders a 5% discount on their daily rates.

If the policy is about to lapse, the carrier must offer to lower the coverage or the premium.

#### New York: Unlimited or Dollar-for-Dollar Asset Protection<sup>5</sup>

The New York State Partnership for Long-Term Care originally offered only the total asset protection model, which required consumers to buy a more comprehensive state-defined benefit package. By doing so, they protected all assets from Medicaid. Recently, New York added a dollar-for-dollar model.

With a total asset protection plan, the policyholder may sell, transfer, or spend assets before, during, and after applying for benefits without affecting eligibility for Medicaid so long as he exhausts the minimum policy benefits.

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<sup>5</sup> New York State Partnership for Long-Term Care: Medicaid & the Partnership.  
<http://www.nyspltc.org/medicaid>

In 2015, there were four programs:

**Program 1: Total Asset 50**

<b>Minimum Benefit Period</b>	3 years nursing-home care 6 years home care
<b>Maximum Benefit Period</b>	Unlimited
<b>Minimum Daily Benefit</b>	Nursing home: \$284 in 2015 Home care: \$142 in 2015 (50% or more of nursing-home benefit)
<b>Maximum Elimination Period</b>	100 days
<b>Inflation</b>	Up to age 79: compound

**Program 2: Total Asset 100**

<b>Minimum Benefit Period</b>	4 years (nursing-home or home care)
<b>Maximum Benefit Period</b>	Unlimited
<b>Minimum Daily Benefit</b>	Nursing home: \$284 in 2015 Home care: \$284 in 2015 (equal to nursing-home benefit)
<b>Maximum Elimination Period</b>	100 days
<b>Inflation</b>	Up to age 79: compound

**Program 3: Dollar for Dollar 50**

<b>Minimum Benefit Period</b>	1.5 years nursing-home care 3 years home care
<b>Maximum Benefit Period</b>	2.5 years nursing-home care 5 years home care
<b>Minimum Daily Benefit</b>	Nursing home: \$284 in 2015 Home care: \$142 in 2015 (50% or more of nursing-home benefit)
<b>Maximum Elimination Period</b>	60 days
<b>Inflation</b>	Up to age 79: compound

**Program 4: Dollar for Dollar 100**

<b>Minimum Benefit Period</b>	2 years (nursing-home or home care)
<b>Maximum Benefit Period</b>	2.5 years (nursing-home or home care)
<b>Minimum Daily Benefit</b>	Nursing home: \$284 in 2015 Home care: \$284 in 2015 (equal to nursing-home benefit)
<b>Maximum Elimination Period</b>	60 days
<b>Inflation</b>	Up to age 79: compound

### Indiana: Hybrid Asset Protection<sup>6</sup>

Indiana switched to a hybrid model in 1998 and consumers can choose between dollar-for-dollar and total asset protection.

An Indiana resident who buys qualified long-term care policy with a minimum daily benefit of \$115 in 2015 and a pool of benefits below the state-set dollar amount of \$320,883 in 2015 protects the client's assets only in the amount of the policy's pool of benefits. However, if the individual buys a policy with a pool of benefits equal to or larger than the state-set dollar amount, he protects unlimited assets.

As of 2015 Indiana mandates compound inflation protection regardless of age.

### Massachusetts: Selective Asset Protection<sup>7</sup>

Massachusetts is not a Partnership state, but it does protect some assets in a similar way. It will not place a lien on an individual's home if he has a policy that meets the following standards:

- Minimum nursing-home benefit period: 2 years
- Minimum nursing-home daily benefit: \$125 in 2015

## **Limitations of Partnership Programs**

- Policyholders' income is not protected from Medicaid, and must be paid toward the costs of care.

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<sup>6</sup> Long Term Care Insurance or Life/Annuity LTC Hybrid? May 24, 2013. LTCA Inc. <http://www.ltcindiana.com/blog/long-term-care-insurance-or-lifeannuity-ltc-hybrid>

<sup>7</sup> Massachusetts State Asset Protection Laws. Asset Protection Society. <http://www.assetprotectionsociety.org/massachusetts-state-asset-protection-laws/>

- The policyholder may spend his Partnership policy's coverage while still living in the community. Since Medicaid pays little or nothing for care in the community, he might then be forced to reallocate income and/or invade capital.
- Most states require the purchase of compound inflation protection regardless of age. This may make the policy unaffordable. Do you want someone on Medicaid if they have a substantial pension or monthly annuity payment?

For these reasons, companies not offering Partnership products can still be very competitive in these states.

In view of all the limitations, it makes sense to keep your client off Medicaid in the first place. If that is your objective, then consider dropping inflation protection as previously suggested and recommending a higher daily benefit. Yes, you will sacrifice Partnership protection, but the client will nonetheless be highly unlikely to have to resort to Medicaid.

## **Other Provisions**

**Portability:** Partnership plans are portable, but the policyholder may have to move back to the issuing state to have assets protected if he applies for Medicaid (except Indiana and Connecticut, which in 2001 adopted a reciprocity program).

**Grandfather provision:** If the Partnership plan is discontinued for any reason, all policies will be honored.



# Section D

## Summary

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The LTC insurance industry has changed dramatically since the first policy was sold in 1965. To understand where we have come from helps you appreciate what is offered today. Policies have moved from non-tax-qualified plans for care in a nursing home to policies offering coverage for all levels of care and tax incentives in order for more consumers to be able to afford the premiums and qualify for benefits at home, in assisted living, skilled nursing homes or specialty dementia units.

With a wide range of benefits you will be able to offer quality protection to your prospective clients at affordable prices. Partnership programs in almost all states also offer asset protection through the policies that meet specific requirements. Learn what your state Partnership program offers in the event your prospective client has interest in Medicaid spend-down in the future.

### Key Points D

The first LTC insurance policies were limited in benefits, required preliminary steps to take in order for benefits to be paid such as prior hospitalization and prior skilled services before payment, Alzheimer's disease was not a covered ailment, and post-claim underwriting was allowed. In addition, the claims determinations were much like Medicare qualifications, meaning the reason for the payment of benefits was based on medically necessary triggers, not on the chronic illness definition of today. (Page #185)

The early policies from 1965 to the mid-90s had unclear and vague policy language. No offer of tax incentives was made until 1997. Since 1993 there is clear direction through standards and rules promulgated by the National Association of Insurance Commissioners (NAIC). (Page #183)

In 1993, the NAIC developed a model act and model regulations that established minimum standards for long-term care policies—the *1993 NAIC Long-Term Care Insurance Model Act and Model Regulations*. It is updated yearly to reflect changes in policy coverage. (Page #187)

### **Key points of the NAIC Model Regulation (Page #188)**

- Standardized definition of LTCI
- Standardized policy language: All policies must make these benefits available in the following settings:
  - Care received at home
  - Adult day care centers
  - Assisted-living care, room and board, if benefit triggers are met
  - Care provided in non-skilled or skilled nursing facilities
  - Specialized units for Alzheimer’s disease and other forms of dementia
- Benefits are payable for a pre-determined period of time, as defined in the policy’s benefit period clause. Due to the average length of time these benefits are used, 36 months, the need for lifetime or unlimited benefits is no longer a priority and the insurance companies no longer offer benefits that never end, in the stand-alone policies. Linked benefits offering Life or Annuity coverage plus LTC benefits may offer a lifetime benefit to add to the base policy.
- To qualify for benefits, a policyholder must meet certain requirements, called benefit triggers, and, in addition, satisfy an elimination period.

## **Physical Limitations (ADL Deficiencies) (Page #191)**

The inability to perform activities of daily living (ADLs) is used in long-term care policies as an important step on the path toward, and measure of the need for, receipt of benefits. To help you remember all six, they are listed below in the order we do them each morning in about the first 30 minutes of awakening (Page #194)

- Transferring (from bed to chair, wheelchair, walker, etc.)
- Toileting and the associated hygiene
- Bathing
- Dressing
- Eating
- Continence

All tax-qualified policies require inability to perform at least two ADLs from a list of at least five of these six. Most policies today require the loss of two out of six ADLs.

ADL assistance can be defined as either hands-on assistance—sometimes called “direct human assistance,” or stand-by assistance. Stand-by assistance is a better definition as it recognizes a lower degree of ADL limitation. (Page #194)

Cognitive impairment is generally defined as deterioration or loss of intellectual capacity as certified by a licensed health care practitioner and verified by clinical evidence and standardized tests that measure impairment in the areas of: (Page #195)

- Short- or long-term memory
- Orientation as to person, place and time
- Deductive or abstract reasoning
- Judgment as it relates to safety awareness

## **The Four Most Significant Flexible Benefit Provisions (Page #207)**

1. Benefit Amount
2. Benefit Payment: Most policies today employ a pool-of-benefits (also called pool-of-funds) approach to determining total plan benefits. The pool is determined simply by multiplying the daily benefit by 365 and the number of years selected in the policy. The pool is available to be spent on a variety of care services. Policies pay benefits from the pool in one of three ways: reimbursement, indemnity or cash.
  - a. A reimbursement policy pays based on compensable expenses on extended care up to the daily benefit.
  - b. An indemnity (or per diem) policy pays the full contract benefit regardless of the actual expenses incurred. There are two types of indemnity benefits: Cash benefit indemnity pays the full benefit, in cash, monthly regardless of expenses, who takes care of you, where, or how often; Daily or "professional" indemnity pays the full daily benefit regardless of actual expenses incurred upon the showing of at least one covered, compensable event per day (that for which the carrier will pay), such as a home care visit or a visit to an adult day center. Very few companies offer any type of indemnity benefit today.
  - c. With a cash benefit, the policyholder receives a portion of the daily benefit upon presenting to the carrier a plan of care. A few insurance companies offer this benefit in order for family or friends to be compensated to provide care at home, without submitting a bill for services.
3. Benefit Period: This is the period of time the benefit payments last after payment has started. Common provisions range from one year to ten, although some states require at least a two-year benefit period to be offered.

4. **Elimination Period:** Sometimes called the waiting period, qualification period or beginning date, it is the period of time that must elapse after a benefit-triggering event has occurred, before coverage starts. Conceptually similar to an insurance policy's deductible, elimination periods are a means of controlling premium costs; the longer the elimination period, the smaller the policy's premium, all other factors being equal.

### **Suitability (Page #196)**

HIPAA also adopted the NAIC's guidelines for suitability of purchase and applications for tax-qualified policies. You will find a Personal Worksheet in the required application forms that must be completed. To complete this form, you have to ask applicants to indicate their asset and income ranges.

Many producers believe that Medicare will pay for a flat 100 days of care. 100 days is the maximum benefit, and most beneficiaries receive less than a month of covered care, and then only if specific conditions are met first.

### **Tax Benefits of Tax-qualified Policies (Page #230)**

The Internal Revenue Code regards tax-qualified policy benefits as payments received in accordance with a health insurance contract in reimbursement for actual expenses on medical care. Benefits are therefore tax-free up to these limits as follows:

- All benefits from a policy that reimburses actual expenses are tax-free.
- All benefits from a policy that pays a set dollar amount (per diem) when the patient is terminally ill are tax-free.
- All benefits from a policy that pays a set dollar amount (per diem) when the patient is chronically ill are tax-free only up to \$340 per day in 2016
- If the per diem amounts exceed the limitations, benefits are taxable only to the extent the benefits exceed the actual expenses.

## **Deductibility of Premiums (Page #231)**

Tax-qualified LTCI contracts are treated as health and accident plans. Deductibility of the premium payment depends on which type of taxpayer, an individual or an entity, is claiming the deduction. Furthermore, the taxpayer's method of accounting—cash or accrual—determines the timing of the deduction.

## **Partnership Programs (Page #258)**

The stated objectives of Partnership Programs are to:

- Improve consumers' understanding of the challenges of financing extended care.
- Reduce consumers' fears of impoverishment due to extended care.
- Cap the use of public expenditures (primarily through Medicaid) in financing extended care.

Although these objectives are worthy, the real attraction for the states in offering Partnership programs is that very, very few policyholders go on Medicaid.

The *Deficit Reduction Act of 2005 (DRA '05)* encourages states to apply to the Centers for Medicaid and Medicare Services (CMS) for waivers to offer Partnership programs. Prior to the act, CMS mandated the states to practice estate recovery. It obviously makes no sense to protect a person's assets from Medicaid only to have them recaptured by an estate recovery effort at death. Waivers of states' recovery obligations are now routinely granted. (Page #260)

## **Limitations of Partnership Programs (Page #265)**

- Policyholders' income is not protected from Medicaid, and must be paid toward the costs of care.
- The policyholder may spend his Partnership policy's coverage while still living in the community. Since Medicaid pays little or nothing for care in the

community, he might then be forced to reallocate income and or invade capital.

- Most states require the purchase of compound inflation protection regardless of age. This may make the policy unaffordable.

## Section D Quiz

1. The following are all examples of LTC policy “step-downs” eliminated by the 1993 NAIC Model Act & Regulations EXCEPT:
  - A. Prior hospitalization
  - B. Nursing home stay before home care
  - C. 90-day ADL certification
  - D. Skilled care before custodial care
  
2. Which of the following statements is TRUE regarding guaranteed renewability?
  - A. Coverage and benefits are guaranteed as long as premium is paid
  - B. Premiums are guaranteed
  - C. The policy is non-cancellable
  - D. Policyholders have a right to buy more coverage every year
  
3. Which of the following is NOT a LTCI Activity of Daily Living?
  - A. Transferring
  - B. Mobility
  - C. Eating
  - D. Continence

4. Which of the following is NOT an example of a linked-benefit policy?
  - A. Life insurance with a LTC accelerated death benefit
  - B. Home Equity Conversion Mortgage
  - C. Life insurance with a LTC extension of benefits rider
  - D. Income annuity that increases the benefit if LTC services are used
  
5. When considering the LTC policy's benefit period, "pool of money" means:
  - A. The amount of money available for care or payable at death
  - B. The total of all premiums paid
  - C. How much money is available each month
  - D. The total LTC benefit payable regardless of time
  
6. A policy's Elimination Period is:
  - A. The number of days that must pass before benefit payments begin
  - B. Based on how many days Medicare pays for skilled care
  - C. Counted the same way in all policies
  - D. Usually waived when entering a nursing home
  
7. The Health Insurance Portability and Accountability Act provides for:
  - A. Guaranteed premiums
  - B. Tax-free benefits
  - C. Tax deductible premiums for all policyholders
  - D. Payment of claims that are medically necessary

8. Which of the following business entities provides for the largest LTC insurance premium tax deduction for its owner(s)?
- A. Sole proprietorship
  - B. Partnership
  - C. C-corporation
  - D. S-corporation
9. Which of the following statements is TRUE regarding Contingent Nonforfeiture?
- A. It is automatically included on all newly-issued policies
  - B. It is only available as an extra-cost rider
  - C. It guarantees premiums will never increase
  - D. It allows insurance companies to increase premiums to promote lapses
10. Partnership LTC is designed to:
- A. Encourage the use of Medicaid benefits for extended care
  - B. Encourage the purchase of LTC insurance
  - C. Save insurance companies from excessive claim costs
  - D. Give tax incentives to states that implement it

# SECTION E:

# IMPLEMENTING LTC INSURANCE COVERAGE

## Overview

At this point, you should have a good understanding of:

- Extended care and what causes the need for care
- A need for extended care is about the consequences for those the client loves
- The differences between the roles of primary earner and primary caregiver
- Consultative engagement
- The importance of creating a plan
- The CLTC® Three Step Planning Process and how to present it to the client
- What pays for extended care
- Policy language and coverage options
- Partnership programs
- Handling objections



# Chapter E1:

## CLTC® Client Interview Road Map

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### How to Use this Road Map

The Road Map provides the tools you need to confidently approach new and existing clients and engage them in a discussion about the consequences not having a plan for extended care will have on the emotional, physical and financial wellbeing of those they care about.

### Need for Care Caused by Impairments

There are impairments:

1. Physical is defined as chronic diseases that can be managed with medication and therapy but can never be cured by either. As these conditions progress they severely compromise the client's ability to negotiate ADLs.
2. Cognitive is defined as a marked decline in intellect that compromises the individual's ability to interact with others and or his or her environment.

The critical word is "compromise." As taught, men (see below) believe it is their responsibility to take care of their families. *Consultative Engagement* (see page #283)

suggests that should care be necessary those they love would have no choice but to put their lives aside, at great cost, to take care of them.

## Understanding the Psychology of Denial

In order to expand the market it is essential that you reach out to those who do not want to talk to you. Generally they are healthy men with no prior experience. To do so means understanding the psychology of denial.

### Cognitive Dissonance

*Cognitive Dissonance* is the discomfort felt when one's beliefs are challenged by facts to the contrary.

We build a set of beliefs to live by. When they are challenged by facts that undermine those beliefs, it creates a state of Cognitive Dissonance. There are three ways to deal with the discomfort:

1. Ignore that which makes us feel uncomfortable.
2. Rationalize our behavior.
3. Change our behavior.

### Applying Cognitive Dissonance to the Sale of Insurance

How people respond to a discussion of an unexpected need for care (or death or disability) is based, to a large degree on their role in the family. There are two: primary earners and primary providers of care.

Primary earners: The role of primary earners is to provide for and protect those they love at all stages of their lives.

- If men, they are generally hardwired to do so.
- If women...hold that thought.

Primary providers of care: Their role is to help create a family, provide a place of safety in which to raise and nurture children, if any.

- If women, they are generally hardwired to do so.

If talking with men who are primary earners, they must believe they will be available to execute their prime directives at all stages of life. Therefore, in their mind the risk of not being able to do so, whether it be from an unexpected death or disability or, in this case, a need for care, in their mind is... essentially zero.

If women are primary earners, they also believe they will not need care. However, their response is far more nuanced. Whether through genetics, social convention or both, they are more involved with the raising and nurturing of children. With this responsibility comes a natural awareness of the consequences of providing care.

Therefore, unlike men who believe there are no ifs, ands or buts about needing care, women will usually...

- Hesitate before answering...
- Then respond that they hope they don't need care.

Other ways of expressing it:

- Men know they are not going to need care; therefore, there can be no consequences. Women hope they don't need care.
- Men live in a world of no risk. Women live in a world of consequences.
- Women filter unexpected events through a prism that refracts into predictable consequences.

A review of current Risk Based Selling shows that it creates Cognitive Dissonance which makes it impossible to sell a product to men with no prior experience.

# Extended Care is Not a Place or Condition

If you ask a client what they think extended care/long-term care is, the answer likely to be that it's a condition like dementia, Parkinson's, stroke, or not being able to take care of yourself. Many also think it is a place like a nursing home or assisted living. The problem with suggesting that it could be is that reasonable people, particularly primary earners, believe that there is no chance of either. If they believe care will never be needed, then why purchase a product to cover it?

The better way to think about the subject is to think about a need for care, not as a condition or place but rather a life-changing event caused by impairments:

"Alan, if I may, what do you think extended care is?"

"A nursing home?"

Answer: No

"Dementia or something like that?"

Answer: No

"Not being able to take care of yourself?"

Answer: No

Alan then asks...

"What is it?"

"Alan, it's not a place like a nursing home or a condition. It's a life-changing event that would have devastating consequences to your wife and children and your ability to keep financial promises during retirement."

# A Review of CLTC Principles

## Consultative Engagement

CLTC principles are based on Consultative Engagement: The client is educated...

- About how an unexpected need for care would so compromise the individual...
- That he (or she) would not be able to execute his prime objectives of providing and protecting those he loves...
- Therefore, causing irreversible consequences to them

Consultative Engagement is predicated on the belief that those who love someone other than themselves will take action to protect those individuals but they must be given compelling reasons to do so. In this case there are two sets of consequences:

1. Emotional and physical
2. Financial

Other uses:

- Life insurance.
- Disability Income insurance.

## The Importance of Asking: Tell Me Who and/or What is Important to You

Put simply, people insure things and others that are important to them.

"If I may, what responsibilities do you now have you didn't think you would have 10–15 years ago?"

"Do you see taking most if not all of your financial commitments into the future in one form or another?"

Note: These commitments will be used further in the interview when it is suggested that the individual may not be able to keep them and pay for care at the same time.

## **The Three-Step Process Leading to Three Key Agreements**

Step 1: The client must agree that he could live a long life, and if he does, he may need extended care.

Step 2: The client must agree that if extended care were needed there would be serious consequences to the emotional, physical, and financial wellbeing of those who would provide that care. If he does, then you can put together a plan that mitigates those consequences.

Step 3: The client must agree that the only viable funding source for that plan is LTCL.

## **The Plan**

The plan is to allow your client to remain safe, at home, while mitigating the two sets of consequences created by needing care. It preserves:

- The emotional, physical and financial wellbeing of his or her family by allowing them to supervise care, not provide it
- The client's retirement portfolio so it can continue to generate income, minimize taxes and provide for those the client loves at death

# What Products that Fund a Plan Actually Do

Regardless of design (traditional, asset based or life insurance with an accelerated benefit rider or chronic care rider), products that fund a plan do nothing more than provide a predictable stream of income that, in turn, is used to fund the plan to keep your client safe at home while preserving the emotional, physical and financial wellbeing of those he or she cares about. Here's how...

- It changes the dynamics of event by allowing caregivers to supervise rather than provide care.
- It becomes a second gift of life to children who do not have to place their lives aside to provide care.
- It protects the client's primary source of income from retirement funds, which means they can continue to be used to keep financial commitments (lifestyle).
- It allows the tax and estate plan to execute properly which likely includes minimizing taxes and securing the financial viability of a surviving spouse or others.

# Universal Selling Scenario

There are two types of clients—Existing and Prospective. Regardless of the type, the question is the same... “Have you or someone you know had a prior experience with extended care?”

## ***EXAMPLE: EXISTING CLIENT WHO IS MARRIED WITH CHILDREN***

“Alan, any questions on the (financial or insurance) portfolio we just reviewed?”

“No, I am up to date”

“I am not sure I ever asked you this (Choose one or more):

- “What responsibilities do you now have that you didn’t think you’d have 10-15 years ago”
- “Do you use most if not all of your financial responsibilities you now have into the future in one form or another?”

The client shares those commitments.

“I need to talk to you about what would happen to Ellen and your children emotionally, physically and financially should you live a long life and perhaps need care over a period of years. I also need to discuss what paying for that care would do to your future plans to keep financial commitments.”

If the response is:

“What do you mean?”

Ask...

“Have you ever rolled up your sleeves and provided care to someone who was

chronically ill for a number of years?"

If the answer is "yes," ask ...

- "What happened?"
- "Where was the care provided and who provided it?"
- "What impact did it have on the care providers?"
- "What impact did it have on the family's finances?"
- "What impact did reallocating income have on the family's ability to keep prior financial commitments?"
- "Did it lead to an unintended invasion of their investment portfolio? If so, were there tax implications?"
- "Did anyone have to take money out of his or her pockets to help?"

There are four reasons you are asking these questions:

- Experience is persuasive. The client is likely to listen to your ideas about creating a plan to protect his family if he has either seen or become involved first hand in providing care.
- Asking these questions lets the client know that you understand the profession of extended care.
- It gives you an opportunity to share your experiences, which creates a bond.
- You may learn that the client's definition of extended care is different than yours.

For example the individual may tell you his dad had cancer or bad knees or congestive heart failure but was still able to take care of himself. If that is the case treat the individual as having no prior experience.

**EXAMPLE: RESPONSE TO CLIENTS WITH NO PRIOR CARE EXPERIENCE**

"Let me first ask, do you know what extended care is?"

"Nursing homes"

"No."

"Alzheimer's?"

"No."<sup>1</sup>

"What is it?"

Answer...

"Alan, it's not a condition like Parkinson's or dementia, because between you and me...do you think it's going to happen to you?"

"Not really"

"It is however a life-changing event that would have devastating consequences to your wife and children and to your ability to keep financial commitments. It's caused by impairments, which by definition severely compromise your ability to get through the most basic of daily routines. As they progress they would so

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<sup>1</sup> Keeping answers to one word forces the client to give you another answer. Never agree that it is a condition. It will allow him to tell you the condition will never happen. It is an event requiring assistance, involving his family.

compromise you that your family would have no choice but to put their lives aside to provide for what amount to constant care resulting in serious consequences emotionally and physically.

“There are financial consequences as well. Paying for care will disrupt every plan you have in place to secure the financial viability of your family. It starts with a reallocation of income which means you may not be able to keep current commitments. If the illness lasted long enough it would likely cause an invasion of your capital.

“Please understand, I am not suggesting you will need care. That is, I am not focusing on the risk of getting a chronic illness, but rather on the severe consequences if you did.”

Assuming the client is thoroughly educated about the consequences not having a plan would have on those he cares about, start the transition to *the Three Key Agreements*.

## Using the Three-Step Process to Establish Key Agreements

**Step 1: The client must agree that he could live a long life, and if he does, he may need extended care.**

“So Alan, let me ask you, do you believe it’s possible that you could live a long life?”

A reasonable client answers “yes.”

"If so, do you think it's possible, if not probable, that you could need care for a few years along the way?"

A reasonable client answers "*perhaps,*" "*maybe*" or "*yes.*"

Note: If he agrees, you have established Agreement 1. If not, go to Overcoming Objections on page #293.

**Step 2: The client must agree that if extended care were needed, there would be serious consequences to the emotional, physical and financial wellbeing of those who would provide the care.**

"I think you now understand that providing care would have devastating consequences to your family. So the question is... what's your plan to mitigate those consequences?"

Note: The client will likely say, "*I don't know.*"

"I'd like to create a plan that allows you to remain safe at home while preserving the emotional, physical and financial wellbeing of those you care about (use specific names if appropriate). May I do that?"

Note: If he says yes, you have established Agreement 2.

"The plan is straightforward. It's to allow you to remain safe, at home, while preserving the emotional, physical and financial wellbeing of your family. This is done by:

- Allowing them to supervise care, not provide it
- This preserves their emotional and physical wellbeing.
- Preserving your income so it can continue to be used to keep financial obligations
- Making sure assets never have to be used to pay for care"

### **Step 3: The client must agree that the only viable funding source for that plan is LTCI**

“Now that the plan is in place, what do you think will fund it?”

Note: At this point the client may bring up any number of alternatives including:

- Self-funding
- Medicare
- The VA
- Medicaid

Please review how to overcome these objections. If he answers, “*I don’t know,*” then move directly to LTCI.

## **The Case for Traditional and Non-Traditional Insurance**

“I want to talk to you about insurance as a funding source for the plan I put together to allow you to remain in the community should you need care, while preserving the wellbeing of your family. First, what do you think products like LTCI do?”<sup>2</sup>

The client/prospect responds...

“It pays for nursing homes.”

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<sup>2</sup> You want to find out what the client thinks it does up front so you can correct him.

Answer: No<sup>3</sup>

“It pays for my care.”

Answer: No

“It protects my assets.”

Answer: No

The client replies: “I thought that’s what they do.”

“All my clients do. They don’t protect you because (A) you don’t think you are going to need care in the first place and (B) even if you did your family would take care of you. The purpose of these products is to protect your family. Here’s how:

- The policy generates a stream of income, which in turn “funds” the plan.
- The income then allows the family to hire professionals to provide care, which fundamentally changes the dynamics of the event.
- Instead of being a care provider, with all the consequences that accompany it, your family member can now become a care supervisor. In turn, this makes it far more likely the insured can remain at home longer.
- If the children see that the healthy parent is not buckling from the stress, it allows them to continue focusing on their lives. In effect you have given them a second gift of life.

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<sup>3</sup> The product has nothing to do with the client. Agreeing that it does will give him the opportunity to tell you he will not need care. LTCI should always be positioned as a funding source for the plan to protect his family.

- If there is a stream of income to pay for care, there is no reason to reallocate your primary sources of income, which means you can keep your financial commitments.
- Since care is effectively covered, it does away with the need to use capital, thereby preserving your estate plan.”

## Overcoming Objections

“I don’t think I will live a long life. My dad died at 60.”

(Statement made after statement of consequences to the client’s family)

“You may not. But if you do and ever need care, do you begin to see how serious the consequences would be to your family?”

or...

“You may not, but respectfully, tell me in your own words what you think taking care of you over a period of years will do to the emotional, physical and financial wellbeing of your family?”

“What if I never need care?”

“You may not, but, if you did, do you understand what taking care of you over an extended period of years would do to the emotional, physical and financial wellbeing of your family?”

“Look, if I need care my kids will take care of me.”

“Tom, you have to think for a minute about what taking care of you over a period of years will do to their emotional and physical wellbeing. The issue with extended care is safety: if you cannot get through the most basic of daily routines because of a chronic illness or cognitive impairment, the consequences

could be severe. I can also tell you from my experience that it is unlikely that both of them will provide your care. That may very well lead to hard feelings.”

“I’ll take care of my mother.”

“I know you will. I want to talk to you about a way you can do it better and longer. It’s part of a plan that allows your mom to remain at home safe and have you supervise, not provide her care.”

“I’ll just put a gun in my mouth.”

“Please don’t say that. You’re not going to put a gun in your mouth. Please answer the question: what do you think providing care to you over a period of years will do the emotional, physical and financial wellbeing of your wife and children?”

“I am interested in learning about LTCI or I am just interested in getting a quote.<sup>4</sup>”

“The subject is not LTCI, the subject is extended care and the consequences that not having a plan for care will have on your family, income stream and retirement portfolio.”

## **Responding to the Objection that the Client has Sufficient Wealth to Pay for Care**

“My (CPA, FA, estate planning attorney) told me I have more than enough assets to pay for cost of care.”

(Assuming the client does have sufficient assets)

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<sup>4</sup> It’s assumed this objection would be brought up at the very beginning of the discussion. Never take the “bait.” Doing so leads you down the road of product, pricing, etc.

"You actually do. A couple of thoughts though:

"Assets do not pay for care, income does. Paying for care is just another expense in life, no different than a car payment, mortgage and utility bills. Day to day expenses are paid from cash flow. The problem is that paying for extended care requires a reallocation of income, which is already committed to lifestyle expenses. Using income to cover the cost of care and continue to keep financial commitments is, in effect, double counting it.

"You do, however, likely have sufficient assets to pay for care but the assets in your portfolio are really capital in nature; their purpose is to generate income to keep your financial commitments. Using capital creates a number of issues including:

- Unnecessary taxes.
- Subjecting the portfolio to market conditions; if you sold when the market was down it would create an actualized loss.
- Liquidity: Most of your net worth is tied up in (fill in the blank with investments such as a business, real estate, etc.)
- Every dollar you use to pay for care is one less dollar available to generate income.

"In other words using income or capital to pay for care disrupts every plan you created to minimize taxes, keep financial commitments and pass on an estate essentially intact."

#### In the Alternative:

"There's no question that you do. A thought if I may. The wealth you have accumulated through hard work is likely carefully accounted for in your estate. Every dollar you use to pay for care is one less dollar available to (fill in with charities, children, grandchildren etc.).

"I am a veteran. The VA will pay for my care."

"The VA is primarily a health care not custodial care provider. There are limited home care services but the financial criteria are very strict. No services are available if your monthly income generally exceeds \$2,000. There is one additional program, the Aid & Attendance Enhanced Pension Benefit, but again you have too much income to qualify."

"Medicare will pay for my care."

"Medicare is health insurance. It pays for medical and rehabilitative services, not custodial care."

"...but it paid for my mother-in-law.

"It likely did, but the law changed in 1998."

"My attorney told me Medicaid would pay for my care in a nursing home."

"Medicaid will pay for custodial care in a skilled nursing home.

"The problem is that the plan we agreed on calls for keeping you at home. Simply put...

- Medicaid cannot be a viable funding source for the plan because it pays little or nothing for home care, adult day care, and or assisted living.
- Medicaid is of no help in protecting the emotional and physical wellbeing of your caregivers for all the years you are home.
- Medicaid is not free. If you have qualified funds or low-cost-based assets, there are serious tax considerations.
- Once on Medicaid, your wife (husband) could lose most if not all of your monthly income"

## Power Phrases

- So tell me, what's important as you start to think about the future.<sup>5</sup> By that I mean, what responsibilities do you now have that you didn't think you would have had 10–15 years ago?
- Do you see taking most if not all of your current financial commitments into the future in one form or another?
- I need to talk to you about what would happen to Ellen and the children emotionally, physically and financially should you live a long life and perhaps need care over a period of years.
- The operative word should you need care is compromised. By that I mean chronic illnesses can become so debilitating, those who you said you would take care of would have choice but to take care of you.
- Extended care is not a condition like Parkinson's or dementia or a place like a nursing home or assisted living. It's a life-changing event that would have serious consequences to those you invited into your life and took responsibility for.
- You may never need care over a period of years but if you did, may I ask, what do you think providing care would do to your family emotionally and physically?
- In response to the statement: I am not going to a nursing home. No one is suggesting that you are. The fact is that your family will do everything possible to keep you at home. Without a plan providing care will have serious consequences to them.

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<sup>5</sup> Try to use the word "future" rather than "retirement" because many people plan on continuing to work in later life. People will insure things that are important to them. Remember there is no such thing as a discretionary expense to those with financial resources.

- Tell me in your own words what you think taking care of you over a period of years will do to the emotional, physical, and financial wellbeing of those you love?
- Providing care to chronically ill people often makes healthy caregivers chronically ill.
- Extended care doesn't bring families together, it tears them apart.
- People do not go to nursing homes when they should. They go when the caregiver becomes so worn out from providing care that there is no choice.
- Put simply, should you ever need care over a period of years, your life is not going to end ... someone else's life is going to end.
- The damage in an extended care situation is not when you go to a nursing home it's when your family decides to keep you home.
- Assets don't pay for care income does.<sup>6</sup> The problem is that your income is already committed to expenses few of which are discretionary. Asking income to both pay for care and keep financial promises is, in effect, double counting it.
- You likely do have sufficient assets to pay for care. A couple of thoughts if I may: Assets in portfolios are actually capital; its purpose is to generate income not used to pay for care. Using capital causes a number of serious issues including:
  - Unnecessary taxes
  - Actualizing losses if investments have to be sold in a down market
  - Liquidity: Could you sell assets to pay for care?
  - Every dollar used is one less dollar available to generate income in the future.

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<sup>6</sup> Always reduce assets to what they generate in income.

- Paying for care disrupts every other plan created to secure financial viability.
- And, every dollar used to pay for care is one dollar less that any charity to which you are committed receives.
- Traditional and non-traditional funding solutions act as a firewall in second marriages: It guarantees that assets held separate remain separate should care be necessary.

## Customized Sales Tracks

### Married, No Children

The questions you ask depend to a degree on with whom you are talking. Families come in all sizes and shapes. The following selling scenarios are tailored to:

- Married, no children
- Single, no children
- Married, no children
- Divorced or widowed with children
- Second marriages
- Same sex marriages/relationships
- Clients purchasing LTCI for parents

Notes:

- If you look carefully, there are variations on delivering the message. This is done to show you how flexible employing Consultative Engagement can be.
- Basic objections are addressed in these sales tracks. All others are handled in the Overcoming Objections section.

- The sales tracks end with the client agreeing to allow you to develop a plan (Key Agreement #2).

### Married, No Children

“Alan, any questions on the (financial or insurance) portfolio we just reviewed?”

“No, I am up to date.”

“I haven’t asked you this in a while, but tell me what’s important to you as you look into the future?”

“What do you mean?”

“What responsibilities do you anticipate taking into the future?”

(The client gives you a list of responsibilities)

“I need<sup>7</sup> to talk to you about what would happen to Ellen emotionally and physically should<sup>8</sup> you live a long life and ever need care over a period of years. I also need to discuss what paying for that care would do your ability to keep future financial commitments.”

If the response is:

“What do you mean?”

Ask...

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<sup>7</sup> Using the word “need” expresses a sense of obligation to a client and his or her family.

<sup>8</sup> Please remember that you are not focusing either on the risk of living a long life or of needing care. Doing so creates objections reviewed in Chapter 2 that are almost impossible to overcome. Using the words “should” and “ever” allows you to easily overcome them by simply saying “I never said you would live a long life or need care.” The emphasis then shifts to consequences.

“Have you ever rolled up your sleeves and provided care to someone who was chronically ill?”

If the answer is “yes,” consider asking any number of the following questions:

- What happened?
- How long did the illness last?
- Where was the care provided and who provided it?
  - What impact did it have on the care providers?
  - What impact did it have on the family’s finances?
  - Was any income allocated to pay for care?
- What impact did reallocating income have on the family’s ability to keep prior financial commitments?
  - Did it lead to an unintended invasion of their investment portfolio? If so, were there tax implications?
  - Did anyone have to take money out of his or her pockets to help?
- What did it do to the financial viability of the surviving spouse/children/family?
- Did he/she understand the consequences not having a plan would have on his/her family or friends and his/her retirement portfolio?

If the answer is no:

“So Alan, what do you think extended care is?”

“Nursing home?”

Answer: No

“Dementia or something like that?”

Answer: No

“Not being able to take of yourself?”

Answer: No

Alan asks, “What is it?”

“It’s not a place like a nursing home or a condition. It’s a life changing event that would have devastating consequences to your wife, children and ability to keep financial promises during retirement.”

Continue by explaining what causes a need for extended care, emphasizing the impact on others:

“Extended care is assistance you would need because you have an impairment. There are two types:

- A physical impairment, which is a:
  - Chronic medical condition such as Parkinson’s, MS, stroke, or diabetes. These illnesses can be managed with medication and therapy but cannot be cured. As the illness progresses it compromises your ability to get through the most basic of daily routines.

...or it could be

- A cognitive impairment which is a:
  - Marked or measurable decline in your intellect such as Alzheimer’s or other forms of dementia. As the illness progresses, it compromises your ability to safely interact with your environment or those around you.”

“By definition Ellen would have no choice but to put her life aside to make sure you are safe. You should also know that providing care to you will make her as chronically ill as you are.”

"Then there is the issue of paying for care. It will force a reallocation of your income and assets. The problem is that they were never meant to pay for care which means that paying will disrupt every plan you created to secure financial viability during retirement."

"Now I am not suggesting that any of these things will happen, but do you begin to see what would happen to Ellen emotionally, physically and financially if you needed care?"<sup>9</sup>

"I never thought about it like that."

Assuming the client is thoroughly educated about the consequences not having a plan would have on those he cares about start the transition to the Three Key Agreements:

Step 1: The client must agree he could live a long life and if he does his health may become compromised

"So Alan, let me ask you, do you believe it's possible that you could live a long life?"

A reasonable client answers yes.

"If so, do you think it's possible, not probable that your health may become compromised?"

A reasonable client answers perhaps, maybe or yes.

Note: If he agrees, you have established Agreement 1. If not, go back to Overcoming Objections on page #293.

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<sup>9</sup> Putting the question this way forces him to own the consequences.

Step 2: The client must agree that, if extended care were needed, there would be serious consequences to the emotional, physical and financial wellbeing of those who would provide the care

“I think you now understand that providing care would have devastating consequences to your family. So the question is... what’s your plan to mitigate those consequences?”

Note: The client will likely say, “I don’t know.”

“I’d like to create a plan that allows you to remain safe at home while preserving the emotional, physical and financial wellbeing of those you care about (use specific names if appropriate). May I do that?”

Note: If he says “yes,” you have established Agreement 2.

“The plan is straightforward. It’s to allow you to remain safe, at home, while preserving Ellen’s emotional, physical and financial wellbeing. This is done by:

- Allowing her to supervise care, not provide it; this preserves her emotional and physical wellbeing
- Preserving your income so it can continue to be used to keep financial obligations
- Making sure assets never have to be used to pay for care”

Step 3: The client must agree that the only viable funding source for that plan is LTCL.

“Now that the plan is in place, what do you think will fund it?”

Note: At this point the client may bring up any number of alternatives including:

- Self-funding
- Medicare
- The VA

- Medicaid

Please review how to overcome these objections on page #293. If he answers, *"I don't know,"* then move directly to LTCI.

### The Case for Insurance

"I want to talk to you about insurance as a funding source for the plan I put together to allow you to remain in the community should you need care, while preserving the wellbeing of your family. First, what do you think products like LTCI do?"<sup>10</sup>

The client responds...

"It pays for nursing homes."

Answer: No.<sup>11</sup>

"It pays for my care."

Answer: No.

"It protects my assets."

Answer: No.

The client replies: "I thought that's what they do."

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<sup>10</sup> You want to find out what the client thinks it does up front so you can correct him.

<sup>11</sup> The product has nothing to do with the client. Agreeing that it does will give him the opportunity to tell you he will not need care. LTCI should always be positioned as a funding source for the plan to protect his family.

"All my clients think that. They don't protect you because (A) you don't think you are going to need care in the first place and (B) even if you did your wife would take care of you. The purpose of these products is to protect your family. Here's how:

- The policy generates a stream of income which in turn 'funds' the plan.
- In turn, it allows your wife to hire professionals to provide care, which fundamentally changes the dynamics of the event.
- Instead of a care provider with all the consequences that accompany it, she can now become a care supervisor. In turn this makes it far more likely the insured can remain at home longer.
- If there is a stream of income to pay for care there is no reason to reallocate your primary sources of income, which means you can keep your financial commitments.
- Since care is effectively covered it does away with the need of using capital thereby preserving your estate plan."

## **Single, No Children**

Assumptions: The client has a close network of friends, a brother she is close to and a favorite nephew.

"Roberta, any questions on the portfolio (or insurance) portfolio we just reviewed?"

"No, I am up to date."

"I haven't asked you this in a while but tell me what's important to you as you look forward to retirement?"

"What do you mean?"

"What responsibilities do you anticipate taking into retirement?"

(The client gives you a list of responsibilities)

"I need to talk to you about what would happen to \_\_\_\_\_ (fill in family members the client is close with and or friends) emotionally and physically should you live a long life and perhaps need care over a period of years." I also need to discuss what paying for care would do to your lifestyle, including commitments during and after your death."

If the response is: *"What do you mean?"*

"If I may, have you or someone you know had a prior experience with extended care?"

If the answer is "yes," consider asking any number of the following questions:

- What happened?
- How long did the illness last?
- Where was the care provided and who provided it?
- What impact did it have on the care providers?
- What impact did it have on the family's finances?
- Was any income allocated to pay for care?
- What impact did reallocating income have on the family's ability to keep financial commitments?
  - Did it lead to an unintended invasion of their investment portfolio? Were there tax implications?
  - Did anyone have to take money out of his or her pockets to help?
  - What did it do to the financial viability of the surviving spouse/children family?
  - Did he/she understand the consequences not having a plan would have on his/her family or friends and his/her retirement portfolio?

If the answer is “no,” ask:

“So Roberta, what do you think extended care is?”

“Nursing home?”

Answer: No

“Dementia or something like that?”

Answer: No

“Not being able to take of yourself?”

Answer: No

Roberta asks, “*What is it?*”

“Roberta, it’s not a place like a nursing home or a condition. It’s a life-changing event that would have devastating consequences to your spouse, children, and ability to keep financial promises during retirement.”

Then continue by explaining what causes a need for extended care, always emphasizing the impact on others:

“Extended care is assistance you would need because you have an impairment. There are two types:

- A physical impairment which is a:
  - Chronic medical condition such as Parkinson’s, multiple sclerosis, stroke or diabetes. These illnesses can be managed with medication and therapy but cannot be cured. As the illness progresses, it compromises your ability to get through the most basic of daily routines.

“...or it could be

- A cognitive impairment which is:
  - Marked or measurable decline in your intellect, such as caused by Alzheimer’s or other forms of dementia. As the illness progresses, it compromises your ability to safely interact with your environment or those around you.

“By definition those you love would have no choice but to put aside their lives to make sure you are safe. Here are the direct consequences. Providing care to you will make a caregiver as chronically ill as you are.

“Then there is the issue of paying for care. It will force a reallocation of both your income and assets. The problem is that they were never meant to do so, which means that paying will disrupt every plan you created to secure financial viability during retirement and keep commitments after your death.

Now I am not suggesting that any of these things will happen, but do you begin to see what would happen to those you love emotionally and physically if you needed care?”<sup>12</sup>

“I never thought about it like that.”

Assuming the client is thoroughly educated about the consequences not having a plan would have on those she cares about, start the transition to the Three Key Agreements:

Step 1: The client must agree he could live a long life and if he does his health may become compromised.

“So Roberta, let me ask you, do you believe it’s possible that you could live a long life?”

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<sup>12</sup> Putting the question this way forces him to own the consequences.

A reasonable client answers "yes."

"If so, do you think it's possible, not probable that your health may become compromised?"

A reasonable client answers perhaps, maybe or yes.

Note: If she agrees, you have established Agreement 1. If not, go back to Overcoming Objections on page #293.

Step 2: The client must agree that if extended care were needed, there would be serious consequences to the emotional, physical and financial wellbeing of those who would provide the care

"I think you now understand that providing care would have devastating consequences to your family. So the question is... what's your plan to mitigate those consequences?"

Note: The client will likely say, "*I don't know.*"

"I'd like to create a plan that allows you to remain safe at home while preserving the emotional, physical and financial wellbeing of those you care about (use specific names if appropriate). May I do that?"

Note: If she says yes, you have established Agreement 2.

"The plan is straightforward. It's to allow you to remain safe, at home, while preserving the emotional, physical and financial wellbeing of your family and friends. This is done by:

- Allowing them to supervise care, not provide it. This preserves their emotional and physical wellbeing.
- Preserving your income so it can continue to be used to keep financial obligations.

- Making sure assets never have to be used to pay for care.”

Step 3: The client must agree that the only viable funding source for that plan is LTCL.

“Now that the plan is in place, what do you think will fund it?”

Note: At this point the client may bring up any number of alternatives including:

- Self-funding
- Medicare
- The VA
- Medicaid

Please review how to overcome these objections on page #293. If she answers, “I don’t know,” then move directly to LTCL.

### The Case for Traditional & Non-Traditional Insurance

“I want to talk to you about insurance as a funding source for the plan I put together to allow you to remain in the community should you need care, while preserving the wellbeing of your family. First, what do you think products like LTCL do?”<sup>13</sup>

The client/prospect responds...

“It pays for nursing homes.”

Answer: No<sup>14</sup>

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<sup>13</sup> You want to find out what the client thinks it does up front so you can correct her.

<sup>14</sup> The product has nothing to do with the client. Agreeing that it does will give her the opportunity to tell you she will not need care. LTCL should always be positioned as a funding source for the plan to protect her family.

"It pays for my care."

Answer: No

"It protects my assets."

Answer: No

The client replies: "I thought that's what they do."

"All my clients think that. They don't protect you because (A) you don't think you are going to need care in the first place and (B) even if you did, your family would take care of you. The purpose of these products is to protect them. Here's how:

- "The policy generates a stream of income, which in turn "funds" the plan.
- In turn it allows the family to hire professionals to provide care, which fundamentally changes the dynamics of the event.
- Instead of a care provider with all the consequences that accompany it, he or she can now become a care supervisor. In turn this makes it far more likely you can remain at home longer.
- If there is a stream of income to pay for care there is no reason to reallocate your primary sources of income, which means you can keep your financial commitments.
- Since care is effectively covered it does away with the need of using capital thereby preserving your estate plan."

## **Single with Children**

"Tim, any questions on the portfolio (or insurance) portfolio we just reviewed?"

"No, I am up to date."

"I need to talk to you about what would happen to Ethan and Ben emotionally and physically should you live a long life and perhaps need care over a period of years. I also need to talk to you about what paying for care would do to your portfolio that was never allocated to pay for it."

If the response is: What do you mean?

"If I may, have you or someone you know had a prior experience with extended care?"

If the answer is "yes," consider asking any number of the following questions:

- What happened?
- How long did the illness last?
- Where was the care provided and who provided it?
- What impact did it have on the care providers?
- What impact did it have on the family's finances?
- Was any income allocated to pay for care?
- What impact did reallocating income have on the family's ability to keep financial commitments?
- Did it lead to an unintended invasion of their investment portfolio? Were there tax implications?
- Did anyone have to take money out of his or her pockets to help?
- What did it do to the financial viability of the surviving spouse/children family?
- Did he/she understand the consequences not having a plan would have on his/her family or friends and his/her retirement portfolio?

If the answer is "no":

“So Tim, what do you think extended care is?”

“Nursing home?”

Answer: No

“Dementia or something like that?”

Answer: No

“Not being able to take of yourself?”

Answer: No

Tim asks, “What is it?”

“Tim, it’s not a place like a nursing home or a condition. It’s a life changing event that would have devastating consequences to your children and to your ability to keep financial promises during retirement.”

Continue by explaining what causes a need for extended care, always emphasizing the impact on others:

“Extended care is assistance you would need because you have an impairment. There are two types:

- A physical impairment which is a:
  - Chronic medical condition such as Parkinson’s, multiple sclerosis, stroke or diabetes. These illnesses can be managed with medication and therapy but cannot be cured. As the illness progresses, it compromises your ability to get through the most basic of daily routines.

...or it could be

- A cognitive impairment which is a
  - Marked or measurable decline in your intellect such as Alzheimer's or other forms of dementia. As the illness progresses, it compromises your ability to safely interact with your environment or those around you.

"By definition one of the children would have no choice but to put aside his life to make sure you are safe. Notice I said one, not both. I have rarely witnessed kids sharing the responsibility equally. Here are some ideas of the consequences:

- It will likely force that child to put aside his life. This not only has an impact on his family but his health as well.
- Providing care to chronically ill people often makes healthy caregivers chronically ill.
- Since it is not likely the other sibling could cause serious issues. Let's put it this way, I have rarely seen families brought together by the subject. In fact they are often torn apart.

"I can't imagine you want either son involved?"

"Absolutely not."

"Respectfully Tim, my experience tells me he won't have much of a choice.

"Then there is the issue of paying for care. It will force a reallocation of both your income and assets. The problem is that they were never meant to pay for care which means that paying will disrupt every plan you created to secure financial viability during retirement.

“Now I am not suggesting that any of these things will happen but do you begin to see what would happen to those you love emotionally and physically if you needed care?”<sup>15</sup>

I never thought about it like that.

Assuming the client is thoroughly educated about the consequences not having a plan would have on those he cares about start the transition to the Three Key Agreements:

Step 1: The client must agree that he could live a long life and, if he does, his health could become compromised.

“So, Tim, let me ask you, do you believe it’s possible that you could live a long life?”

“Yes.”

“If you do you think it’s possible, not probable but possible that your health may become compromised?”

“Maybe.”

Step 2: The client must clearly understand the emotional, physical and financial consequences to those he loves if care is needed.

“I think you now understand that providing care would have devastating consequences to your family. So the question is: what’s your plan to mitigate those consequences?”

Note: The client will likely agree that there would be serious consequences and that he does not have a plan.

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<sup>15</sup> Putting the question this way forces him to own the consequences.

"I want to put together a plan that allows you to remain safe at home while preserving the emotional, physical and financial wellbeing of those you care about (include specific names if appropriate). Can I do that?"

"Yes."

Note: If he says "yes," you have established Agreement 2.

"The plan is straightforward. It's to allow you to remain safe, at home, while preserving the emotional, physical and financial wellbeing of your children. This is done by:

- Allowing them to supervise care, not provide it. This preserves their emotional and physical wellbeing.
- Preserve your income so it can continue to be used to keep financial obligations.
- Making sure assets never have to be used to pay for care."

Step 3: The client must agree that the only viable funding source for that plan is LTCL.

"Now that the plan is in place, what do you think will fund it?"

Note: At this point the client may bring up any number of alternatives including:

- Self-funding
- Medicare
- The VA
- Medicaid

Please review how to overcome these objections on page #293. If he answers, "*I don't know,*" then move directly to LTCL.

## The Case for Traditional & Non-Traditional Insurance

"I want to talk to you about insurance as a funding source for the plan I put together to allow you to remain in the community should you need care, while preserving the wellbeing of your family. First, what do you think products like LTCI do?"<sup>16</sup>

The client / prospect responds...

"It pays for nursing homes."

Answer: No<sup>17</sup>

It pays for my care

Answer: No

"It protects my assets"

Answer: No

The client replies: "I thought that's what they do."

"All my clients think that. They don't protect you because (A) you don't think you are going to need care in the first place and (B) even if you did your family would take care of you. The purpose of these products is to protect your family. Here's how:

- The policy generates a stream of income which is used to "fund" the plan.

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<sup>16</sup> You want to find out what the client thinks it does up front so you can correct him.

<sup>17</sup> The product has nothing to do with the client. Agreeing that it does will give him the opportunity to tell you he will not need care. LTCI should always be positioned as a funding source for the plan to protect his family.

- In turn, it allows your children to hire professionals to provide care, which fundamentally changes the dynamics of the event.
- Instead of a care provider with all the consequences that accompany it, the children can now become care supervisors. In turn, this makes it far more likely you can remain at home longer.
- In effect this plan ends up being a second gift of life to the kids.”
- If there is a stream of income to pay for care, there is no reason to reallocate your primary sources of income, which means you can keep your financial commitments.
- Since care is effectively covered, it does away with the need to use capital, thereby preserving your estate plan.”

## Second Marriages

Assumptions: Couple in their late 50s; assets are held separately; two sets of children

“Bill any questions on the portfolio (or insurance) portfolio we just reviewed?”

“No, I am up to date.”

“There’s one more thing I would like to discuss with you. We need to talk about what would happen to Susan and both sets of children emotionally, physically should you live a long life and ever need care. I also need to talk to you about what paying for care would do your best-thought-out plans to hold assets separately and keep your financial commitments.”

If the response is: “*What do you mean?*”

“Not that it is likely to happen, but if you did need care over a period of years, my guess is that Susan would be making the decisions?”

“Yes.”

"If I may ask, how do you think your children would react to that decision?"

"It's really none of their business."

"Well, whether you like it or not, they may make it their business. It's very important that you have a health care proxy stating that Susan will make those decisions and that your kids know about it."

"Actually, that's a good point, thanks."

"Bill, I know you and Susan hold your assets separately, but let me ask you this question: If Susan ever needed care over a period of years, my guess is that, regardless of how the assets are held, you would spend whatever was necessary to keep her safe."

"No doubt."

"If I may, what would your children think of that idea?"

"I never thought about it like that, but it's really none of their business."

"I have to tell you that they may make it their business which would cause a lot of stress. I want to talk to you about a plan that would make certain that if either of you needed care, the assets of both would remain intact. May I ask you a few more questions?"

"Go ahead."

"Have you or someone you know had a prior experience with extended care?"

If the answer is "yes," consider asking any number of the following questions:

- What happened?
- How long did the illness last?

- Where was the care provided and who provided it?
- What impact did it have on the care providers?
- What impact did it have on the family's finances?
- Was any income allocated to pay for care?
- What impact did reallocating income have on the family's ability to keep financial commitments?
- Did it lead to an unintended invasion of their investment portfolio? Were there tax implications?
- Did anyone have to take money out of his or her pockets to help?
- What did it do to the financial viability of the surviving spouse/children family?
- Did he/she understand the consequences not having a plan would have on his/her family or friends and his/her retirement portfolio?

If the answer is "no":

"So Bill, what do you think extended care is?"

"Nursing home?"

Answer: No

"Dementia or something like that?"

Answer: No

"Not being able to take of yourself?"

Answer: No

Bill asks, "What is it?"

“It’s not a place like a nursing home or a condition. It’s a life-changing event that would have devastating consequences to your wife, children and your ability to keep financial promises during retirement.”

Continue by explaining what causes a need for extended care, emphasizing the impact on others:

“Extended care is assistance you would need because you have an impairment. There are two types:

- A physical impairment, which is a:
  - Chronic medical condition such as Parkinson’s, multiple sclerosis, stroke or diabetes. These illnesses can be managed with medication and therapy but cannot be cured. As the illness progresses it compromises your ability to get through the most basic of daily routines.

“...or it could be

- A cognitive impairment which is a:
  - Marked or measurable decline in your intellect such as Alzheimer’s or other forms of dementia. As the illness progress it compromises your ability to safely interact with your environment or those around you.

“By definition care would be all-consuming. This would force your wife to put aside her life to provide what amounts to 24-hour care. Here are the consequences:

“Providing care will make your wife as chronically ill as you are. This is going to have a direct impact on her children. I can’t imagine they will be happy.”

“If she starts to buckle, perhaps one of your children will hopefully step in. That will have a direct impact on her health, her relationship with her family and her sibling who is not likely to help.”

"By the way it may be one of your step-children. Think about that. I can't imagine you want any of the children involved?"

"Absolutely not."

"Respectfully Bill, my experience tells me they won't have much of a choice.

Then there is the issue of paying for care. It will force a reallocation of both your income and assets. The problem is that they were never meant to do so, which means that paying for care will disrupt every plan you created to secure financial viability during retirement. And that's if you need care.

"You need to consider what would happen to your estate if your wife needed care. That's one aspect that was not covered in the premarital agreement."

"Now I am not suggesting that any of these things will happen, but do you begin to see what a mess would be created if you don't have a plan?"

"I never thought about it like that."

Assuming the client is thoroughly educated about the consequences not having a plan would have on those he cares about, start the transition to the Three Key Agreements:

Step 1: The client must agree he could live a long life and if he does, his health could become compromised.

"So, Bill, let me ask you, do you believe it's possible that you could live a long life?"

"Hope to."

"If so, do you think it's possible, not probable, that your health could become compromised?"

“Hope not, but you never know.”

Step 2: The client must clearly understand the emotional, physical and financial consequences to those he loves if care is needed

“I think you now understand that providing care would have devastating consequences to your family. So the question is what’s your plan to mitigate those consequences? I want to put together a plan that allows you to remain safe at home while preserving the emotional, physical and financial wellbeing of those you care about (substitute specific names if appropriate). Can I do that?”

“Yes.”

“The plan is straightforward. It’s to allow you to remain safe, at home, while:

- Preserving the emotional, physical and financial wellbeing of your wife. This is done by allowing her to supervise care, not provide it. By having others provide care, it is far less likely her children will get involved or create an issue with your children because their mother is not buckling from the pressure.
- Preserving your plan to hold assets separately. Without a plan, her assets may have to be used to help pay for care. The problem becomes acute if you ever apply for Medicaid; her assets would be joined with yours and available to pay for care.
- Preserving your plan to keep financial commitments.”

Step 3: The client must agree that the only viable funding source for that plan is LTCL.

“Now that the plan is in place, what do you think will fund it?”

Note: At this point the client may bring up any number of alternatives including:

- Self-funding
- Medicare

- The VA
- Medicaid

Please review how to overcome these objections on page #293. If he answers, “*I don’t know,*” then move directly to LTCI:

### The Case for Insurance

“I want to talk to you about LTCI as a funding source for the plan. I put together to allow you to remain in the community should you need care, while preserving the wellbeing of your family. First, what do you think the product does?”<sup>18</sup>

The client/prospect responds...

“It pays for nursing homes.”

Answer: No<sup>19</sup>

“It pays for my care

Answer: No

“It protects my assets.”

Answer: No

“I thought that’s what they do.”

“All my clients think that. They don’t protect you because (A) you don’t think you are going to need care in the first place and (B) even if you did your wife would

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<sup>18</sup> You want to find out what the clients think it does up front so you can correct them.

<sup>19</sup> The product has nothing to do with the clients. Agreeing that it does will give them the opportunity to tell you they will not need care. LTCI should always be positioned as a funding source for the plan to protect their family.

take care of you. The purpose of these products is to protect your family. Here's how:

- The policy generates a stream of income which in turn "funds" the plan.
- In turn, it allows your wife to hire professionals to provide care, which fundamentally changes the dynamics of the event.
- Instead of being a care provider with all the consequences to both sets of children that accompany it, she can now become a care supervisor. In turn this makes it far more likely the insured can remain at home longer.
- If there is a stream of income to pay for care, there is no reason to reallocate your primary sources of income, which means you can keep your financial commitments.
- It also means that your wife's assets and income are preserved. So in effect having a plan and funding it correctly allows the pre-marital agreement to execute properly at your death."

## **Same-Sex Relationships**

Assumptions: Couple in their late 50s; assets are held together; two children; interviewed together

"Any questions on the portfolio (or insurance) portfolio we just reviewed?"

"No, we're up to date."

"Ed, there's one more thing: I need to talk to you about the consequences living a long life and perhaps needing care over an extended period of years will have on the emotional and physical wellbeing of Robert as well as your children. I also have to discuss the financial impact it would have on your retirement portfolio, which was never allocated to pay for it."

If the response is: "*What do you mean?*"

Ask...

"Have you or someone you know had a prior experience with extended care?"

If the answer is "yes," consider asking any number of the following questions:

- What happened?
- How long did the illness last?
- Where was the care provided and who provided it?
- What impact did it have on the care providers?
- What impact did it have on the family's finances?
- Was any income allocated to pay for care?
- What impact did reallocating income have on the family's ability to keep financial commitments?
- Did it lead to an unintended invasion of their investment portfolio? Were there tax implications?
- Did anyone have to take money out of his or her pockets to help?
- What did it do to the financial viability of the surviving spouse/children family? Did he/she understand the consequences not having a plan would have on his/her family or friends and his/her retirement portfolio?

If the answer is "no":

"So Ed, what do you think extended care is?"

"Nursing home?"

Answer: No

"Dementia or something like that?"

Answer: No

“Not being able to take of yourself?”

Answer: No

Robert asks, “*What is it?*”

“Robert, it’s not a place like a nursing home or a condition. It’s a life changing event that would have devastating consequences to your spouse, children and ability to keep financial promises during retirement.”

Continue by explaining what causes a need for extended care, emphasizing the impact on others:

“Extended care is assistance you would need because you have an impairment(s). There are two types:

- A physical impairment which is a:
  - Chronic medical condition such as Parkinson’s, MS, stroke, or diabetes. These illnesses can be managed with medication and therapy but cannot be cured. As the illness progresses it compromises your ability to get through the most basic of daily routines.

...or it could be

- A cognitive impairment which is a:
  - Marked or measurable decline in your intellect such as Alzheimer’s or other forms of dementia. As the illness progress it compromises your ability to safely interact with your environment or those around you.”

“By definition those you love would have no choice but to put aside their lives to make sure you are safe. Here are the direct consequences:

“Providing care to you will make you will make Ed as chronically ill as you are. It will likely force one of the children to put aside his life to help. This not only has an impact on his family but his siblings who may not help. I have often seen that when a child is involved it doesn’t bring the family together...it tears them apart.

“I can’t imagine you want either child involved?”<sup>20</sup>

“Absolutely not.”

“Respectfully, gentlemen, my experience tells me that they won’t have much of a choice.

“Then there is the issue of paying for care. It will force a reallocation of both your income and assets. The problem is that they were never meant to do so which means that paying will disrupt every plan you created to secure financial viability during retirement.

“Now I am not suggesting that any of these things will happen, but do you begin to see what would happen emotionally and physically if either of you needed care?”<sup>21</sup>

“I never thought about it like that.”

Assuming the client is thoroughly educated about the consequences not having a plan would have on those he cares about, start the transition to the Three Key Agreements:

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<sup>20</sup> If there is a daughter always mention her in this setting. Fathers are very protective of their daughters. This allows the conversation to focus, once again, on the consequences to those he loves, not the risk of needing care.

<sup>21</sup> Putting the question this way forces him to own the consequences.

Step 1: The client must agree he could live a long life and, if he does, his health could become compromised.

“So, guys, let me ask you, do you believe it’s possible that you could live a long life?”

“Hope to.”

“If you did, do you think it’s possible, not probable that your health could become compromised?”

“You never know.”

Step 2: The client must clearly understand the emotional, physical and financial consequences to those he loves if care is needed

“I think you now understand that providing care would have devastating consequences to your family. So the question is: what’s your plan to mitigate those consequences?”

“I want to put together a plan that allows you both to remain safe at home while preserving the emotional, physical and financial wellbeing of those you care about (substitute specific names if appropriate). Can I do that?”

“We want to hear your ideas.”

“The plan is very straightforward. It’s to allow you to remain safe, at home, while preserving the emotional, physical and financial wellbeing of your family. This is done by:

- Allowing the one providing care to supervise not provide it. This preserves the caregiver’s emotional and physical wellbeing.
- Having a source to pay for that care. Doing so allows you to keep your financial commitments.”

Step 3: The client must agree that the only viable funding source for that plan is LTCI.

“Now that the plan is in place, what do you think will fund it?”

Note: At this point the client may bring up any number of alternatives including:

- Self-funding
- Medicare
- The VA
- Medicaid

Review how to overcome these objections on page #293. If he answers, “*I don’t know,*” then move directly to LTCI:

### The Case for Insurance

“I want to talk to you about LTCI as a funding source for the plan I put together to allow you to remain in the community should you need care, while preserving the wellbeing of your family. First, what do you think the product does?”<sup>22</sup>

The client / prospect responds...

“It pays for nursing homes.”

Answer: No<sup>23</sup>

“It pays for my care.”

Answer: No

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<sup>22</sup> You want to find out what the client thinks it does up front so you can correct him.

<sup>23</sup> The product has nothing to do with the client. Agreeing that it does will give him the opportunity to tell you he will not need care. LTCI should always be positioned as a funding source for the plan to protect his family

"It protects my assets."

Answer: No

"I do not know."

Answer...

Each responds: "I thought that's what they do."

"All my clients think that. They don't protect either of you because (A) you don't think you are going to need care in the first place and (B) even if you did your partner would take care of you. The purpose of these products is to protect each other. Here's how:

The policy generates a stream of income which in turn 'funds' the plan.

- In turn, it allows your partner to hire professionals to provide care, which fundamentally changes the dynamics of the event.
- Instead of a care provider with all the consequences that accompany it, the healthy partner can now become a care supervisor. In turn, this makes it far more likely the insured can remain at home longer.
- If there is a stream of income to pay for care, there is no reason to reallocate your primary sources of income, which means you can keep your financial commitments.
- Since care is effectively covered, it does away with the need to use capital, thereby preserving your estate plan."

## **Clients Purchasing LTCI for Parents**

Assumptions: Client's parents are alive, in their 60s, in good health and have a modest estate; client has a brother and sister, with the latter likely to provide care.

"Peter, can I take a few minutes to discuss a situation that might have a significant impact on your wellbeing?"

"OK, what's up?"

"Are your parents alive?"

"Yes."

"How old are they?"

"Early 60s."

"Are they financially secure?"

"They have modest assets and income."

"Do you worry about them?"

"Actually I am beginning to. Why are you asking?"

"It concerns what would happen to you and your sister if your dad or mom ever needed care over a period of years. If for example your dad had a chronic illness what do you think taking care of him would do to your mom emotionally and physically?"

"What do you mean?"

"Have you or someone you know had a prior experience with extended care?"

If the answer is "yes," consider asking any number of the following questions:

- What happened?
- How long did the illness last?
- Where was the care provided and who provided it?
- What impact did it have on the care providers?
- What impact did it have on the family's finances?
- Was any income allocated to pay for care?
- What impact did reallocating income have on the family's ability to keep financial commitments?
- Did it lead to an unintended invasion of their investment portfolio? Were there tax implications?
- Did anyone have to take money out of his or her pockets to help?
- What did it do to the financial viability of the surviving spouse/children family?
- Did he/she understand the consequences not having a plan would have on his/her family or friends and his/her retirement portfolio?

If the answer is "no":

"Peter, what do you think extended care is?"

"Nursing home?"

Answer: No

"Dementia or something like that?"

Answer: No

"Not being able to take of yourself?"

Answer: No

Peter asks, "What is it?"

"Peter, it's not a place like a nursing home or a condition. It's a life changing event that would have devastating consequences to your wife, your children and your ability to keep financial promises during retirement."

Continue by explaining what causes a need for extended care, emphasizing the impact on others:

"Extended care is assistance you would need because you have an impairment. There are two types:

- A physical impairment which is a:
  - Chronic medical condition such as Parkinson's, multiple sclerosis, stroke or diabetes. These illnesses can be managed with medication and therapy but cannot be cured. As the illness progresses it compromises your ability to get through the most basic of daily routines.

...or it could be

- A cognitive impairment which is a:
  - Marked or measurable decline in your intellect such as Alzheimer's or other forms of dementia. As the illness progresses, it compromises your ability to safely interact with your environment or those around you."

"By definition you or sister would have no choice but to put aside your lives to make sure you are safe. It works something like this for example:

"If your dad needed care, your mom would have no choice but to put her life aside to provide it. I can tell you from experience that taking care of chronically ill people makes healthy people chronically ill."

"If your mom started to buckle, either you or your sister would have no choice but to get involved. That's likely to cause some friction."

"What would that do to your relationship with her if she provided the care?"

"I am beginning to get your point."

"One more thing, do you see it as a possibility that you or your sister may have to help out financially?"

"Maybe. You know I never thought about it like that."

"I want to put together a plan that preserves the emotional, physical and financial wellbeing of your parents and make your life easier if either needs care. Can I do that?"

"Absolutely"

## Confidential Fact Finders

### Fact Finder #1—Married or in a Committed Relationship

<b>Married or in a Committed Relationship (no prior commitment)</b>	
Appointment Date:	Meeting held at:
Name:	D.O.B.                      Age:
Spouse/partner:	D.O.B.                      Age:
Address:	City:
State	Zip
How long?	
Contact numbers (check next to the one you prefer to be reached at)	<input type="checkbox"/> Home: _____ <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Email: _____
Occupation	
Employer	
Occupation: Spouse/Partner	
Employer: Spouse/Partner	
Children:	Yes _____ No _____
Child #1	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	

Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Child #2	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Child #3	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Grandchildren?	Yes _____ No _____
Grandchild #1—Name:	Age:

Grandchild #2—Name:	Age:
Grandchild #3—Name:	Age:
Special needs children?	Yes_____No_____
Have you made arrangements to support the child during your retirement years?	Yes_____No_____
If so, discuss what impact paying for care would have on your ability to continue providing for the child and or fund a life policy, if there is one.	
Have you established a special-needs trust?	Yes_____No_____
Health (including medications)	
Client:	
Spouse/partner:	
Current Health Insurance Plan(s)	

<b>Financial Worksheet</b>	
Liquid (CDs, savings etc.)	\$
Tax-deferred (IRA, 401[k], etc.)	\$
Annuities	\$
Mutual funds	\$
Stocks	\$
Other	\$
Grand total of portfolio	\$
Value of real estate	\$
Income	
Client	
Social Security	\$
Annuities	\$
Other	\$
Spouse/Partner	
Social Security	\$
Annuities	\$
Other	\$
Grand Total	\$

per month x 12 = \$      yearly	\$
Life Insurance	
What type?	
Face Amount	
Cash Value	
Reasons for Purchasing?	
Lifestyle	
Lifestyle includes vacation home(s), boat, membership in club(s), private school fees for loved ones, tithing, contributions to an alma mater, etc.	
Please list:	
Additional notes (or add additional children):	

Fact Finder #2—Single, No Children

<b>Single People with No Children</b>	
Appointment Date:	Meeting held at:
Name:	D.O.B.                      Age:
Address:	City:
State	Zip
How long?	
Contact numbers (check next to the one you prefer to be reached at)	<input type="checkbox"/> Home: _____ <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Email: _____
Occupation:	
Employer:	
Are there any family members you are close with?	Yes _____ No _____
Family Member #1	
Name:	Age:
Relationship (brother/niece, etc.)	
Describe your relationship (close/estranged, etc.)	
Family Member #2	
Name:	Age:
Relationship (brother/niece, etc.)	
Describe your relationship	

(close/estranged, etc.)	
Family Member #3	
Name:	Age:
Relationship (brother/niece, etc.)	
Describe your relationship (close/estranged, etc.)	
Family Member #4	
Name:	Age:
Relationship (brother/niece, etc.)	
Describe your relationship (close/estranged, etc.)	
Family Member #5	
Name:	Age:
Relationship (brother/niece, etc.)	
Describe your relationship (close/estranged, etc.)	
Special needs relatives?	Yes_____No_____
Have you made arrangements to support this individual during your retirement years?	Yes_____No_____
If so, discuss what impact paying for care would have on your ability to continue providing for the child and or fund a life policy, if there is one.	
Have you established a special-needs trust?	Yes_____No_____

Health (including medications)	
Current Health Insurance Plan(s)	
<b>Financial Worksheet</b>	
Liquid (CDs, savings etc.)	\$
Tax-deferred (IRA, 401[k], etc.)	\$
Annuities	\$
Mutual funds	\$
Stocks	\$
Other	\$
Grand total of portfolio	\$
Value of real estate	\$
Income	
Social Security	\$
Annuities	\$
Other	\$
Grand Total	\$
per month x 12 = \$     yearly	\$

Life Insurance	
What type?	
Face Amount	
Cash Value	
Reasons for Purchasing?	
Lifestyle	
Lifestyle includes vacation home(s), boat, membership in club(s), private school fees for loved ones, tithing, contributions to an alma mater, etc.	
Please list:	
Additional notes (or add additional children):	

Fact Finder #3—Second Marriage/Committed Relationship

<b>Second Marriage/Committed Relationship</b>	
Appointment Date:	Meeting held at:
Name:	D.O.B. <span style="float: right;">Age:</span>
Spouse/partner:	D.O.B. <span style="float: right;">Age:</span>
Address:	City:
State	Zip
How long?	
Contact numbers (check next to the one you prefer to be reached at)	<input type="checkbox"/> Home: _____ <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Email: _____
Occupation	
Employer	
Occupation: Spouse/Partner	
Employer: Spouse/Partner	
Children:	Yes _____ No _____
Child #1	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your	

part, and if so, what are they?	
Child #2	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Child #3	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Grandchildren?	Yes_____No_____
Grandchild #1—Name:	Age:

Grandchild #2—Name:	Age:
Grandchild #3—Name:	Age:
Special needs children?	Yes _____ No _____
Have you made arrangements to support the child during your retirement years?	Yes _____ No _____
If so, discuss what impact paying for care would have on your ability to continue providing for the child and or fund a life policy, if there is one.	
Have you established a special-needs trust?	Yes _____ No _____
Health (including medications)	
Client:	
Spouse/partner:	
Current Health Insurance Plan(s)	
<b>Financial Worksheet</b>	

Is there a prenuptial agreement?	Yes_____No_____
Are assets held separately?	Yes_____No_____
If yes, what arrangements have you made for distribution at death?	
If either needed care over a period of years, do you see it as a possibility that money, now held separately, may have to be used to help pay for the cost?	
Liquid (CDs, savings etc.)	\$
Tax-deferred (IRA, 401[k], etc.)	\$
Annuities	\$
Mutual funds	\$
Stocks	\$
Other	\$
Grand total of portfolio	\$
Value of real estate	\$
Income	
Client	
Social Security	\$
Annuities	\$

Other	\$
Spouse/Partner	
Social Security	\$
Annuities	\$
Other	\$
Grand Total	\$
per month x 12 = \$      yearly	\$
Life Insurance	
What type?	
Face Amount	
Cash Value	
Reasons for Purchasing?	
Lifestyle	
Lifestyle includes vacation home(s), boat, membership in club(s), private school fees for loved ones, tithing, contributions to an alma mater, etc.	
Please list:	

Additional notes (or add additional children):	

Fact Finder #4—Divorced or Widowed, and Children

<b>Divorced or Widowed, and Children</b>	
Appointment Date:	Meeting held at:
Name:	D.O.B.                      Age:
Spouse/partner:	D.O.B.                      Age:
Address:	City:
State	Zip
How long?	
Contact numbers (check next to the one you prefer to be reached at)	<input type="checkbox"/> Home: _____ <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Email: _____
Occupation: Spouse/Partner	
Employer: Spouse/Partner	
Is your former spouse/partner alive?	Yes _____ No _____
If so, is he/she remarried?	Yes _____ No _____
Relationship (e.g., close, not speaking)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	

Children:	Yes _____ No _____
Child #1	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Child #2	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Child #3	
Name:	Age:
Occupation	

Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your part, and if so, what are they?	
Grandchildren?	Yes _____ No _____
Grandchild #1—Name:	Age:
Grandchild #2—Name:	Age:
Grandchild #3—Name:	Age:
Special needs children?	Yes _____ No _____
Have you made arrangements to support the child during your retirement years?	Yes _____ No _____
If so, discuss what impact paying for care would have on your ability to continue providing for the child and or fund a life policy, if there is one.	
Have you established a special-needs trust?	Yes _____ No _____
Health (including medications)	

Client:	
Current Health Insurance Plan(s)	
<b>Financial Worksheet</b>	
Liquid (CDs, savings etc.)	\$
Tax-deferred (IRA, 401[k], etc.)	\$
Annuities	\$
Mutual funds	\$
Stocks	\$
Other	\$
Grand total of portfolio	\$
Value of real estate	\$
Income	
Social Security	\$
Annuities	\$
Other	\$
Life Insurance	
What type?	

Face Amount	
Cash Value	
Reasons for Purchasing?	
<p>Lifestyle</p> <p>Lifestyle includes vacation home(s), boat, membership in club(s), private school fees for loved ones, tithing, contributions to an alma mater, etc.</p>	
Please list:	
<p>Additional notes (or add additional children):</p>	

Fact Finder #5—Parents

<b>Clients Purchasing LTCI for Parents</b>	
Appointment Date:	Meeting held at:
Client Name:	
Parents still married or divorced?	
Mother's Name:	D.O.B.                      Age:
Address:	City:
State	Zip
How long?	
Father's Name:	D.O.B.                      Age:
Address:	City:
State	Zip
How long?	
Contact numbers (check next to the one you prefer to be reached at)	<input type="checkbox"/> Home: _____ <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Email: _____
Occupation: Mother	
Employer: Mother	
Occupation: Father	
Employer: Mother	
Issues (remarried, estranged, etc.)	
Do any of these issues create a continuing financial obligation on your	

parents' part, and if so, what are they?	
Children:	Yes_____No_____
Child #1	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your parents, and if so, what are they?	
Child #2	
Name:	Age:
Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your parents, and if so, what are they?	
Child #3	
Name:	Age:

Occupation	
Relationship with child (issues, etc.)	
Issues (divorced, financial, health, children from prior relationship)?	
Do any of these issues create a continuing financial obligation on your parents, and if so, what are they?	
Grandchildren?	Yes_____No_____
Grandchild #1—Name:	Age:
Grandchild #2—Name:	Age:
Grandchild #3—Name:	Age:
Special needs children?	Yes_____No_____
Have your parents made arrangements to support the child during their retirement years?	Yes_____No_____
If so, discuss what impact paying for care would have on their ability to continue providing for the child and or fund a life policy, if there is one.	
Have they established a special-needs trust?	Yes_____No_____

Health (including medications)	
Mother:	
Father:	
Current Health Insurance Plan(s)	
<b>Financial Worksheet</b>	
Liquid (CDs, savings etc.)	\$
Tax-deferred (IRA, 401[k], etc.)	\$
Annuities	\$
Mutual funds	\$
Stocks	\$
Other	\$
Grand total of portfolio	\$
Value of real estate	\$
Income	
Social Security	\$
Annuities	\$

Other	\$
Life Insurance	
What type?	
Face Amount	
Cash Value	
Reasons for Purchasing?	
Lifestyle	
Lifestyle includes vacation home(s), boat, membership in club(s), private school fees for loved ones, tithing, contributions to an alma mater, etc.	
Please list:	
Additional notes (or add additional children):	



# Chapter E2:

## Creating the Right Policy

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Now that you have created the plan with the client, you must be ready to make recommendations of benefits and features of a policy based on the following:

1. Where does the client want to live while receiving extended care?
2. Who will be there to provide the care?
3. What will pay for it?

What follows is a general discussion of the key considerations in implementing the appropriate style of policy. Until the late 1980s, there were only nursing home policies. With the recognition of home care, assisted living and dementia care facilities as viable living situations for receiving care, and the possibility that a client may not qualify for a traditional LTCI product, there are now more choices to include in your presentation.

The key issues are the type of policy, the policy design, and the benefit payments.

### Type of Policy:

- Traditional Long-Term Care Insurance, often referred to as “stand alone” policies

- Individual with or without spouse/partner discount
- Two Individual plans with shared benefits
- Life Insurance with an LTC Rider
- Linked Life Insurance with LTC included.
- Life Insurance with an Accelerated Benefit (ABR) Rider.
- Linked Annuity with LTC included.

Policy Design:

- Daily or monthly benefit and coinsurance:
- Benefit period or “pool of money”
- Elimination period
- Inflation protection

Benefit payments:

- Reimbursement
- Partial Cash for Homecare

## **Type of Policy**

Traditional Long-Term Care Insurance

**INDIVIDUAL WITH OR WITHOUT SPOUSE DISCOUNTS**

A single person can purchase a policy without any spouse discount but he/she may add a spouse/partner at a later date and both will receive a discount. For two people in the same household, each person purchases a policy and receives a couple’s discount in the 35% range if both are approved and less of a discount if only one is approved for coverage. Generally, when a spouse/partner dies, the insurance company does not remove the couple discount.

## TWO INDIVIDUAL PLANS WITH SHARED RIDER

Both applicants must apply for the same coverage and may share the benefits by pooling the total maximum benefits together so that either or both persons have access to the combined total. Or there may be a third pool of money beyond their two benefits that either may access. This depends on the insurance company plans. Generally, the companies offer a reduced benefit to a remaining spouse, as long as the policy is still active, if one uses up all of the combined benefits.

### *ADVANTAGES*

- The sharing provision permits a policyholder who has exhausted his own benefits to use his spouse's.
- The benefit of the insured who does not use it all carries over to the survivor.

Consider, however:

- Benefits may be insufficient for the individual whose pool has been used to subsidize the other insured.

### Life Insurance with an LTC Rider

When adding the long-term care rider, any payout is an acceleration of the life insurance death benefit:

- Select the long-term care specified amount
- The long-term care benefits are paid income tax free after qualifying requirements are met.
  - If long-term care benefits are not needed, the beneficiaries will receive an income tax-free death benefit as long as the policy remains in force.
  - If long-term care is needed, the beneficiaries will still receive the greater of any unused long-term care benefits or perhaps 10% of the based policy's specified amount (less any policy indebtedness) thanks to the guaranteed minimum death benefit.

### Linked Life Insurance (whole-life or universal life chassis) with LTC included

Here is the demographic for this product:

- Is between the ages of 50 and 65 with average investible assets of \$500,000 to \$1 million or more.
- Tends to be an individual who thinks with his head, not heart. He is willing to pay for extended care, but has been shown how he can both leverage his money and maintain liquidity.

Generally the product combines a universal- or whole-life chassis with a full long-term care policy linked to the death benefit. The LTCI contract derives 100% of its funding from the death benefit. The extended care benefit is paid out as either a percentage of death benefit (between 2–4% generally) or by choosing a number of years (generally 2, 3 or 4).

The product's benefits are generally presented as follows:

- A lump sum (usually \$75,000 to \$100,000) in order to have a decent payout of LTC benefits on a monthly basis, is used to purchase a death benefit. The funds do not come from the broader pool of assets under management but rather are in easily accessible and thus low-return assets such as CD's, money market accounts and savings. A 1035 Exchange may be utilized to move the single premium amount from another financial instrument.
- The client is shown how he obtains instant leverage through at least doubling the single or multiple payment premiums used to purchase the product. He quickly realizes it would be close to impossible to get that return in existing accounts.
- He is then informed that the funds remain liquid for full refund (no earned interest) for period of time (usually 15 years or whenever the client wants the premium back) and there is no surrender charge.
- The product allows the insured to extend the pool of funds beyond the death benefit for long-term care coverage.

- In addition, there may be a Continuation of Benefits Rider to add for an additional annual premium that will allow the monthly LTC benefit to grow annually as well as may offer lifetime benefit.

#### *ADVANTAGES*

- A payout from the policy, one way or the other, is assured.
- Most carriers guarantee a minimum.
- Death benefit.
- The policy qualifies for status under IRC Section 1035: The policyholder can roll over cash-surrender value into a policy of this type.

Consider, however:

- Inflation protection is not built in, although it can be purchased for an additional premium.

#### Life Insurance with an Accelerated Benefit Rider

- Chassis: life insurance (generally universal life).
- Benefit: Majority of the death benefit is accelerated for billable LTC expenses.
  - Payment period is set by carrier.
  - Benefits are received tax-free.

#### *ADVANTAGE*

- These riders cost very little and allow dual use of the death benefit.

Consider, however:

- There is no inflation protection.
- Paying for care may neutralize the original purpose of the insurance.

### Linked Annuity with LTC included

Few carriers currently offer this design because of historically low interest rates. The demographic for this product generally consists of people between the ages of 50 and 65 who have existing non-qualified annuities. This product may make sense to someone who is willing to use his or her own money (the annuity and other assets) to self-insure. The product is created by taking an existing non-qualified annuity and exchanging pursuant to IRC §1035 for a vehicle that allows its use for extended care.

Here are the particulars:

- Chassis: single-premium, non-tax-qualified annuity paying current market rates.
  - The contract has a built-in long-term care benefit that is accessed as a new income stream payment of qualified extended care services.
  - Generally, there is a 1:1 relationship between the face value of the annuity and the care benefit. However, some carriers offer the opportunity of multiplying the care benefit, however simplified underwriting for the LTC benefit is required.

#### **ADVANTAGES**

- Payments for extended-care expenses from the annuity are not taxed, pursuant to the Pension Protection Act. Benefits from the care benefit are also not taxed.
- No loss of annuity if care is not needed, and the annuity proceeds can be passed to the beneficiary(ies).

Consider, however:

- In states with a high cost of care, the client has to fund the product with a substantial annuity.
- No inflation protection; benefits grow only at the pace of the annuity.

## **Policy Design: Daily or Monthly Benefit and Coinsurance**

We used to insure to the highest cost of care, nursing homes. However, today most people are using their policy benefits at home. Therefore, it is wise to know the area cost of home care as well as assisted living and try to insure to those amounts with the need for self-funding a higher cost should the client ever go to a nursing home. With the newer policies and higher premiums, making sure a client has an affordable policy is very important so that she will keep the policy in force, even with potential future rate increases.

Add up the client's income, including income from investments that would normally be rolled over, and subtract the client's probable expenses, including nonessentials that he would like to afford. The difference is the amount available for him to pay out-of-pocket, which is called coinsurance.

From the cost of care, subtract the coinsurance. The result is the daily or monthly benefit to cover.

As you have seen, covering the entire maximum cost of care with insurance does not, for most clients, provide the best value. If they opted to do that, they might pay higher premiums while being unable to use the disposable income and income subject to reinvestment from which coinsurance could be drawn. Most clients' concern is not that an illness, accident, or frailty will threaten the continued growth of their principal, but rather that their income may need to be reallocated, affecting their lifestyle, or possibly it may eventually force an invasion of principal.

### Coinsurance

Coinsurance involved determining discretionary income available to reduce the cost of long-term care coverage.

Should a person need round-the-clock care at home, coinsurance is impractical for a number of reasons:

- This could actually cost more than going to a facility.

- It is difficult to find caregivers for three shifts, coordinate them and be confident that they will show up consistently.
- Few people are comfortable with strangers continuously coming in and out of their home.
- If the family decides on round-the-clock care, it is likely that a full-time worker, paid informally, would provide the services at lower cost than a skilled nursing facility.

Here, then, are the steps in calculating coinsurance:

- Determine the maximum likely cost of care, which is probably that of nursing-home care, in the client's geographical area, as discussed above.
- Calculate from your fact finder what the annual net income is likely to be at retirement, including income from non-pension investments that would normally have been reinvested.
- Calculate what expenses, other than those for which LTCI would pay, are likely to be, using your fact finder. This should be relatively straightforward if the client has worked with a retirement advisor. Many clients have continuing commitments after retiring. Ask if your client is:
  - Helping children in financial trouble because of divorce, poor judgment in handling money, etc.
  - Providing for a handicapped child
  - Assisting grandchildren with education costs
  - Having a commitment to making donations to charities or religious organizations
- Subtract the total expenses from the net income.
  - The net of the previous step divided by 365 is the daily amount available for coinsurance, or by 12 for the monthly amount available.
  - The highest cost of care previously determined, less the amount available for coinsurance, equals the recommended LTCI benefit.

**EXAMPLE: A SINGLE RETIREE USING INFLATION PROTECTION**

Alan Sykes is 62, retired, widowed, he has the following assets:

Investment portfolio	\$600,000
Average annual rate of return	4 %
Annual income from assets	\$24,000
IRA	\$500,000
IRA annual drawdown at 5% interest over 25 yrs.	\$35,000
Social Security	\$18,000
Income before income taxes	\$77,000
Income taxes (assuming 16% for federal and state)	\$12,000
Net income after income taxes	\$65,000
Annual expenses	\$50,000
Annual discretionary income, currently reinvested (net income – expenses)	\$15,000
Daily discretionary income	\$41
Daily cost of care in an assisted living in Alan’s area <sup>1</sup>	\$109
Annual cost of care	\$40,000

**DISCUSSION**

“Alan, the highest cost of potential care would likely be in an assisted living community at about \$109 per day or about \$3300 per month. However, I am

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<sup>1</sup> According to the *2015 Genworth Cost of Care Survey*, the average nationwide cost of an assisted living facility is \$3600 per month or \$120 per day.

going to recommend that you purchase a \$100 a-day benefit, or \$3,000 per month, and use your discretionary income of \$41 to make up the difference.

“The reason is that this is insurance and may never be used. Even if you did use it, purchasing \$150 per day would allow your portfolio to continue to grow. I am not convinced this is the best use of insurance dollars. The goal of the product is to make sure that:

- Your income continues to be used to keep your commitments.
- The portfolio does not have to be liquidated with the attendant consequences we discussed (taxes; market timing; liquidity; ultimately a “financial death spiral”);
- Your estate remains intact to be passed on to those you love or to whom you’ve made financial commitments (charities, etc).”

Coinsurance may never be needed.

NOTE: Medicaid planning is not a consideration in the co-insurance process. Designing for co-insurance allows a client to effectively remain at home while preserving income and lifestyle.

Question: Does Alan coinsure the risk from the first day he draws benefits?

Answer: No. He will use the coinsurance amount only if he needs the highest cost of care.

Remember: few people end up in nursing homes. A daily benefit would generally buy the following coverage without using coinsurance:

- Nine hours of home care at \$20 per hour
  - Home care is generally needed 4–6 hours a day, in the morning, at lunch and at bedtime.
- Six hours of home care and adult daycare at \$60 per day

- Assisted living, assuming the cost is less than \$5,000 per month
  - Even if it were greater, the additional costs would be covered by the savings brought by the insured not living in his home.

## **Benefit Period “Pool of Money”**

Today the insurance companies are no longer offering lifetime or unlimited benefits so freely to their applicants. The need for a lifetime of coverage isn't great since the average length of claim is about three years. Also, the companies would have to charge so much more in premium to continue taking the risk of people needing care for many, many years.

The way the total maximum benefit or pool of money is calculated is to multiply the daily or monthly benefit by a starting maximum number of years and that becomes the total maximum benefit. However, we are seeing the companies not referring to the number of years anymore; more reference is being made as to how much money the policy starts with, and adding growth for a more meaningful pool of money in later years.

### **EXAMPLE:**

\$6,000 monthly maximum amount X 5 year benefit = \$360,000.00 pool of money

The following discussion presupposes the use of inflation protection.

With adding inflation protection, the \$360,000 pool of money and the monthly benefit will grow, which will extend the amount of time an insured will have to use up the benefits. Clients with a prior experience with extended care are likely to select a benefit period of five, six or more years when available.

However, the above is not applicable if you decide that inflation protection is too expensive and opt for a higher daily benefit and a reduced benefit period. See Part D, Chapter 2.

## Elimination Period (EP)

### **DAYS OF SERVICE**

If you choose “days of service” or service-day Elimination Period, this means the insured must pay out-of-pocket for covered care in order for a day to count toward the EP. A typical 90-day EP may take more than three-months to fully satisfy if paid, covered care is not received every single day. Medical insurance or Medicare-paid days may also count, but remember that even though Medicare may pay up to 100-days of care in a skilled nursing/rehabilitation facility, the 100 days are not guaranteed, and the average is less than one month. If a “service day” EP is the only option, it is recommended that the client purchased a shorter EP than might otherwise be considered, for example a 30-day service EP versus a 90-day EP.

### **CALENDAR DAYS**

Paid care services are not required to satisfy a calendar day elimination period. Once the insured is determined to be benefit eligible, the calendar begins to run even if the only care received is uncovered informal care. If the applicant can afford a 30- or 60-day EP, the benefit payments will come sooner than a 90-day EP.

## Hybrid EP

Hybrid Elimination Periods shorten the waiting period but cost more than days-of-service:

- “7 for 1”
  - A week of the Elimination Period will run for every week during which one day of compensable service is received.
- “7 for 3”
  - A week of the Elimination Period will run for every week during which three days of compensable service are received.

- Zero-day elimination for home care and a 90-day Elimination Period for facility care. Consider that the policy benefits pay on day one of home care charges, as the caregiver(s) may need extra help right away. Most carriers offer a zero-day elimination period at home included in the policy benefits or as a rider.

Could a one-year Elimination Period make sense? Yes, if the client has a pre-existing policy. That policy runs during the high Elimination Period. Just remember that paying out-of-pocket for one year of care today may be affordable in order to have a reduction in premium cost; however, you will need to discuss how much more that 365 days will cost out-of-pocket several years in the future.

Inflation protection: Please review the inflation protection options in Section D.

## **Reimbursement or Cash-Benefit**

Reimbursement pays up to the daily or monthly maximum benefit based on submitted bills. It is useful for:

- Keeping the cost of the premium down
- "Stretching" the benefit pool because only what is needed for compensable care is used and the balance stays in the pool to use later

Cash-benefit pays a partial daily or monthly benefit without having to show a compensable service; all that is required is a plan calling for covered care. Some of the insurance companies are offering a partial amount (35%-40%) of the benefits for care at home which can be paid to informal caregivers. If the policy holder plans to live out of the U.S. for months per year, the partial cash benefit can be used to pay anyone.

The advantages are:

- Benefits may be collected while outside the country.
- Excess coverage for those who have capped out on disability income.
- Coverage can be used for nontraditional treatment.

## Section E2: Case Studies

The following case studies are useful examples of the application of the information gathered in an interview. Remember that there is almost never one correct solution to the needs of a particular client. Your responsibility is to advise him of the reasonable options, explain them, and let him decide.

### Married Couple, Children, Modest Estate

#### Profile

Names	Jeffrey and Julie Sizemore
Marital status	Married 30 years
Ages	Jeffrey 59, Julie 58
Geographic location	Iowa
Employment status	Jeffrey: IT Specialist \$125,000; Julie: Yoga instructor
Part-time	\$25,000
Children & ages	Three children: John, 28; Susie 27; Geoff 26
Location of children	John: Boston, married with 2 children under 10; Susie: Des Moines, single; Geoff: Miami, single
Anticipated retirement portfolio	
Qualified assets:	\$350,000;
liquid	\$100,000
stocks and bonds:	\$125,000
Anticipated annual retirement income	\$79,280.00
Combined Social Security:	\$44,280

Pension:	\$20,000
Retirement portfolio & IRA:	\$15,000
House & other assets	
Couple own their home:	\$350,000
	\$75,000 home equity loan
No other debt	
Annual expenses	\$39,000

Reason(s) for inquiry

Jeffrey's mother has dementia, and the family is struggling to keep her at home with them. Julie is the primary caregiver and cannot provide care without outside help.

During the interview, the couple have told you they:

- Do not want their children to rearrange their lives to provide care. They do understand, on the basis of your input, that one, probably Susie since she lives closest to them, will likely provide some care while the other two siblings will provide telephone support but not financial support or caregiving.
- Want to remain at home or would consider assisted living if necessary.
- Must preserve their assets to provide income for approximately 40 more years and support the surviving spouse.

An Economic and Lifestyle Analysis Reveals:

- Jeffrey plans to retire in his late 60s. Patricia plans on retiring in four or five years and then do volunteer work at her church.
- They like to travel, especially to see the grandchildren.
- Retirement portfolio income plus other income stated above can support their retirement lifestyle.

- They want to try and keep at least \$5,300 per year from their investment portfolio as discretionary income.
- Coinsurance: net income less expenses. The couple agree they could afford to pay \$5,000 (\$416 per month) toward the cost of their care without invading principal.
- Nursing-home care in their area is approximately \$7,000 per month, but they hope to not have to go beyond assisted living

### Plan of Care

To stay home as long as possible and use assisted living, which is about \$4,500 per month, to remain in the community

They are convinced, on the basis of your input, that LTCI will:

- Allow the healthy spouse to provide care as long as there is additional paid care to provide relief
- Allow the child or children that are available to provide care to do so better and longer by paying for formal care
- Preserve their lifestyle
- Preserve principal, thus allowing the healthy spouse to continue executing the retirement plan

### Recommendations

Monthly benefit: \$5,000

- Couple can coinsure \$416 per month. \$416 per month will cover the majority of care at home or in assisted living and allows the clients to “buy up” if they are not comfortable. Suggesting this gives you credibility.

Policy type: Individual policies with sharing provision and couple discount if both approved.

- Couples believe that at least one of them will use the policy.

Reimbursement, with partial cash: Affordable premium

- Stretches payout

Benefit period: 8-years shared

- Price is always an issue, even when people say it isn't.
- It is highly unlikely they will need care past this period. This provides adequate coverage. However, some of the diseases that cause dementia are hereditary; if this is true of Jeffrey's mother, he may have inherited a higher risk of needing care for a longer period.
- Reimbursement stretches period of coverage.
- Let the couple "buy up" to a ten-year benefit period, if offered.

Inflation protection: Use their state's Partnership Program. (See Chapter D6).

Elimination: Zero elimination home care and 90 days' of service for a facility. You can add the calendar days' rider for facility but the chances are some other insurance will be paying during the elimination period anyway.

## Single with Children, Modest Assets and Income

### Profile

Name	Sherry Noble
Marital status	
Single	
Age	61
Geographic location	Atlanta
Employment status	Psychologist in her own practice
Children & ages	One child: Mellissa, 33, married with two children, ages 4 and 7
Location of child	Chicago
Anticipated retirement portfolio	Investments & IRA: \$300,000; liquid: \$75,000
Anticipated annual retirement income	\$65,200
Social security:	\$ \$25,200
Retirement portfolio & IRA:	\$20,000
Net rental income:	\$20,000
Credit card debt	\$15,000
Supports her daughter	\$1,000 per month.
House & other assets	
Owns her home:	\$250,000
Rental property worth	\$250,000

### Reason(s) for Inquiry

She does not plan on remarrying; understands that her daughter has obligations and works in Chicago and providing care will not be possible unless Sherry moved there; she is still helping daughter and son-in-law monthly and wants to help pay for grandchildren's education; cannot stand the thought of ever going on Medicaid.

On the basis of the interview, you have determined that the client:

- Wants to remain in the community as long as possible, but understands, from your input that it will be difficult because there is no family there to provide unpaid care. Her daughter might consider moving to Atlanta, but she doesn't want to uproot the grandchildren.
- Is willing to consider a continuing care retirement community in the future. This allows her to maintain her independence while knowing that care can be provided as she requires it without moving again.
- Wishes to pass her estate intact to her child, who has a modest financial future.

An economic and lifestyle analysis reveals:

- The client plans to retire in her early 70s.
- She wishes to travel to Europe to explore cultural attractions. Perhaps she can do that while she is still working.
- Retirement portfolio income plus other income stated above can support her retirement lifestyle.
- Her expenses are anticipated to be \$3,400 per year less than her net income. However, that may increase to \$7,000 per month, if she became substantially impaired, forcing her to cut back or eliminate her credit card debt and assistance to her daughter's family.
- Coinsurance: net income less expenses. She feels comfortable paying \$150 per month towards the cost of her care without invading principal.

- Nursing-home care in her area: \$85,000 per year (\$7,083 per month)

Plan of Care

To move into a continuing care retirement community (CCRC), investing \$500,000 from the sale of both properties

She is convinced, on the basis of your input, that LTCI will:

- Help her pay for home care or hospice in the apartment, and upgrade to private rooms in the assisted living or nursing facility onsite
- Allow her to preserve principal if she needs assisted-living or nursing-home care at the CCRC
- Allow her daughter to continue her parenting and/or career in Chicago
- Preserve the majority of her portfolio so it can be inherited by her daughter and pay for the grandchildren’s education
- Allow her daughter to inherit the residual from the initial CCRC buy-in when her unit is sold

Recommendations

Monthly benefit:	\$4,000
Nursing home cost is	\$7,000 per month

- Client can coinsure \$4,500 per month, which is insignificant. She would like to continue providing some income to her daughter.

Policy type: Individual, no couple discount. Standard health rating.

Reimbursement, with or without partial cash:

- More affordable without the cash alternative
- Stretches payout

Benefit period: 4 years

- Price is always an issue even when people say it is not.
- It is highly unlikely she will need care past this period. This provides adequate coverage.

Inflation protection: Look at the Partnership program requirement in Georgia if she wants to avoid Medicaid and conserve assets.

Elimination: Hybrid "7 for 1" or zero elimination home care and 90 days of service in a facility

## Single, No Children

### Profile

Name	Mary Julison
Marital status	Single
Age	63
Geographic location	Boston
Employment status	Secretary
Income:	\$55,000 per year
Children & ages	None. She does have nephews and nieces.
Anticipated retirement portfolio	
Investments & IRA:	\$200,000
Anticipated annual retirement income	\$48,200
Social Security:	\$25,200
State pension:	\$15,000
Retirement portfolio & IRA:	\$8,000
House & other assets	

She has \$4,000 in credit card debt.

### Reason(s) for Inquiry

Mary took care of her father and saw him run through life savings; she is starting to think about where she will live when she gets older and who will take care of her.

On the basis of the interview, you have determined that the client...

- Does not want to remain at home with care, she couldn't manage hiring the professionals herself. She wants to go to assisted living if she needs care.
- Does not want her nephews and nieces or sister and brother to take care of her and is willing to consider a continuing care retirement community (CCRC) in the future. This would allow her to maintain her independence, but without owning property she doesn't have enough money to invest in the upfront requirement.
- Wishes to pass money on to her nephews and nieces, but is willing to consider a "planned" invasion of principal to keep the cost of LTCI reasonable.

An economic and lifestyle analysis reveals:

- The client plans to retire in the next two to five years. If she is healthy she may consider working into her 70s.
- She has no particular hobbies or interests other than to do volunteer work and "travel a little bit."
- The income from her portfolio and her other stated income are sufficient to support her retirement lifestyle.

Coinsurance: net income less expenses

The only discretionary income available to coinsure the cost of care would come from her pension, investments and IRA. It may not be wise for her to coinsure at all.

Nursing-home care in her area: \$90,000 per year

### Plan of Care

To have enough monthly benefit to pay for assisted living and know that if she moves to a nursing home she may need to spend her income until she qualifies for Medicaid.

She is convinced, on the basis of your input, that LTCI will:

- Protect her income from her principal, which she understands may have to be used to supplement the policy should she need a high level of care.
- Allow her to use her own money and probably not be able to pass her principal to her nephews and nieces.

### Recommendations

Daily benefit: \$150

- Nursing home cost is \$90,000 (\$7,000 per month).
- The \$150 per day can cover some home care or hospice in her apartment.
- Recommending she purchase \$150 per day is likely to be met with an expense objection. Suggest that if she needed care, she could make a planned invasion of principal.
- Inflation protection recommendation is 3% compound.

Policy type: Individual Reimbursement

- Affordable
- Stretches payout

Benefit Period: 3 years

- Price is always an issue even when people say it is not.
- It is highly unlikely she will need care past this period. She will need to plan to go to Medicaid in a nursing home should she run out of benefit or principal.

Elimination: Hybrid: 90 days of service is less expensive in premium than calendar days EP.

Please consider presenting asset-based solutions when the clients have enough money to pay a single or annual premium for life/ltc or annuity/ ltc plans.

- Client was uninsurable with the traditional health LTC carriers given medical conditions, so as it turned out the asset based alternative was the only option OR the client didn't want to "just throw her money away" by funding a traditional LTC plan without a return of premium rider.
- As it turned out, traditional health LTC wasn't an option anyway because of how she presented medically. (More on this in Chapter E3)
- And she also wanted a solution to best LEVERAGE her money. The majority of the money she put into the contract will be paid for either by: Her qualified LTC expenses, the beneficiary of her estate, or some combination of the two.

Now, more than ever it is imperative to really understand clients'/prospects' funding needs after you are able to find options for them underwriting-wise. This client wanted to implement a funding strategy where she paid one time. Many times asset-based carriers will entertain offers that the traditional health carriers will not, based on underwriting.

Many times, underwriting dictates the LTC solution that you implement; it helps that there can be multiple funding strategies.

We as advisors need to take the time to understand our clients' medical history and also their ability to pay a one-time premium for asset based solutions:

- 10 year medical history
- 10 year surgical history
- Medications that they have taken or are taking

As said earlier, after education, you need to find the "takers" out there—in other words—which LTCL carriers would entertain these clients based on their medical history.

Market exploration can become more critical the more health history the client has. After you identify the potential LTCL carriers, you can then contemplate things like plan design and potential funding strategies.



# Chapter E3:

## The Carrier's Role in Implementation

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The producer has an obligation not only to disclose important information to the client, but when his client applies for a policy, to collect data about him for the insurer. While most states require all long-term care policies to be guaranteed renewable (as long as the premiums are paid) once issued, the insurer is never required to issue a policy in the first place. Applicants who present too high a risk are deemed uninsurable.

Separating the uninsurable applicant from the many insurable ones, done through a process called underwriting, is one of the most important responsibilities of the carrier. Insurers are interested in obtaining as complete a picture as possible of an applicant's risk profile. The role of the producer, who usually has much better knowledge of the applicant than the insurance carrier, is of paramount importance in this endeavor.

### **The Application**

The richest source of underwriting data is the policy application. Without applying, the client will never know if he might be approved for or denied coverage. The application represents the client's offer to enter into a contractual arrangement with an insurer, and as a legal document it becomes a part of the contract. More

important to the carrier's risk management though, is the underwriting information in the client's answers to the application's questions. Because of the application form's important legal and underwriting function, producers have to ensure that it is completed accurately and in its entirety. It is preferable that the producer ask the questions and complete the application for the applicant who will sign after reviewing the information.

Most states prohibit producers from making any changes to an application once the applicant has signed it. If an error is discovered, arrangements should be made to return the application to the applicant for any necessary corrections. Never use whiteout; errors must be crossed out and initialed by the applicant. In most states, the changing of or adding information to a signed application by anyone other than the applicant is a misdemeanor.

## **The Producer's Report**

A standard part of any insurance application is the producer's report. Usually attached to the application, the report is completed by the producer after the client has filled out and signed the application form. This section of the application generally gives the producer the opportunity to explain to the insurer what he knows of the applicant. The report furnishes the insurer with key information about the applicant that might not be apparent in the application.

Producers who fail to tell insurers all they know and observe about the applicant seriously undermine the carriers' ability to make accurate underwriting decisions.

## **Underwriting LTCI and Linked Benefits**

Once the application is submitted, it is put through the underwriting process, which usually takes four to eight weeks. The underwriting period may be lengthened by delays in obtaining supporting information that may be requested by the insurer.

During the underwriting period, applicants are often anxious to learn how things are proceeding. Realizing this, you should make a practice of keeping in touch with the applicant.

While insurers are more knowledgeable in extended care risks now than in the past, the risks they assume by insuring extended care remain difficult to gauge. For example:

- Carriers realize that in insuring extended care, they face a higher degree of adverse selection—acceptance of clients relatively likely to file significant claims—than in selling most other insurance products simply because the majority of purchasers are older. Those who express interest in LTCI may already face a much higher risk of needing extended care, or have already discovered the immediate need for it and most likely will not qualify for coverage.
- The law of large numbers (a mathematical principle underlying actuarial science) doesn't lend support to LTCI. The numbers are just too small. Insurers have not yet sold enough policies or paid enough claims to make truly accurate predictions of their exposure to risk in this area. This is why they are so cautious.
- The subjective nature of extended care is a problem for carriers. For example, at what point does a person really lose the ability to feed or bathe himself? Other factors are the uncertain future costs of extended care, and largely unpredictable availability of friends or family members to provide home health care. These all contribute to making LTCI risks difficult for insurers to predict.
- Another factor in underwriting considerations is the ability of the insurer to pay claims 40 to 50 years from now. If the interest rates on their investment reserves isn't favorable, then more restrictive underwriting may be necessary so as to not take undue risk.

Long-term care insurance, like all forms of health insurance, is underwritten on the basis of morbidity. Life insurance, on the other hand, is based on mortality projections. Morbidity is the probability of incurring a disabling illness at a particular age, while mortality is the likelihood of dying at a particular age.

Because of their concern with morbidity, LTCI underwriters are especially interested in the health background of applicants. And, because morbidity covers a range of carrier losses (from mild to extreme), even people with a history of medical problems may be insurable. Of course, the basic purpose of underwriting is to identify the degree of risk represented by the applicant, and a history of medical problems will usually require the underwriter to assign a substandard rating to the applicant. Caution: producers are not underwriters and should not “guess” if underwriting will be favorable, however pre-qualifying an applicant by calling or emailing an underwriter may be the best indicator of deciding whether to take an application at all.

Many long-term care insurers will offer coverage to people who have had cancer, strokes, heart bypass surgery, and diabetes. However, applicants with a history of medical problems should generally expect to be rated—offered a policy with a premium higher than that payable by a standard-risk policyholder. Some carriers make counter-offers: they may offer standard rates but lengthen the elimination period or offer only 50% benefits for certain coverage.

LTCI underwriting focuses on five major considerations:

- The applicant’s ability to perform the activities of daily living and maintain himself independently in the community
- His build (height and weight)
- His medical history
- His lifestyle. Carriers are becoming more interested in how an applicant takes care of himself
- His financial ability to pay premiums now and in the future

This is determined on the Personal or Suitability Worksheet.

Even a quick look at the medical and financial sections of a LTCI application will confirm this. The questions on the application combine to determine an applicant's predisposition to extended care confinement and home health care utilization.

## **Simplified or Full Underwriting**

Insurers have several ways of gathering information from applicants to determine their insurability; the insurance application and producer's report are merely their first steps. If necessary, underwriters request a current medical report, furnished by a paramedical facility, which provides a current review of the applicant's medical condition. Concern about pre-existing conditions is usually handled by obtaining attending physician's statements (APSS) from the physicians who have treated the applicant.

Some insurance companies decide eligibility for coverage by using the questions answered to the satisfaction of such a carrier, it will issue a policy. This practice is known as simplified issue and would generally not apply to individual LTCI but to a group plan or a linked benefit product.

Carriers that use the simplified-issue approach to underwriting see it as the easiest and most economical way of determining eligibility for coverage. Instead of incurring the time and cost of ordering exams and obtaining doctor's records, these companies believe they can screen out troublesome conditions potentially leading to claims simply on the basis of the answers provided on the application.

Often, insurers who use simplified issue will also conduct personal health interviews by telephone to confirm the answers to the application questions (see below) and may conduct a cognitive exam.

### The Personal Health Interview

To confirm the answers to application questions recorded by the producer, most insurers today conduct *Personal Health Interviews (PHIs)* either by phone or nurse

visit. A PHI is managed by a trained representative who may ask additional questions to verify or elaborate upon information provided through the application. Companies using PHIs report that the use of these interviews:

- Shortens the time needed for underwriting
- Provides better underwriting information than that obtained from inspection companies;
- Allows insurers deeper insight into the lifestyles (and, accordingly, product needs) of their customer base
- Enhances customer relations
- Obtains answers to unanswered questions and verifies accuracy of information;
- Ultimately reduces underwriting expenses

### Cognitive Assessments

Of all the possible paths to the need for extended care, cognitive impairment (for example, as a result of Alzheimer's disease or senile dementia) generally causes actuaries and underwriters the greatest concern.

To identify better potential risks in this area, some long-term care insurers now conduct cognitive assessments by telephone or in person as part of underwriting. These evaluations, intended to screen out potential cognitive claims, can include questions regarding the applicant's lifestyle and current events.

### Paramedical Exams (Medical Reports)

While medical reports have been widely used in life insurance underwriting, more companies use them in underwriting LTCI.

However, with the decrease in the use of simplified underwriting, the use of medical reports, compiled by paramedical facilities, can be expected to increase, especially in underwriting applicants who have not visited a physician for several years.

## Policy Delivery

Most states today require that all life and health policies be personally delivered to their owners, and that producers take time to fully explain the entire contract. This is considered important for at least two reasons:

- By personally explaining every clause and provision in the contract, the producer will further educate the client about the policy. This may help to avoid embarrassing—if not costly—misunderstandings down the road when a claim arises for care that might not be covered.
- Most states require long-term care policies to provide a 30-day free-look period, beginning with the policy delivery, during which the policyholder can return the policy for a full refund of any premiums paid. By explaining the policy, the producer provides the policyholder with the information the latter needs to decide whether to keep the policy or make changes to the benefits.

There is another important reason for personally delivering and explaining a policy: Doing so reinforces your commitment to the client, a sure way to solidify the relationship.

## **Summary of the Interview and Underwriting Process**

**Initial Interview:** The producer educates the client about the consequences of extended care and financing alternatives, and gathers information about the client's needs and budget.

**Implementation:** The producer, using facts gathered at the interview, designs an extended care plan that fits the client's needs and budget.

**Second Interview:** A second appointment is usually required, during which the producer makes his recommendations.

**Outline of Coverage and Application:** The producer must furnish the applicant with an outline of coverage prior to accepting a signed application. The application must

be completed accurately and in its entirety. The outline of coverage and application become part of the entire contract.

**Producer's Report:** With the completed application, the producer must furnish the carrier with his own notes concerning the applicant.

**Premium Deposit and Receipt:** If a premium deposit is paid with the application, coverage will be effective from its submission if the applicant is determined, through underwriting, to be insurable under the risk classification for which he is applying. This is explained in the receipt, which must be given to any applicant who pays a premium deposit with his application.

**Explanation of the Underwriting Process:** Insurance professionals can relay any concerns or misunderstandings their applicants may have in the initial stage of policy issuance by explaining the purpose—and process—of what to expect in the underwriting process.

**Application Submission to the Carrier:** After reviewing the application for accuracy, the producer is legally obligated to forward the application and premium deposit (if one was paid) to the home office without delay.

**Underwriting Verification:** Some insurers will telephone applicants to verify the accuracy of information provided in the application. In some cases, especially when the applicant is of an advanced age, a face-to-face interview may be requested to help the underwriter determine cognitive alertness.

**Attending Physician's Statement (APS):** If a pre-existing condition is identified through the application, the underwriter will request an APS from the physician who has treated the applicant.

**Underwriting Decision:** On the basis of information gathered through the application, personal interviews, medical reports and APS forms, the carrier makes an underwriting decision. If the applicant is insurable, a risk classification may be assigned (for example, preferred, standard or substandard).

**Policy Issue:** If the applicant is insurable, and if the applicant agrees to any alteration in the terms of the contract (such as substandard rating) required by the carrier, the policy is issued and sent to the producer for personal delivery to the new policy owner.

**Policy Delivery:** The producer must schedule a delivery appointment, during which the entire policy is explained, including any ratings, restrictions, and special provisions such as the 30-day free-look period. If a premium deposit was not paid with the application, a premium must be paid when the policy is delivered.

Note: The National Association of Insurance Commissioners (NAIC) has created the publication, "A Shopper's Guide to Long-term Care Insurance," and more than half the states now require that it be given to the policyholder at some point prior to policy delivery. By giving it to the client during the initial interview the client will have the Guide to review before making a decision.





# Section E

## Summary

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Each LTCI policy is different. The insurance companies offer a variety of benefits and features and the prospective client is the one setting the premium cost based on his age and the benefits chosen.

Your responsibility as a professional advisor is to know how to design a plan for care based on what the prospective client needs and the plan meets his budget. By paying attention from the moment you meet the client, asking questions, and then working together to develop the plan, the policy details and funding options will fall into place easily.

Always submit complete information to the carrier in order for the underwriting

Typically the producer's report will answer questions such as:

- Have you observed in the applicant any physical or mental impairments in walking or speaking, or any form of tremor?
- Do you have any information on the applicant's health that might adversely affect the issuance of this insurance and is not disclosed in the application?
- Have you explained to the applicant the limitations of benefits, exclusions, contestable period and general underwriting procedures, including the phone interview and paramedical exam, if required?
- Have you interviewed the applicant in person when this application was taken?

Generally, the producer's report is a statement of the physical and cognitive condition of the applicant, as the producer has observed it. We realize you are not professionally trained underwriters but making observations and noting them in the report may help the underwriters with their determinations.

Additional questions on other insurance policies the producer may have sold to the applicant help carriers determine whether the producer routinely churns his clients, selling them new policies in order to receive a new first-year commission. This practice has resulted in calls for the leveling of producers' commissions: for example, instead of 50% of the first-year premium and a 5% yearly renewal, a more level commission structure could pay 20% of the premium for the first three years, and a 2% renewal thereafter.

Some producer's reports ask the producer to sign a statement like this one:

"I have reviewed the current health insurance policies the policyholder owns, and have determined that the sale of this policy is appropriate to the applicant's needs. I also attest that the amounts of coverage being applied for are appropriate to this client, and that the client can afford to pay the premium."

Other carriers ask the client to certify that the producer has accurately completed the application.

Producers who fail to tell carriers all they know and observe of applicants seriously undermine the insurers' ability to make accurate underwriting decisions. That, in turn, may precipitate higher declines and future rate increases.

When in doubt about what you observe, contact the underwriting department of the carrier you are representing or the underwriting specialist in your broker's office.

# Key Points E

## Creating the Right Policy (Page #363)

Until the late 1980s, there were only nursing home policies. With the recognition of home care, assisted living and dementia care facilities as viable living situations for receiving care, and the possibility that a client may not qualify for a traditional long-term care insurance product, there are now more choices to include in your presentation.

You must be ready to make recommendations of benefits and features of a policy based on the following:

1. Where the client wants to live while receiving extended care? Most people want to remain at home.
2. Who will be there to provide the care? Family members provide most of the custodial care.
3. What will pay for it? Know the various funding sources.

## Key Issues (Page #363)

The key issues are the type of policy, the policy design, and the benefit payments.

## Type of Policy (Page #364)

### Type of Policy: Traditional Long-Term Care Insurance

Traditional Long-term Care Insurance often referred to as "stand-alone" policies. Keep in mind these policies are generally "use it or lose it."

Advantage

- They offer much flexibility in being able to craft an appropriate solution

- Life Insurance with an LTC Rider. With a death benefit and long-term care benefits the policyholder “wins” one way or the other. This is the same with an ABR rider.
- A payout from the policy, one way or the other, is assured.
- Most carriers guarantee a minimum death benefit.
- The policy qualifies for status under IRC Section 1035: The policyholder can roll over cash-surrender value into a policy of this type.

#### Type of Policy: Life Insurance with an Accelerated Benefit (ABR) Rider

##### Advantage

These riders cost very little and allow dual use of the death benefit.

#### Type of Policy: Linked Annuity with LTC included

The policyholder has the proceeds of the annuity for beneficiaries when all of the long-term care benefits are not used.

##### Advantages

- Payments for extended care expenses from the annuity are not taxed, pursuant to the Pension Protection Act. Benefits from the care benefit are also not taxed.
- No loss of annuity if care is not needed, and the annuity proceeds can be passed to the beneficiary(ies).

## **Policy Design (Page #369)**

There are basically four moving parts to select as the plan design develops:

- Daily or monthly benefit and coinsurance: this amount should be increasing with inflation protection over the years if you include it in the policy design.

- Benefit period or “pool of money”: keep in mind that this amount will be increasing with inflation protection over the years if you include it in the policy design.
- Elimination period: consider what the policyholder will pay out-of-pocket now and perhaps 25 years from now when the benefits are needed. Ninety days of elimination period is the standard.
- Inflation protection: younger clients need more growth on their benefits than people in retirement age. When a client is over age 70 consider a higher daily or monthly benefit and no inflation protection in order to keep the premium affordable.

### **Benefit Payments (Page #373)**

- Reimbursement: the majority of plans sold are with this type of payout of benefits.
- Partial Cash for Homecare: this is becoming more popular as friends and family may need monetary help in order to provide care at home.

### **The Carrier’s Role in Implementation (Page #389)**

The producer has an obligation not only to disclose important information to the client, but when his client applies for a policy, to collect data about him for the insurer.

The richest source of underwriting data is the policy application. Without applying, the client will never know if he might be approved for or denied coverage. The application represents the client’s offer to enter into a contractual arrangement with an insurer, and as a legal document it becomes a part of the contract. More important to the carrier’s risk management though, is the underwriting information in the client’s answers to the application’s questions.

A standard part of any insurance application is the producer’s report. Usually attached to the application, the report is completed by the producer after the client

has filled out and signed the application form. This section of the application generally gives the producer the opportunity to explain to the insurer what he knows of the applicant. The report furnishes the insurer with key information about the

### Long-Term Care Insurance Underwriting Focuses on Five Major Considerations (Page #392)

- The applicant's ability to perform the ADLs and maintain himself independently in the community
- His build (height and weight)
- His medical history
- His lifestyle; carriers are becoming more interested in how an applicant takes care of himself
- His financial ability to pay premiums now and in the future

## **Summary of the Interview and Underwriting Process (Page #395)**

### Initial Interview (Page #395)

The producer educates the client about the consequences of extended care and financing alternatives, and gathers information about the client's needs and budget.

### Implementation (Page #395)

The producer, using facts gathered at the interview, designs an extended care plan that fits the client's needs and budget.

### Second Interview (Page #395)

A second appointment is usually required, during which the producer makes his recommendations.

### Outline of Coverage and Application (Page #395)

The producer must furnish the applicant with an outline of coverage prior to accepting a signed application. The application must be completed accurately and in its entirety. The outline of coverage and application become part of the entire contract.

### Producer's Report (Page #396)

With the completed application, the producer must furnish the carrier with his own notes concerning the applicant.

### Premium Deposit and Receipt (Page #396)

If a premium deposit is paid with the application, coverage will be effective from its submission if the applicant is determined, through underwriting, to be insurable under the risk classification for which he is applying. This is explained in the receipt, which must be given to any applicant who pays a premium deposit with his application.

### Explanation of the Underwriting Process (Page #396)

Insurance professionals can relay any concerns or misunderstandings their applicants may have in the initial stage of policy issuance by explaining the purpose—and process—of what to expect in the underwriting process.

### Application Submission to the Carrier (Page #396)

After reviewing the application for accuracy, the producer is legally obligated to forward the application and premium deposit (if one was paid) to the home office without delay.

### Underwriting Verification (Page #396)

Some insurers will telephone applicants to verify the accuracy of information provided in the application. In some cases, especially when the applicant is of an

advanced age, a face-to-face interview may be requested to help the underwriter determine cognitive alertness.

#### Attending Physician's Statement (APS) (Page #396)

If a pre-existing condition is identified through the application, the underwriter will request an APS from the physician who has treated the applicant.

#### Underwriting Decision (Page #396)

On the basis of information gathered through the application, personal interviews, medical reports and APS forms, the carrier makes an underwriting decision. If the applicant is insurable, a risk classification may be assigned (for example, preferred, standard or substandard).

#### Policy Issue (Page #397)

If the applicant is insurable, and if the applicant agrees to any alteration in the terms of the contract (such as substandard rating) required by the carrier, the policy is issued and sent to the producer for personal delivery to the new policy owner.

#### Policy Delivery (Page #397)

The producer must schedule a delivery appointment, during which the entire policy is explained, including any ratings, restrictions, and special provisions such as the 30-day free-look period. If a premium deposit was not paid with the application, a premium must be paid when the policy is delivered.

## Section E Quiz

1. All of the following are effective planning “power phrases” EXCEPT:
  - A. Extended care is not a place ... it’s an event
  - B. Providing care to chronically ill people often makes healthy caregivers chronically ill
  - C. Do you really want your children to have to change your diapers?
  - D. Should you ever need care, your life doesn’t end ... but the life, or lifestyle, of those you love will
  
2. Which of the following statements is TRUE for clients in a second marriage?
  - A. Their pre-nuptial agreement provides some degree of Medicaid asset protection for the spouse who doesn’t need care
  - B. Children from a previous marriage should not be considered in the extended care planning process
  - C. Extended care planning and LTC insurance allows all other financial and estate plans to work the way they were designed
  - D. If either spouse needs care, divorce is an easy way to protect assets from being used for care expenses

3. Same sex couples should consider:
  - A. That LTC insurance provides full "marital" benefits even if not legally married
  - B. Getting legally married because otherwise they will pay more for LTC insurance
  - C. Planning on Medicaid benefits for extended care since same-sex marriage is now legal
  - D. Self-funding since assets can't be protected unless legally married
  
4. The concept of a client co-insuring a portion of expected extended care costs allows for all of the following EXCEPT:
  - A. Lower LTC insurance benefits and premiums
  - B. The recognition that some amount of care can be self-funded
  - C. Protecting assets from Medicaid spend-down
  - D. The focus to remain on extended care planning as a cash-flow problem
  
5. A daily benefit reimbursement policy is:
  - A. The most expensive benefit option
  - B. Provides the most flexibility for the use of benefit dollars
  - C. Allows for a greater stretching of the benefit period
  - D. A good idea for single people who may not be able to manage much home care on their own

6. Indemnity benefits provide all of the following EXCEPT:
- A. Tax-free benefits
  - B. Flexibility in how policy benefits are spent
  - C. Greater stretching of the benefit period
  - D. "Future-proof" coverage for new types of professional caregiving
7. What should an advisor do if the policy being purchased has a "service day" Elimination Period?
- A. Encourage clients to use a longer EP to save premium dollars
  - B. Encourage clients to use a shorter EP than usual
  - C. Explain that Medicare-paid days will count toward the EP, so the "service day" definition is not important
  - D. Remind the client she can shorten her EP at any time in the future
8. If a client is interested in a Continuing Care Retirement Community (CCRC), then which of the following is TRUE:
- A. LTC insurance will pay for all monthly costs once a person is living in a CCRC
  - B. LTC insurance is not needed because the CCRC buy-in will be covered by home equity and the monthly fees can be easily covered by cash flow
  - C. Planning on moving to a CCRC at some unknown time in the future is a realistic extended care plan
  - D. Once benefit eligible, LTC insurance can pay for care before or after moving into a CCRC

9. When completing an application for LTC insurance, an agent should always:
- A. Let the client complete the application on her own
  - B. Use the application as an additional pre-underwriting, fact-finding process
  - C. Refrain from adding extra details about a medical condition
  - D. Have the client decline to disclose financial information on the Suitability Worksheet
10. Which of the following statements is TRUE about policy delivery?
- A. LTC insurance policies should be delivered when convenient for the agent and client
  - B. Agents should deliver a copy and keep the original policy in his own files for safekeeping
  - C. The policy must be delivered within 30 days of receipt by the agent
  - D. Clients can refuse to sign a policy delivery receipt to extend their free-look period

# SECTION F:

## THE TEN RULES OF ETHICAL CONDUCT

These rules specifically relate to three key elements in the presentation of information about extended care with the goal to promote the protection of a family and implement appropriate funding solutions:

1. The interview
2. Evaluation of the appropriateness of coverage based on an analysis of needs
3. Proper representation of the client's case to the insurance carrier

Our intent is to place what you've learned in this course in the framework of ethical conduct and assist you in holding your profession in high esteem. Your role is a combination of professional duty to the client, to your company, and your profession.

These standards are to be used in conjunction with your own company's rules, the *CLTC® Code of Professional Responsibility*, and other professional codes of conduct. In a larger sense they are simply restatements of right and wrong. Mark Twain once said: "When in doubt, tell the truth."



# Chapter F1:

## The Ten Rules of Ethical Conduct

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To be committed to the ethical presentation of options and solutions for extended care coverage, a producer must:

- I. Conduct business under the assumption that the client is a willing and able participant.
- II. Conduct the interview as a process to establish a plan to protect the client's family, not an opportunity to sell product.
- III. Understand that a client's wishes and needs may be two different things, and that your responsibility is to focus on needs.
- IV. Understand that the client's best interest is foremost in the proper presentation and implementation of solutions to meet the client's needs.
- V. Understand that LTCI may not be the most appropriate solution to the client's needs, and if it's not, advise the client of this and offer to assist in implementing the proper plan.
- VI. Attempt to minimize the cost of insurance by recommending only necessary coverage, and when appropriate, copayment by the insured.

VII. Consider an insurance funding solution as only one part of a client's total financial situation, and advise him to employ the counsel of other professionals when appropriate.

VIII. Never disparage a competitor's product, services, business practices, or personal character.

IX. Never use misleading or false language in advertising and marketing materials, and fully disclose if endorsers are profiting from the sale of a product.

X. Present an unbiased, objective assessment of the client's health history and suitability of coverage to the carrier.

I. Conduct business under the assumption that the client is a willing and able participant.

An educated client is your best customer. You should always consider how this person accumulated the net worth that he now asks you to help protect. His participation is critical in the ultimate success of your plan and protection solution.

As a willing and able participant, your client is involved in all aspects of the decision-making process related to his plan for receiving extended care services. He was involved in his financial planning for many years before you entered the picture, and he expects to participate in this process. He has specific information regarding the family budget, family history, and his wishes if he needs extended care, which can then be woven into a successful plan for such care. You will be assisting him with this plan. It is the CLTC designee's responsibility to engage the client in the process. There may be times when one spouse acts on the behalf of both spouses, but it is imperative that you interview both parties to fully understand their intentions and motives.

## CASE STUDY

An agent meets with a couple who have had personal experience providing care. The couple have not yet decided their extended care options, but think that their children would help out.

Inappropriate approach: The agent decides that this couple doesn't understand the realities of providing care and begins to recite statistics supporting demographic trends that children tend to live far from their parents and are preoccupied with making a living and raising their children. The intent of this approach is to convince the prospects that only LTCI can ensure their care. However, it is not the plan that protects the insured it protects the family from never-ending caregiving.

Appropriate approach: The agent engages the prospects in the discussion of the realities of their children's lives, including:

- Where are they living?
- Who is married?
- Who has children?
- Who is working? (Is there a child who is a stay-at-home spouse?)
- What is the state of financial viability
- What are the children's positions, if any, on providing care? Which one will step up to direct or give the care and which ones will only provide telephone or visit support?

The answers to these questions help the agent formulate both a plan of care and how much insurance will be necessary to properly fund it on the basis of the prospects' responses.

For example: The couple have a daughter who is single, has no children, lives in the same area, and has made clear her willingness to help. This could permit a longer elimination period, a greater degree of coinsurance, and the recommendation of a partial cash payout, which would help pay the daughter for the care she provides.

II. Conduct the interview as a process to establish a plan to protect the client's family, not an opportunity to sell a product.

The first responsibility of a professional is to solicit facts. Use open-ended questions that will allow for a better exchange of information. Then listen to your client's answers, taking notes when appropriate. Organize those facts into a coherent picture of the client's personal situation and then bring to bear options that solve the issues raised. We suggest that during the interview you listen and establish credibility, rather than displaying product details. Using the interview as an opportunity to sell may cause the client to be defensive and suspicious of your motives.

**CASE STUDY**

After meeting with the prospects for fifteen minutes, the agent recognizes that this couple has not given much thought to the issues surrounding extended care. They have a family and adequate financial resources to protect. The agent has production goals to meet and is approaching the end of the goal period.

Inappropriate approach: The agent decides to bypass the needs-development, educational approach, and recommends the company and product design that he believes will close the sale.

Appropriate approach: The agent asks questions and provides information, educating the prospects about the consequences of needing care without having a plan, not to the sick individual, but to the healthy spouse, their children and the couple's retirement portfolio.

Next, the agent completes a fact finder, which allows for the proper recommendation of both the plan and the insurance to cover it.

III. Understand that a client's wishes and needs may be two different things, and that the producer's responsibility is to focus on needs.

A client's motivations sometimes may revolve around wishes that he would like to come true, not needs (the necessities in his particular situation). The two are not always the same.

What a client wishes for may not be what he needs. You have an ethical obligation to explain the difference, and focus on what the client needs, in listening and analyzing the facts he presents.

Reinforcing a client's wishes, when you know they are not in his best interest, may cause critical analysis by other professionals such as lawyers, accountants and financial planners.

Long-term care insurance is primarily a needs-based product. This does not mean that it is unethical to sell it to suit the client's wants. You do, however, have an obligation to explain the difference between the two, and let the client decide.

**CASE STUDY**

An agent meets with a couple who recently inherited a sizeable sum of money and want to make sure that it isn't spent on extended-care services. They ask the agent for the biggest LTCI policy available.

Inappropriate approach: The agent does not ask enough questions to determine what is suitable for their budget. The agent runs a sample illustration using what he thinks should be presented and does not determine a budget to pay premiums. The policy is issued but they question the process upon delivery and want new recommendations. The couple think they received a policy with what they wanted but become unsure.

Appropriate approach: The agent precedes any discussion of policy benefits by inquiring where the couple would want to receive care. The agent proceeds to give them current cost estimates for services and facilities, not as national averages, but

specific to the community in which they are likely to be living, whether it is their own, or perhaps where a child is living, or where they intend to retire. These include:

- Home care delivered by home care aides and licensed professionals
- Meals-on-Wheels or equivalent
- Adult day care
- Assisted living
- Skilled nursing-home care, if necessary
- Coinsuring a portion of the cost of care, both during the elimination period and on an ongoing basis
- The history of inflation and its potential effect on the future cost of care
- The advantages and disadvantages of the amount of money available to pay for their care

The couple are engaged in all aspects of the policy design decisions and end up owning a policy with less than the maximum benefits available. After learning about LTCI from the agent, the couple end up with the policy they need and, now that they've considered what they need, it is also exactly what they want.

#### IV. Understand that the issue of suitability is foremost in the proper implementation of LTCI.

Suitability is a critical consideration in the sale of LTCI. You must always place the needs of the client in the context of his sustained ability to pay for the product. This ability is directly influenced by:

- The client's ability to pay the premiums as selected
- The maximum total benefit pool of money
- The ability of the client to pay some amount out-of-pocket should the care be more than the benefit level

## CASE STUDY

The agent meets with a 50-year-old client who owns her home and has no debt, but very limited income and assets, raising suitability concerns.

Inappropriate approach: The agent selects the insurer with the lowest suitability standards. He recommends a policy design that includes:

- A minimal daily benefit, such as \$50, which, he states, will be helpful in keeping the client at home
- A long elimination period
- No current inflation protection, but rather the option to purchase such coverage later

The result of this advice is that the daily benefit, while perhaps covering some home care, will be inadequate for any meaningful coverage. The error is compounded by the fact that the client will likely not be able to afford the inflation option, because it is probably priced on attained age. This individual will likely have to resort to Medicaid benefits, therefore negating the purpose of the policy and wasting the prospect's limited funds.

Appropriate approach: Ask if she has children and if they would help pay premiums for a policy.

If not, consider this client may not be suitable to purchase LTCI, and refer them to an attorney who understands Medicaid planning.

V. Understand that LTCI may not be the most appropriate solution to the client's needs and if it's not, advise the client of this and offer to assist in implementing the proper plan.

Sometimes, when you give a client the right answer, you will be sacrificing commission income. You should realize that this is a sacrifice only in the short term.

You never make a wrong decision when you give a client the advice that's right for him. In the long run, that advice brings you more business, because clients appreciate and respect your honesty.

The sale of LTCI is a profession, and like all professionals, you must raise the good of your clients and the community above your own self-interest.

#### CASE STUDY

During an interview, an agent is told that a couple have minimal assets (\$50,000) and Social Security income, but they have had prior experience caring for a mother and want to know how to get LTCI. They have no children.

Inappropriate approach: The agent shows them two or three brochures on LTCI and promises that he will find them a "good deal." He suggests a 180-day elimination period with \$100 per day maximum daily benefit, for a three-year benefit term without any inflation protection, thinking this might be affordable for them. The agent disregards suitability, hoping to find a carrier that will issue a policy.

Appropriate approach: The agent tells them that creating an appropriate policy would generate a premium that they cannot sustain. The agent asks questions about their extended family's ability to assist with the premium because, most likely, the brothers and sisters or their children will provide the care. In this situation, the couple will qualify for Medicaid should one or both need care, and this may be an appropriate choice. The agent should refer the couple to a competent attorney who understands Medicaid planning.

#### VI. Attempt to minimize the cost of insurance by recommending only necessary coverage and, when appropriate, copayment by the insured.

It is simply good business to recommend the appropriate amount of coverage for the client's particular situation. In the long run, the policy is likely to remain in effect and, therefore, be available for the client if needed. Coinsurance may make sense based on the client's ability to pay. It has the effect of:

- Lowering premium cost, thereby helping to ensure the policy will remain in effect
- Encouraging the client to use the benefits only when absolutely necessary by requiring him to assume a portion of the expense
- This helps keep the premium stable in the coming years, and that, in turn, means the policy is more likely to remain in effect; reinforcing your image as a professional, because the client may be expecting you to sell the maximum benefits.

#### CASE STUDY

An agent has been approached by a retired couple in their mid-sixties. They have a clear idea of the life they wish to lead and where the funding for it will come from. They believe LTCI may be appropriate as a backup if care is needed for a long period of time.

Inappropriate approach: The agent tries to convince the couple, using statistics, that they will almost certainly need care and that costs then will be much higher than they are now. He then recommends a policy with:

- A high daily benefit (resulting in little or no coinsurance)
- A 180-day elimination period to offset the additional premium for the high daily benefit
- A long benefit period

Appropriate approach: The agent completes the fact finder, determining that, in fact, the couple can coinsure a substantial portion of the likely cost of care. He recommends:

- A daily or monthly benefit consistent with the clients' ability to coinsure a substantial portion of the maximum cost of care, as revealed by the fact finder

- Either a shorter elimination period or hybrid (zero home care, 90-day facility), not because the prospects may actually need the benefit right away, but because a child is likely to place the claim, and he or she would want the money right away
- A benefit period consistent with what the fact finder documented regarding longevity and history of illnesses in the couple's families

VII. Consider a funding solution as only one part of a client's total financial situation, and advise him to employ the counsel of other professionals when appropriate.

By suggesting the assistance of other professionals, you enhance your credibility by showing the client that you are knowledgeable in all aspects of extended care finance and are confident enough in your suggestions to submit them to others' scrutiny.

#### CASE STUDY

The agent's prospects are a couple in their late 50s who have a financial planner, an attorney and an accountant who question whether the agent's suggestions regarding a long-term care insurance policy are appropriate. They therefore ask the agent to discuss his recommendations with them.

Inappropriate approach: The agent becomes defensive and tells the couple that, in his experience, lawyers and CPAs really don't understand long-term care insurance. He goes back to product design and reviews the many features offered, hoping the prospects will make a decision independently of their other advisors.

Appropriate approach: The agent tells his prospects that he appreciates their need to talk with people that they know and trust, and offers to be available to discuss the plan.

VIII. Never disparage a competitor's product, services, business practices or personal character.

Criticizing a competitor or his product brings discredit to the profession. Disparaging others not only makes your client feel uncomfortable, but distracts from your central purpose—determining the client's need for your assistance and how best to implement your suggestions. You may point out the differences in coverage and implementation without speaking ill of a competitor or his company.

**CASE STUDY**

An agent's prospects have told you that they've been talking to a competitor about LTCI and are requesting your expertise. The agent knows the competitor.

Inappropriate approach: The agent tells the prospects that he has heard that the competitor's advice is self-serving and that the issue of competency has been brought up more than once. The point of the comments is to both disparage the competitor and establish the agent as the only person the prospects should talk to.

Appropriate approach: The agent listens to the competitor's advice and develops a strategy that addresses the prospects' needs and concerns. The discussion of product, if appropriate, is secondary.

Using this approach likely will lead to a good decision by the clients because the agent has relied on ideas, not character innuendo.

IX. Never use misleading or false language in advertising and marketing materials, and fully disclose if endorsers are profiting from the sale of a product.

Using misleading or false statements in marketing efforts is not only unethical, but illegal in every state. Misrepresenting your endorsers as disinterested third parties when, in fact, they are profiting from your sales, is also wrong.

## CASE STUDY

An insurance sales agent advertises free seminars on catastrophic illness. The copy promises “informative timely information on Medicaid, presented by a leading attorney.”

At the seminar, the attorney states that Medicaid is making it harder to protect assets and that LTCI is an option that should be considered.

Inappropriate approach: The agent representation is unethical because he fails to inform the audience he is an insurance broker who will profit from the presentation if people purchase insurance.

Appropriate approach: He should disclose that he is a licensed broker and stands to make a commission from the sale of an insurance product.

### X. Present an unbiased, objective assessment of the client’s health history and suitability of coverage to the carrier.

Your “producer’s report” to the carrier is a critical part of the underwriting process. The insurer needs to know not just the client’s financial and medical data, but your opinion of the product’s suitability to his situation. Failure to disclose information or shading the truth is unethical and brings discredit to the industry.

## CASE STUDY

During an interview, an agent notices that the client has difficulty answering simple questions, such as, “How many children do you have?” and “Can you give me their names?” The client repeats himself several times and can’t maintain focus. The agent then turns to the spouse and poses the same questions. He thus determines that she is the one making the decisions for both of them.

Inappropriate approach: The agent decides that the client is just tired or unwilling to answer his questions. He proceeds to take an application, but relies upon the answers given by the healthy spouse. He then has both sign the application.

Appropriate approach: During the interview, the agent deliberately tries to assess the prospect's mental acuity by continuing to ask simple questions such as, "Have you seen the news today?" "What is the date today?" "Where do your children live?" "Can you give me the city and state?" "Has your doctor mentioned anything about memory loss?" "When did you see him last?"

The answers to these questions help the agent determine if the application process should continue. Even mild memory loss precludes an applicant from qualifying for LTCI. If the totality of the answers would lead a reasonable person to conclude that the client is unlikely to qualify for coverage, the agent should notify the applicants of this. If they insist, the application can still be submitted for the well spouse, but it is recommended that other alternatives, such as the use of a LTCI annuity or a reverse mortgage, be discussed.

### The Producer's Report

A standard part of any insurance application is the Producer's Report. Usually attached to the application, the report is completed by the producer after the client has completed and signed the application. The report permits the producer to furnish the carrier with additional information on the applicant that might not be apparent elsewhere in the application; for example, how the producer came to meet the client, how long they've been acquainted, and any impairments the producer has observed during the application interview.

Typically the Producer's Report will answer questions such as:

- Have you observed in the applicant any physical or mental impairments in walking or speaking, or any form of tremor?
- Do you have any information on the applicant's health that might adversely affect the issuance of this insurance and is not disclosed in the application?
- Have you explained to the applicant the limitations of benefits, exclusions, contestable period and general underwriting procedures, including the phone interview and paramedical exam, if required?

- Have you interviewed the applicant in person when this application was taken?

Generally, the Producer's Report is a statement of the physical and cognitive condition of the applicant, as the producer has observed it. We realize you are not professionally trained underwriters, but making observations and noting them in the report may help the underwriters with their determinations.

Additional questions on other insurance policies the producer may have sold to the applicant help carriers determine whether the producer routinely churns his clients, selling them new policies in order to receive a new first-year commission. This practice has resulted in calls for the leveling of producers' commissions: for example, instead of 50% of the first-year premium and a 5% yearly renewal, a more level commission structure could pay 20% of the premium for the first three years, and a 2% renewal thereafter.

Some Producer's Reports ask the producer to sign a statement like this one:

"I have reviewed the current health insurance policies the policyholder owns, and have determined that the sale of this policy is appropriate to the applicant's needs. I also attest that the amounts of coverage being applied for are appropriate to this client, and that the client can afford to pay the premium."

Other carriers ask the client to certify that the producer has accurately completed the application.

Producers who fail to tell carriers all they know and observe of applicants seriously undermine the insurers' ability to make accurate underwriting decisions. That, in turn, may precipitate higher declines and future rate increases.

When in doubt about what you observe, contact the underwriting department of the carrier you are representing or the underwriting specialist in your broker's office.

## **Conclusion**

These standards are to be used in conjunction with the *CLTC® Code of Professional Responsibility*, your company's rules, and other professional codes of conduct. In a larger sense they are simply restatements of right and wrong. Mark Twain once said: "When in doubt, tell the truth."



# Chapter F2:

## The Interview

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Assume that someone is watching and do it right—whether it is an initial or subsequent interview. The initial interview introduces the client and advisor to each other. It serves two functions:

1. It affords the client the opportunity to establish a frame of reference relating to the producer; and
2. It furnishes the producer with the essential information he needs to suggest options.

### **The introduction**

During the introduction, you have an ethical obligation to state:

- Who you are
- Whom you work for
- What you hope to accomplish

It is essential that you clearly state the financial interests for which you work. The client has an absolute right to this information, because he will need it when determining whether to purchase a product or service from you.

If, for example, you are an agent, explain what an agent is and differentiate it from a broker. Provide some background about the person or company you represent.

You should set out in general terms what you hope to accomplish at the meeting. You must always state that you hope to accomplish these goals through the use of a funding solution. You should not use words or phrases intended to frighten and mislead such as:

"You will lose your life savings if you need nursing-home care."

"Medicaid is welfare, and that means you will not get into a good nursing home."

"Statistically speaking, the chance of you needing long-term care is xx%."

A producer who engages in such conduct either assumes the client is not capable of critical thought, or, most likely, attempts to deny him the opportunity to exercise it so as to manipulate him into a purchase.

Failure to introduce oneself properly, and the use of language intended to mislead, frighten or manipulate the client are violations of these ethics rules:

I. Conduct business under the assumption that the client is a willing and able participant.

II. Conduct the interview as a process to establish a plan to protect the client's family, not an opportunity to sell product.

The gathering of essential information

You cannot accurately present options to the client until you have thoroughly gathered the pertinent facts, including:

- A complete history of the client and his family;
- A complete financial history;
- Your client's motives in considering LTC insurance, important in helping separate needs from wants.

Failure to gather this information is a violation of these ethics rules:

III. Understand that a client's wishes and needs may be two different things, and that your responsibility is to focus on needs.

IV. Understand that a client's wishes and needs may be two different things, and that the producer's responsibility is to focus on needs.



# Chapter F3:

## General Rules of Conduct

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In addition to the general ethical principles outlined earlier in this section, you should review and follow your company's policy on ethical conduct, as well as the *CLTC® Code of Professional Responsibility* in the next chapter. Also applicable is a set of general rules that is part of the *Unfair Trade Practices Act*, which has been adopted by most states.

The *Unfair Trade Practices Act* consists of two sections: Unfair Marketing Practices and Unfair Claims Practices. The latter applies to carriers, and is not discussed here.

The Unfair Marketing Practices section prohibits the following conduct:

### **Misrepresentation**

A producer may not use misleading or incorrect information in the sale of LTCI.

Example: Tom is an insurance producer who often states to his potential clients that he is an "expert" in LTCI and sells every single policy offered by every carrier, which is an untrue statement.

### False Advertising

A producer may not use any marketing material with the intent of stating untruths or half-truths.

Example: Mary purchases ads in local newspapers and says that she can guarantee that premiums will not rise in the future.

### Defamation

It is unethical to damage the character and/or reputation of a competitor or his products.

Example: William was a career or captive agent with ABC Insurance Company but is now on his own as an independent agent. He willingly tells his clients and customers that ABC doesn't know what it is doing and the prices are too high.

### Twisting

A producer may not suggest that a client let an existing policy lapse so that the producer may sell him a similar policy.

Example: Randy meets with a couple who have been paying for their policy for several years and he suggests they "dump" that policy and buy a new one from him because he can get them a better price.

### Rebating

Offering a client an inducement to purchase insurance is considered unethical and is illegal in some states.

Example: Brenda thanks her new clients by offering to pay for their weekend trip or will return some of the first premium to them.

### Bait and Switch

This practice consists of using a bargain-priced item to attract customers and then encouraging them to purchase a higher-priced one. It has been used, illegally, to lure potential insurance clients who might not otherwise be inclined to respond.

Example: Nick calls a potential client to set an appointment and tells him that he has a new "special deal" to offer to him and they should meet soon to get in on the offer. When the client meets with him Nick says he doesn't think the deal is a good one and he has something else they should buy that will cost them more.



# Chapter F4:

# The CLTC® Code of Professional Responsibility

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*The Code of Professional Responsibility* was adopted on June 8, 2006, to provide ethical principles and rules for all persons who have been certified to use the *Certified in Long-Term Care (CLTC)®* designation. Its Principles, Cannons, and Rules are built on and presume adherence to the other ethical standards presented previously in this section.

Advising potential clients about funding options, including LTC insurance, is an honorable profession that is dishonored when its practitioners employ abusive sales practices. The root causes of abusive—unethical—practices are:

- Lack of education
- Lack of character

To deal with the first issue, CLTC® has employed a multidisciplinary approach—embodied in this very coursework—which is designed to ground the members of this profession thoroughly in its many components. Unfortunately, no amount of education can overcome lack of character.

Even people of character, however, can stray. Ethics flow not just from character, but also from conformance to a set of rules and standards. Professionals can make bad decisions when they do not have a set of standards to guide them.

# **The Certified in Long Term Care (CLTC)® Code of Professional Responsibility**

## **Introduction**

Integrity without knowledge is weak and useless, and knowledge without integrity is dangerous and dreadful. -Rasselas (1759) ch.41, by Samuel Johnson.

Financial services professions have come under increasing scrutiny as breaches in moral conduct and legal compliance have become more widespread. Companies, firms, and associations have adopted stricter rules of conduct for their agents, representatives, licensees, and members. These rules concern establishing trust, servicing client needs, and creating recommendations for services and products that are appropriate to clients' situations. It is a well-established fact that when trust, needs-based selling, and long-standing client relationships exist, there are few, if any, complaints as to ethical misconduct.

## **Preamble**

The Code of Professional Responsibility (Code) was created in 2006 by The CLTC Board of Standards (Board) with the purpose of providing ethical principles and rules for all persons who have been recognized and certified by the Corporation for Long-Term Care Certification, Inc. or the Corporation for Certification for Long-Term Care, LLC, (Grantor) to use the Certified in Long-Term Care (CLTC)® designation. The Board and/or Grantor determine who is recognized and certified to use the designation.

Implicit in a CLTC® designee's certification is an obligation not only to comply with the mandates and requirements of all applicable laws and regulations, but also to take the responsibility to perform all professional services and activities in an ethical

and professionally responsible manner. For the purposes of this Code, a person who has been recognized and certified by the Board and/or Grantors to use the designation is known as a Certified in Long-Term Care® designee or CLTC® designee (Designee). This Code applies to all CLTC® designees and consists of four parts:

I. The Principles of Conduct, II. The Canons, III. The Rules, IV. The Disciplinary Procedures.

## **I. Principles of Ethical Conduct**

**The Principles of Ethical Conduct** apply to all Designees in their work with clients, peers, and all other support services personnel in meeting the needs of clients. The Principles are as follows:

To conduct your business with clients, including prospects and professionals, according to the same high standards of honesty and fairness that you would apply or demand for yourself.

To provide competent and consumer-focused sales and service.

To engage in active and fair competition.

To provide fair and expeditious handling of client business, complaints and disputes.

To provide promotional and sales materials to your clients, and prospects that are clear as to purpose, and honest and fair as to content.

To continue to increase your competency through ongoing education. Being competent means having the necessary skills, knowledge, commitment and attitude to do a professional job.

## **II. The Canons**

**The Canons** express, in general terms, the ethical and professional ideals expected of Designees who should strive to adhere to them in their business and professional activities. The Canons are standards of exemplary professional conduct; goals, that are intended as sources of guidance for each Designee.

**Canon 1. Competence:** A Designee shall continue to increase the necessary knowledge and skills required to serve clients competently.

**Canon 2. Confidentiality:** A Designee shall protect the privacy of clients and others with whom the Designee has a professional relationship or has reason to have confidential information, unless the client has specifically released the Designee from such duty or such information is required to be divulged in response to proper legal process.

**Canon 3. Professionalism:** A Designee shall serve the public, clients, his/her employers with the highest levels of professionalism, integrity, impartiality, objectivity and ethical behavior. The Designee shall work to enhance the reputation of the Board and/or Grantor as well as their respective members and staff. A Designee shall strive to extend public knowledge of the work of the Board, the Grantor, and all Designees.

**Canon 4. Fairness:** A Designee shall perform professional services in a manner that is fair and reasonable to clients, prospective clients, colleagues, and employers. The designee shall disclose any conflicts of interest associated with the providing of such services.

**Canon 5. Integrity:** A Designee shall provide services with honesty and integrity while developing trust in the interests of the client above his/her own interests.

**Canon 6. Diligence:** A Designee shall act with timeliness and consistency in the fulfillment of all professional duties.

### **III. Rules**

**The Rules** set forth practical guidelines that are drawn from the tenets embodied in The Canons. As such, The Rules provide the standards of ethical and professional conduct that are expected in particular situations. It should be noted that The Code does not, in any way, attempt to define the behavior of a Designee for the purposes of civil liability. As previously stated, the Canons apply to all Designees. However, due to the nature of a particular Designee's field of activity, certain of The Rules may not

be applicable to that Designee. The universe of endeavors by a Designee is, indeed, diverse; a particular Designee may be performing all, some, or none of the typical services provided by other professionals. As a result, in considering The Rules, a Designee must first recognize what specific services he/she is rendering and then determine whether or not a specific Rule is applicable to those services.

#### Rules Relating to the Canon of Competence

**Rule 101:** A Designee shall stay informed of developments in his/her area of expertise and participate in on-going education throughout the Designee's professional career in order to improve professional competence in all fields in which the designee is involved. As a distinct part of this requirement, the Designee shall satisfy all minimum continuing education requirements established by his/her licensing authority and the Board or Grantor.

**Rule 102:** A Designee shall offer advice only in those areas in which the Designee has competence. In those areas in which the Designee is not professionally competent, he/she shall seek the counsel of qualified individuals and/or refer clients to such persons.

#### Rules Relating to Confidentiality

**Rule 201:** A Designee shall not reveal or use for his/her benefit, without the client's consent, any personally identifiable information relating to the client relationship or the affairs of the client except and to the extent disclosure or use is reasonably necessary: (a) To establish an advisory or brokerage account, to affect a transaction for the client, or as otherwise authorized in order to carry out the client's engagement; or  
(b) To comply with legal requirements or legal process; or  
(c) To defend the Designee against charges of wrongdoing; or  
(d) To defend the Designee in connection with a civil dispute between the Designee and the client.

For the purposes of this Rule, the improper use of client information is a violation of this Rule, regardless of whether it actually causes harm to the client.

**Rule 202:** A Designee shall maintain the same standards of confidentiality to employers and employees as to clients.

**Rule 203:** A Designee doing business as a partner or principal of a firm owes to his/her partners or co-owners a responsibility to act in good faith. Good faith includes, but is not limited to, adherence to reasonable expectations of confidentiality both while in business together and thereafter.

#### Rules Relating to the Principle of Professionalism

**Rule 300:** A Designee shall be considered to have voluntarily relinquished his/her right to use the designation if he/she fails to pay his/her renewal fee within the allotted time required or specified in his/her payment plan, or if he/she fails to complete any mandatory continuing education requirement as may be enacted by the Board or Grantor.

**Rule 301:** A Designee who has been considered to have relinquished his/her designation for failure to pay his/her renewal fee shall have no rights to use the CLTC® designation in any form, other Designee or "graduate" benefits, including, but not limited to the following: CLTC® website access, access or use of any CLTC® - produced content, E-alerts, partnership discounts, newsletters, CLTC® Journal, and contact listing on the CLTC® website.

**Rule 303:** A Designee shall show respect for other professionals by engaging in fair and honorable competitive practices.

**Rule 304:** A Designee who has knowledge that another Designee has committed a violation of this Code which raises substantial questions as to that designee's honesty, trustworthiness or fitness as a Designee, shall promptly notify the Board or the Grantor's designated authority in writing. For purposes of this Rule, knowledge means no substantial doubt.

**Rule 305:** A Designee who has knowledge that is not required to be kept confidential under this Code, which raises a substantial question of unprofessional, fraudulent or

illegal conduct by a Designee or other person, shall promptly inform the appropriate regulatory and/or professional disciplinary body, as well as the Board or Grantor's designated authority. For purposes of this Rule, knowledge means no substantial doubt.

**Rule 306:** A Designee who has reason to suspect illegal conduct within the designee's organization shall make timely written disclosure of the available evidence to the designee's immediate supervisor and/or partners or co-owners. If the Designee is convinced that illegal conduct exists within the Designee's organization, and that appropriate measures are not being taken to remedy the problem, the Designee shall, where appropriate, alert the proper regulatory authorities and the Board or Grantor's designated authority.

**Rule 307:** In all professional activities, a Designee shall perform services in accordance with:

- (a) Applicable laws, rules, and regulations of governmental agencies and other applicable authorities; and
- (b) Applicable rules, regulations, and other established policies of the Board and/or Grantor.

**Rule 308:** A Designee shall not engage in any conduct which reflects adversely on his/her integrity or fitness as a Designee, the Board, or the Grantor.

**Rule 309:** A Designee shall return a client's own original documents in a timely manner.

**Rule 310:** A Designee shall exercise reasonable and prudent professional judgment in providing professional services.

**Rule 311:** A Designee shall always act in the best interest of the client.

### Rules Relating to Fairness

**Rule 401:** A Designee shall, in rendering services to a client, disclose:

- (a) All material information relevant to the professional relationship, including but not limited to conflict(s) of interest(s), changes in the Designee's business affiliation, address, telephone number, credentials, qualifications, licenses, and agency relationships, as well as the designee's scope of authority within his/her business, or employment relationship; and
- (b) The information required by all laws applicable to the relationship in a manner that complies with such laws.

**Rule 402:** A Designee who practices financial planning shall make timely written disclosure of all material information relative to the professional relationship, including conflict(s) of interest(s) and sources and amount of compensation when required by regulatory authorities, as well as the following:

- (a) A statement setting forth the philosophy of the Designee (or his/her firm) in working with clients, and
- (b) Resumes of principals and employees of the firm who are expected to provide services to the client, and a description of those services.

**Rule 403:** A Designee who is an employee shall perform professional services with dedication to the lawful objectives of the employer and in accordance with this Code.

**Rule 404:** Prior to establishing a professional relationship, a Designee may provide the prospective client references and recommendations from present or former clients, provided that such references and recommendations do not violate the confidentiality provisions of this Code.

### Rules Relating to Integrity

**Rule 501:** A Designee shall not solicit clients through false or misleading communications or advertisements, either written or oral.

**Rule 502:** A Designee shall not, during the course of rendering professional services, engage in conduct that involves dishonesty, fraud, deceit or misrepresentation, or

knowingly make a false or misleading statement to a client, employer, employee, professional colleague, governmental or other regulatory body or official, or any other person or entity.

**Rule 503:** A Designee shall not give the impression to a client or prospective client that the designee is representing the views of the Board, Grantor, or any other group, unless the designee has been expressly authorized to do so. The designee's personal opinions shall be clearly identified as such.

**Rule 504:** A Designee is prohibited from the unauthorized or misleading use of Board or Grantor approved credentials, or unauthorized or misleading use of proprietary information belonging to either the Board or Grantor such as the CLTC® Graduate list or any other proprietary content.

**Rule 505:** A Designee shall conduct him/herself with honesty, honor, and dignity.

**Rule 506:** A Designee shall give written credit to the Grantor when authorized by the Grantor to re-print, disseminate, publicize or edit any proprietary content belonging to the Grantor or any of its respective representatives.

#### Rules Relating to Diligence

**Rule 601:** A Designee shall act promptly in serving clients, employers, principals, and other users of the designee's services.

**Rule 602:** A Designee shall carefully evaluate a client's circumstances prior to making a recommendation and the designee shall make and/or implement only those recommendations that are appropriate for the client.

**Rule 603:** A Designee shall properly supervise subordinates with regard to their delivery of services to the client, and the designee shall not accept or otherwise condone any subordinate's conduct that is in violation of this Code.

## **IV. The Disciplinary Procedures Introduction:**

The Code of Professional Responsibility establishes minimum standards of acceptable professional behavior for individuals who are members of the Corporation and who are entitled to use the designation Certified in Long-Term Care (CLTC)®. Adherence to the Code is mandatory for all Designees, and its provisions will be strictly enforced. Use of the designation is a proclamation to the public that the Designee is a person in good standing with the Board or Grantor, and to whom members of the public can entrust their affairs with confidence. In order to maintain high standards of professional conduct, those Designees who have demonstrated that they are unable, or are likely to be unable, to discharge their professional responsibilities shall be subject to appropriate disciplinary procedures.

### The Board of Standards:

The CLTC Board of Standards (Board) or any other appropriate authority designated by the Grantor to serve as the Board, is charged with the duty of investigating, reviewing, and taking appropriate action with respect to a designee's alleged violations of the Code and it shall have original jurisdiction over all such disciplinary matters and procedures.

The Board is authorized to:

- Enlist the aid or assistance of one or more Designees to assist with investigations or to serve temporarily as a Hearing Officer;

- Appoint staff members, which may include persons who will investigate and prosecute alleged violations of the Code;

- Periodically report to the Grantor on the operation of the Board;

- Adopt amendments to The Disciplinary Procedures; and

- Adopt such other rules or procedures as may be necessary or appropriate to govern the internal operations of the Board.

### **Initiation of a Disciplinary Procedure:**

The disciplinary process is initiated by the filing of a written complaint: anyone may file a complaint against a Designee including another Designee, an allied professional, a client, a prospective client, or the Grantor.

The complaint must set forth the name, address, and daytime telephone number of the person filing the complaint.

The complaint is filed with the Board, either directly to a member or through the Grantor. Upon filing, the charged designee will be promptly notified and requested to respond to the complaint within fifteen (15) days.

Within forty five (45) days following the fifteen day time period, the Board will determine, in view of the filings, whether the allegations are sufficient to support a probable finding of ethical misconduct. If so, a hearing may be conducted for the taking of evidence. The designee charged with misconduct has the right to demand a hearing. If the Board finds that the evidence is insufficient, the complaint will be dismissed in writing, and the charged designee and complaining party notified within fifteen days.

### **The Ethics Fact Finding Hearing:**

The ethics hearing will be conducted before a Hearing Officer who will be appointed by the Board. The Hearing Officer must be a Designee, and he/she will serve as such without pay.

The Hearing Officer's function is to determine whether there has been a violation of *The Code of Professional Responsibility*.

Both parties, the complainant and the charged designee, may participate in the hearing, either in person or by additional filings. If the parties participate in person, they may call witnesses on their behalf and present their own testimony.

At such an evidentiary hearing, there are no rules of evidence.

If the charged Designee desires the testimony be taken by a Court Reporter, it will be done so at the Designee's expense.

At the conclusion of the hearing, the Hearing Officer shall submit to the Board, within twenty (20) days, his/her written findings of fact and conclusions as to whether there was a violation of the Code. If the Hearing Officer concludes that there was a violation of the Code, the Hearing Officer shall recommend a penalty.

The Board, after receiving the Hearing Officer's findings and conclusions, will make the final determination as to whether there was a violation and the penalty that is to be assessed. The Board will notify the designee of its decision.

If the Hearing Officer finds and concludes that there was no violation of the Code, the complaint shall be dismissed.

## **Penalties:**

The Board is empowered to impose any of the following forms of discipline:

**1. Censure:** The Board may order private censure of a Designee; that form of censure shall be an unpublished written reproach sent by the Board to a censured designee. Further, the Board may order that a public letter of censure be issued against a designee, which letter shall be a publishable written reproach of the designee's behavior.

**2. Suspension:** The Board may order suspension of the right of the designee to use the designation for a specified period of time, not to exceed (12) months for those individuals it deems may ultimately be reinstated. In the event of suspension, it shall be standard procedure to publish the fact of suspension together with identification of the Designee in a press release or in such other form of publicity as is selected by the Board. A Designee who receives a suspension for a fixed period may apply to the Board for reinstatement immediately upon the termination of the suspension. A

Designee shall not be reinstated until all Renewal fees, due during the period of Suspension, have been paid in full. At the end of the imposed suspension and after all payment and continuing education requirements have been satisfied, the status of the designee shall be returned to "Certified Current" by the Board.

**3. Revocation:** The Board may order permanent revocation of a Designee's right to use the designation. In the event of a permanent revocation, it shall be standard procedure to publish the fact of the revocation together with identification of the Designee in a press release, or in such other form of publicity as is selected by the Board. Revocation shall be permanent. A Designee whose designation has been revoked by the Board shall not be entitled to the return of any paid Renewal fees, including: Annual, Monthly, or Lifetime Membership.

**4. Relinquishment:** If a CLTC fails to fulfill the Board's or Grantor's continuing education requirements and/or to pay all Renewal fees in a timely manner and in accordance with his/her selected payment plan, or fails to acknowledge and pledge to abide by the terms of the *Code of Professional Responsibility*, he/she shall be considered to have relinquished his/her right to use or carry the designation, Certified in Long-Term Care, (CLTC)®, and his/her right of access to Designee "graduate" benefits.

Upon failure to pay Renewal fees, as scheduled, the administrative office of Grantor shall have the right to change the designee's status from "Certified Current" to "Relinquished". Relinquishment is not a judgment of the Board, but, rather a status change rendered by the administrative office of the Grantor. Relinquishment remains in effect until such time that all past due continuing education is made current and Renewal fees are paid, provided such past due fees are paid within twenty-four (24) months of the relinquishment: thereafter, the former designee must obtain a new designation.

A Relinquished, Revoked, or Suspended Designee must immediately stop using the CLTC® designation in any form, including on printed materials without exception. The Board and/or Grantor reserves the right to notify a Designee's managers,

employer, represented companies, compliance departments, and/or regulators of his/her Relinquished, Revoked, or Suspended status.

Certification for Long-Term Care, LLC  
Revised, January 1, 2016



# Section F

## Summary

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The CLTC® designation employs a multi-disciplinary approach designed to ground the members of this profession thoroughly in its many components. Unfortunately, no amount of education can overcome lack of character. Even people of character, however, can stray. Ethics flow not just from character but from conformance to a set of rules and standards. Professionals can make bad decisions when they do not have a set of standards to guide them.

A final warning—if it doesn't feel right, it probably isn't right.

Always use your good and professional judgment.

## Key Points F

Advising potential clients about funding options, including LTCL, is an honorable profession that is dishonored when its practitioners employ abusive sales practices.

A set of ten rules governs the promotion of LTCL. These rules are related to three key elements in the presentation of information to promote the protection of a family and funding solutions.

1. The interview
2. Evaluation of the appropriateness of coverage based on an analysis of needs
3. Proper representation of the client's case to your carrier

## **The Ten Rules of Ethical Conduct (Page #413)**

- I. Conduct business under the assumption that the client is a willing and able participant.
- II. Conduct the interview as a process to establish a plan to protect the client's family, not an opportunity to sell product.
- III. Understand that a client's wishes and needs may be two different things, and that your responsibility is to focus on needs.
- IV. Understand that the client's best interest is foremost in the proper presentation and implementation of solutions to meet the client's needs.
- V. Understand that LTCI may not be the most appropriate solution to the client's needs, and if it's not, advise the client of this and offer to assist in implementing the proper plan.
- VI. Attempt to minimize the cost of insurance by recommending only necessary coverage, and when appropriate, copayment by the insured.
- VII. Consider an insurance funding solution as only one part of a client's total financial situation, and advise him to employ the counsel of other professionals when appropriate.
- VIII. Never disparage a competitor's product, services, business practices, or personal character.
- IX. Never use misleading or false language in advertising and marketing materials, and fully disclose if endorsers are profiting from the sale of a product.
- X. Present an unbiased, objective assessment of the client's health history and suitability of coverage to the carrier.

## **General Ethical Rules of Conduct (Page #433)**

The *Unfair Trade Practices Act* section on Unfair Marketing Practices prohibits the following conduct:

- Misrepresentation
- False advertising
- Defamation
- Twisting
- Rebating
- Bait and switch

### **The CLTC Code of Professional Responsibility (Page #438)**

The *CLTC Code of Professional Responsibility* was adopted on June 8, 2006, to provide ethical principles and rules for all persons who have been designated to use the Certified in Long-Term Care (CLTC) designation.

## Section F Quiz

1. All of the following are considered ethical conduct EXCEPT:
  - A. An advisor must focus on what a client needs, not just what she wants
  - B. Recommending a coverage amount that is less than the expected cost of extended care is appropriate in many circumstances
  - C. Including additional medical history information in a cover letter
  - D. Telling a client how she should deduct business-paid premiums
  
2. If a prospective client does not meet the NAIC financial suitability guidelines, an agent should:
  - A. Tell the client it's OK as long as she signs the appropriate acknowledgements
  - B. Ask if a family member(s) can or will help pay the premiums
  - C. Switch to a product like short-term care that doesn't have a suitability worksheet
  - D. Recommend life insurance with a chronic illness rider instead
  
3. Which of the following is an example of "twisting"?
  - A. Showing clients multiple illustrations to confuse her
  - B. Selling multiple policies to the same person
  - C. Presenting a cheaper policy first then closing on a higher premium
  - D. An inappropriate replacement

4. All of the following could be considered "misrepresentation" EXCEPT:
- A. Disparaging Partnership LTC when the agent is not Partnership certified
  - B. Telling a client you can sell any type of LTC insurance, but you have not completed all the certifications to do so
  - C. Suggesting that past premium rate increases will continue at the same rate and frequency in the future
  - D. Presenting only one company or type of policy because that is all you are licensed and/or contracted to sell
5. The CLTC® Code of Professional Responsibility allows for a designee to lose the right to use the CLTC® designation for violation of the Code
- True
  - False



# Quiz Answers for each Section

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## SECTION A

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

## SECTION B

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

## SECTION C

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

### **SECTION D**

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

### **SECTION E**

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

### **SECTION F**

1. D
2. B
3. D
4. D
5. TRUE

# Glossary

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Note: Words within definitions that are in ALL CAPS are defined elsewhere in the Glossary.

## **ACCUMULATION PERIOD:**

A period of time within which the ELIMINATION PERIOD must be satisfied. If the ELIMINATION PERIOD is not satisfied within the Accumulation Period, the ELIMINATION PERIOD starts over. Not all policies impose this limit.

## **ACTIVITIES OF DAILY LIVING (ADLs):**

The physical activities that policies use to measure your ability—or inability—to safely take care of yourself. The most common ADLs are:

- TRANSFERRING
- TOILETING
- BATHING
- DRESSING
- EATING
- CONTINENCE

The loss of an ADL is measured either by HANDS-ON ASSISTANCE or STAND-BY ASSISTANCE.

**ALTERNATIVE PLAN OF CARE (APOC):**

Specific contract language offered in many policies. The policyholder has the right to negotiate with the carrier to pay for services not explicitly covered by the policy. The policyholder, the policyholder's doctor, and the carrier must all agree on the alternative. An alternative is not guaranteed as the carrier has the right to refuse the request. An alternative is typically only approved if it costs the carrier less than covered services, and it is not a substitute for benefits that were available at time of application, but not chosen.

For example, a facility-only policy will only provide for an alternative facility, not for home care services as an alternative to a facility.

**ASSIGNMENT OF BENEFITS (AOB):**

The policyholder (or power of attorney) can assign the payment of benefits directly to an approved care provider. AOB does not give the provider any other rights in the policy.

**BATHING:**

An ACTIVITY OF DAILY LIVING. Bathing is the ability to wash yourself, either in the tub or shower—including safely getting into and out of the tub or shower; or with a sponge.

**BENEFIT AMOUNT:**

Also called the benefit level. May be expressed as a daily, weekly, or monthly amount. This is the maximum amount a policy will pay for a day (or week, or month) of care. The benefit amount may be higher for nursing-home care than for assisted living and/or home care.

**BENEFIT ELIGIBLE:**

Physically or cognitively impaired according to the policy's BENEFIT TRIGGERS and eligible for the ELIMINATION PERIOD and other policy benefits to begin.

**BENEFIT PERIOD:**

Starts on the first day of benefit payments and ends when you no longer require care or have reached the maximum benefits allowed by your policy. The Benefit Period may be measured by a total number of days, years, or by calculating a total POOL OF MONEY which may last longer than the stated time period if all of the BENEFIT AMOUNT is not used each day or month. Some older policies have separate Benefit Periods for facility and home care that cannot be combined if one or the other is used up first.

**BENEFIT TRIGGERS:**

The condition(s) you must meet to be BENEFIT ELIGIBLE before the policy's ELIMINATION PERIOD starts or other benefits begin. Think of these as the policy's "definition of disability." The three possible triggers are:

- Physical assistance as measured by a loss of ACTIVITIES OF DAILY LIVING (ADLs)
- Supervision due to a COGNITIVE IMPAIRMENT
- MEDICAL NECESSITY

Most policies pay when any ONE condition is met. If a policy requires the loss of both a COGNITIVE IMPAIRMENT and the loss of ADLs, that would be very restrictive.

Most policies, including TAX-QUALIFIED policies written since 1997 do NOT include the "medical necessity" trigger.

**CARE COORDINATION:**

Also called "case management" or "care management. A benefit included in many policies that helps policyholders and their families make informed choices about care needs and services once BENEFIT ELIGIBLE. Benefits are usually limited to a one-time or yearly maximum. Some policies only offer a toll-free number for phone consultation. Some policies allow Care Coordination services for policyholder and other family members even if not BENEFIT ELIGIBLE.

**CASH BENEFIT:**

A type of INDEMNITY (or PER DIEM) policy that pays the full contract benefit in cash, regardless of who provides the care, where or how often, and regardless of expenses incurred (or not). Receipts are not required. Some policies may pay facility benefits on an INDEMNITY basis, while paying home care as a REIMBURSEMENT.

**CRITICAL ILLNESS:**

An alternative definition used to describe benefits that are similar to, but not legally allowed to be called LTCI benefits. Sometimes referred to as a 101(g) benefit, Critical Illness benefits may be part of a life insurance policy allowing part of the death benefit to be paid before death if "critically ill." A Critical Illness benefit usually defines an ADL or COGNITIVE IMPAIRMENT loss as having to be "permanent" to trigger benefits—a limitation that could deny or substantially delay benefits that would otherwise be paid by a true LTC insurance policy. The "permanent" determination also opens the door for disagreements between medical professionals and the insurance company.

**CHRONICALLY ILL:**

Generally means BENEFIT ELIGIBLE. TAX-QUALIFIED LTC policies written since 1997 require that an insured be certified as "Chronically Ill" by a LICENSED HEALTH CARE PRACTITIONER to be considered BENEFIT ELIGIBLE:

A "severe" COGNITIVE IMPAIRMENT requiring SUBSTANTIAL SUPERVISION; or

Unable to perform without SUSTANTIAL ASSISTANCE at least 2 ADLs for an expected period of at least 90 days—this is called an "ADL Certification."

**COGNITIVE IMPAIRMENT:**

A deterioration or loss in mental capacity which requires supervision to protect yourself or others. It is measured by impairment in the following areas:

- Your short term or long term memory,
- Your orientation as to
  - person (who you are)
  - place (where you are)
  - time (day, date, and year)
- Your deductive or abstract reasoning.

**CONTINENCE:**

An ACTIVITY OF DAILY LIVING. The ability to control urinary and/or bowel function. (If incontinent, the ADL definition includes the ability to manage it with a reasonable degree of hygiene (or not).)

**COORDINATION OF BENEFITS:**

The practice paying benefits only after other insurance or government agency has made payment. Sometimes called "benefit offset". Most policies will coordinate with Medicare and workers' compensation to avoid double-payment for the same service. Most policies do not coordinate with other LTC insurance policies unless written by the same carrier and specifically noted in the policy. Many policies will count Medicare-paid days toward satisfying the ELIMINATION PERIOD if also BENEFIT ELIGIBLE.

(Under Medicaid, LTC insurance benefits are considered a form of income that pays first offsetting Medicaid's responsibility.)

**COINSURANCE:**

Also called co-payment, is a percentage of the cost of care that the policyholder must pay on every covered expense. A typical COINSURANCE is 20% meaning for every dollar spent on care, the policy will only reimburse \$0.80. Not every policy includes a Coinsurance provision.

**CUSTODIAL CARE:**

Non-skilled care. Help with ADLs or supervision for COGNITIVE IMPAIRMENT. Custodial care may also involve HOMEMAKER SERVICES including preparation of meals, housekeeping, laundry, transportation, help with managing medicines, and other routine activities. Custodial care can be received at home, in adult day care, assisted living facilities, or nursing homes. Combined with HOMEMAKER services, Custodial Care is now sometimes called LONG-TERM SERVICES AND SUPPORTS.

**DAILY BENEFIT AMOUNT:**

The maximum amount that will be paid for any one day of covered services. See BENEFIT AMOUNT.

**DRESSING:**

An ACTIVITY OF DAILY LIVING. Putting on and taking off clothing and any necessary braces, fasteners, or artificial limbs.

**EATING:**

An ACTIVITY OF DAILY LIVING. Feeding oneself by getting food into the body, or by a feeding tube or intravenously.

(Meal preparation is not part of the Eating ADL. Choking risk could constitute a STAND-BY loss of the Eating ADL. If a feeding tube is required and the policyholder can manage it herself she can perform the Eating ADL. If assistance is needed to attach and properly clean a feeding tube, that would constitute a loss of the Eating ADL.)

### **ELIMINATION PERIOD:**

This is the policy's "deductible." Often abbreviated EP. Usually expressed as a number of days. You must be disabled based on one of the BENEFIT TRIGGERS for the EP to start. An EP is not simply a "waiting period," rather it counts the number of days you are BENEFIT ELIGIBLE and receiving and paying for a covered service. For HOME CARE, typically one-hour of a covered, paid service will count for one day; while uncommon, some policies set a higher minimum number of hours for HOME CARE to count as a day.

The EP may be different for nursing-home care and home care. Newer policies only require the EP be satisfied once; older policies may require a new EP for separate periods of care. A policy may set a total dollar amount that must be spent before benefits begin, but this is not common.

### **EXCLUSIONS:**

All policies specify certain situations in which they will not pay benefits. Common Exclusions are for care:

- Caused by war or act of war
- From intentionally self-inflicted injury or attempted suicide
- Paid by the government (other than Medicaid)
- For which no charge is made in the absence of insurance
- Due to alcoholism or drug addiction
- Received outside the United States

- Provided by a family member

**GRACE PERIOD:**

How long you have to pay your premium after the due date before the policy lapses. The standard grace period is 30 days. This means that you have 30 days after your premium due date to make the payment without losing coverage. Some companies may extend this to 60 or more days.

If a policy lapses after the grace period, but it can be proven that the policyholder was suffering from a BENEFIT ELIGIBLE ADL loss or COGNITIVE IMPAIRMENT at the time of lapse there is an extended 180-day "Unintentional Lapse" reinstatement period.

(Some companies only also allow an "Unintentional Lapse" 180-day reinstatement if COGNITIVELY IMPAIRED at the time of lapse.)

**GUARANTEED RENEWABLE:**

The insurance company cannot cancel your policy for any reason except for not paying premiums. The policy benefits also cannot be changed by the company. If a policy is Guaranteed Renewable, it states this on the cover page. Most LTC insurance is Guaranteed Renewable.

Guaranteed Renewable does NOT mean that premiums are guaranteed. Premiums can increase. It is the coverage that is guaranteed as long as premiums are paid on time.

**HANDS-ON ASSISTANCE:**

Direct, physical assistance of another person, without which the disabled individual would be unable to perform an ADL.

**HIPAA:**

The *Health Insurance Portability and Accountability Act of 1996* went into effect on Jan. 1, 1997. In addition to strict medical information privacy rules, HIPAA established specific federal requirements that a LTC insurance policy must meet to be "TAX QUALIFIED." HIPAA grandfathered all policies issued before 1/1/1997 and are considered TAX QUALIFIED as long as the policy's schedule of benefits are not "materially changed." Policies issued after 1/1/1997 must state on the cover page if it is TAX QUALIFIED or not. [IRC 7702B]

**HOME CARE:**

Private-duty, CUSTODIAL CARE services. Most policies do not use this term to identify CUSTODIAL CARE services as distinguished from skilled "home health care" services. See HOME HEALTH CARE below.

**HOME HEALTH AIDE:**

A person employed by a Home Health (or HOME CARE) Agency or working as an individual, who provides help at home with ADLs, COGNITIVE IMPAIRMENT supervision, and in some cases additionally HOMEMAKER SERVICES. A Home Health Aide may have additional training or certification, e.g., a "CNA—Certified Nursing Aide," to provide higher levels or care or service than a HOME CARE aide. A policy may use Home Health Aide as an all-encompassing term to cover a person who provides any skilled and/or CUSTODIAL CARE services under a HOME CARE benefit.

**HOME HEALTH CARE:**

In most policies this is an all-encompassing term. It is care provided by an agency or individual (if allowed by the policy) and includes services provided by a nurse, home health aide, nutritionist, or occupational, speech, respiratory, or physical therapist. It does not cover services provided by members of your family, or only companion care. Companion care if covered is secondary to a primary CUSTODIAL CARE or skilled care need.

"Home Health Care" generally includes CUSTODIAL CARE services; it does not exclude private-duty home care and in most policies includes HOMEMAKER SERVICES.

Home Health Care is not covered by all policies. When offered, the services may be covered as part of the policy, as an option or rider attached to a facility policy, or as a separate policy.

**HOMEMAKER SERVICES:**

Activities such as meal preparation, housekeeping, laundry, using a telephone, shopping, bill paying, and traveling outside the home are considered Homemaker Services. Help with Homemaker Services alone does not qualify a person for benefits to begin, but once BENEFIT ELIGIBLE most policies will pay for HOMEMAKER SERVICES.

**INDEMNITY:**

Also called PER DIEM. An Indemnity benefit is a fixed amount paid when any care is received, regardless of the cost of care. A policy with a daily (or "Professional") Indemnity benefit will pay the full contract benefit for each day any covered care is received and paid for regardless of the actual charges—receipts are still required. CASH BENEFIT Indemnity pays the full benefit with or without professional care – receipts are not required. See also CASH BENEFIT.

**INFLATION PROTECTION:**

An optional benefit that increases the BENEFIT AMOUNT (and the POOL OF MONEY) over time to keep up with the rising cost of care. Inflation increases can be "automatic" or "pay-as-you-go" purchase options. If a policy schedule shows an inflation benefit, the actual coverage available at time of claim will likely be higher than shown.

**INFORMAL CARE:**

Unpaid care. Care provided by family or friends. Most policies do not pay for Informal Care. A few REIMBURSEMENT policies provide limited benefits for Informal Care. INDEMNITY policies can pay for Informal Care.

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs):**

Meal preparation, housekeeping, laundry, using a telephone, shopping, traveling outside the home, taking medications, bill paying, preparing meals, doing housekeeping and laundry. Clients unable to perform one or more of these without assistance are said to have an IADL limitation.

These limitations may be early warnings of disability requiring long-term care, and evidence of IADL limitations may be used in the underwriting process to deny insurance to an applicant. IADL assistance alone does not qualify a person for benefits to begin, but once BENEFIT ELIGIBLE most policies will pay for IADL services that are considered HOMEMAKER SERVICES by the policy.

**LICENSED HEALTH CARE PRACTITIONER:**

A doctor, nurse (R.N. or L.P.N.), or licensed social worker.

**LIFETIME BENEFIT LIMIT:**

Most insurance companies set a limit on the maximum amount of benefits that a policy will pay, unless it is an "unlimited" or "lifetime" policy. These limits are expressed in terms of years, days or dollars. Most policies do not limit benefits to a period of time but have a maximum POOL OF MONEY. See BENEFIT PERIOD.

**MEDICAL NECESSITY:**

A BENEFIT TRIGGER on some older policies. Usually defined as care needed according to "accepted standards of medical practice" required by the patient's condition,

specified by a "plan of care" written by a doctor, and not just for the convenience of the policyholder or family.

Some carriers have refused to pay benefits for CUSTODIAL CARE under a Medical Necessity trigger arguing it is not strictly "medical" care.

Medical necessity is not allowed in TAX QUALIFIED policies.

### **MENTAL/NERVOUS DISORDER:**

Refers to a mental or emotional disease or disorder that does not have an "organic" origin. Both Alzheimer's disease and other dementias are considered organic in origin; most policies cover these and should clearly say, "Alzheimer's Disease, senile dementia and other organic brain disorders" are covered by the policy.

Some policies exclude coverage for "nonorganic" mental and nervous disorders (generally "psychiatric" conditions) and care needs caused by alcohol or drug abuse.

### **MONTHLY BENEFIT AMOUNT:**

If the home care BENEFIT AMOUNT is expressed as a Monthly Benefit, the policy will reimburse any covered amount per day until it reaches the Monthly Benefit maximum.

For example, a policy with a \$100 DAILY BENEFIT AMOUNT will never reimburse more than \$100 in any one day. An equivalent Monthly Benefit of \$3000 (\$100/day x 30 days) allows for higher reimbursements on high-usage days offset by days where little or no professional care is used. A Monthly Benefit policy of \$3000 could therefore reimburse \$200/day every other day.

### **OUTLINE OF COVERAGE**

A marketing outline with basic, legally mandated disclosures about the policy. Agents are required to give prospective clients an Outline of Coverage no later than when an

application is signed. An Outline of Coverage is not detailed enough to be an acceptable policy evaluation tool for use at time of claim.

**PER DIEM:**

See INDEMNITY benefit. Per Diem is the term used by the Federal Tax Code for an INDEMNITY benefit.

**PHYSICAL IMPAIRMENT:**

Loss of (or need for help with) ACTIVITIES OF DAILY LIVING (ADLs).

**PLAN OF CARE (POC):**

A written POC is required by TAX QUALIFIED policies, but all insurance companies now make a POC part of their standard claim process even for older policies. TAX QUALIFIED policies say the POC can be written by any LICENSED HEALTH CARE PRACTITIONER (LHP). In most cases the client can choose the LHP who writes the POC, or it may be a LHP on an agency's staff. A few policies require the POC be written by a company-appointed care coordinator. The POC must be updated whenever care services or schedules change. A carrier can request a POC monthly. Many caregiving agencies routinely send a copy of the most recent POC with every claim submission, even if it has not changed.

**POOL OF MONEY:**

The maximum BENEFIT AMOUNT payable in dollars. Calculated by multiplying the daily (or weekly, or monthly) benefit by the BENEFIT PERIOD. A Pool of Money policy can pay benefits long than the stated BENEFIT PERIOD if not all the benefits are used each day (or week or month). Most policies have a single Pool of Money for all services—home or facility care, though there could be separate pools for each type.

**PRE-EXISTING CONDITION:**

An illness or disorder for which you received treatment during a specified period of time before the policy took effect—typically 6 to 12 months. A "pre-ex" condition is then not covered for a defined period of time after the effective date—typically also 6 to 12 months. Carriers do consider Pre-Existing Conditions during underwriting, and a pre-ex could cause an application to be declined. Once approved, most individual policies do not impose a pre-ex limit. Usually a pre-ex limit is only seen in "guaranteed-issue" employer group policies where there was limited or no underwriting.

**PRIOR HOSPITALIZATION:**

A STEP-DOWN provision that only pays for care if you were hospitalized immediately before needing long-term care services. A similar STEP-DOWN only pays for home care following a nursing home stay. Not allowed in policies issued since 1993. Older policies may still be in-force with these types of STEP-DOWN limitations.

**REIMBURSEMENT:**

Benefits are paid up to the maximum BENEFIT AMOUNT based on what the policyholder actually spends on covered care. Reimbursement policies will only pay for charges and providers explicitly named and covered in the contract. This is the most common way policies pay for professional care services.

While rare, some policies may only reimburse for "Usual and Customary" charges rather than actual charges; a "usual and customary" reimbursement is likely to be lower than actual charges incurred.

**REINSTATEMENT:**

If the policy lapses by not paying premiums, and you later decide you want to reactivate it, the insurer may allow you to do so, but you will likely have to pass a new health underwriting review. See also: UNINTENTIONAL LAPSE.

**RESPITE CARE:**

Care provided by a paid caregiver as a replacement to care usually received at home from a family member or friend. Respite care is an additional benefit provided to give relief to a person who provides INFORMAL CARE. Respite care may be covered at home, in adult day care, or a residential facility.

**RESTORATION OF BENEFITS:**

A policy may reinstate—or restore—the full BENEFIT PERIOD/POOL OF MONEY if you fully recover (no ADL limitations or COGNITIVE IMPAIRMENT) and have not needed care for a period of time, usually 180 days. Restoration of benefits may be included in the base policy, or may be an optional rider. In some cases only a percentage of the benefit amount you have used is restored.

Example: you have a 3-year policy, receive benefits for 1 year, and then recover and need no care for at least 6 months. The policy restores the year you used, and you would then have three full years of coverage available for a new disability in the future.

**SHARED BENEFITS:**

Also called "Shared Care," Shared Benefits combines the BENEFIT PERIODS/POOLS OF MONEY of a couple into one larger shared benefit. If one spouse (or partner) uses up all of her maximum benefit, she can draw from her spouse's (or partner's) POOL OF MONEY to continue receiving benefits. If a spouse (or partner) dies without using all of his benefits, the unused POOL OF MONEY rolls over to the surviving spouse/partner. Shared Benefits is an optional rider, or it may also be a single joint policy covering both spouses.

Shared Benefits are available to unmarried "domestic partners," as well as gay and lesbian couples. Depending on the insurer, siblings or other family members who live together may also be able to share benefits through this type of option.

**STAND-BY ASSISTANCE:**

The presence of another person within arm's reach that is necessary to prevent injury while the individual is performing an ADL. It is sometimes referred to as Supervisory Assistance. An example is being ready to catch or steady an individual who may fall getting into or out of a chair or bath or shower.

**STEP-DOWN PROVISIONS:**

"Step-down" provisions require a higher level of care before a lower level is covered. Examples include:

- PRIOR HOSPITALIZATION immediately before needing care services;
- Nursing home stay before home care is paid; and/or
- Skilled care must be received before CUSTODIAL CARE is paid.

Step-down restrictions have been illegal to write into new policies since 1993. Older policies may still be in-force that contain these types of benefit limitations.

**SUBSTANTIAL ASSISTANCE:**

TAX-QUALIFIED policies written since 1997 require that an ADL loss require "Substantial Assistance." Most policies will separately define Substantial Assistance, and most include either HANDS-ON or STAND-BY ASSISTANCE as being "substantial."

If a TAX-QUALIFIED policy does not explicitly define Substantial Assistance, the U.S. Treasury Department states that "substantial" includes either HANDS-ON or STAND-BY ASSISTANCE. [IRS Notice 97-31, 1997-1 C.B. 417] Policies CAN explicitly limit the definition of ADL assistance to only HANDS-ON which is more restrictive and is not common.

## **SUBSTANTIAL SUPERVISION:**

TAX-QUALIFIED policies written since 1997 require that a severe COGNITIVE IMPAIRMENT require "Substantial Supervision" as part of the COGNITIVE IMPAIRMENT BENEFIT TRIGGER.

Substantial Supervision is interpreted as meaning 24/7 supervision. This does not mean round-the-clock, paid professional care, but simply that someone, anyone needs to be present at all times for the client's care and safety. This can include a spouse, family, or friends. The PLAN OF CARE for LTC insurance benefits should always describe all caregivers, professional and INFORMAL.

Policies issued before 1997 generally do not include the words "Substantial Supervision" to gauge a COGNITIVE IMPAIRMENT claim. However some companies wrongly apply the "substantial," 24/7 standard to COGNITIVE IMPAIRMENT claims on these older, pre-HIPAA policies. Policies issued before 1997 that do not include the "substantial" language do not require that the supervision be 24/7 even though they are grandfathered as TAX QUALIFIED policies. TQ grandfathering ONLY applies to the tax consequences for premium and benefit payments, it does NOT require or allow a company to retroactively make older policies more restrictive.

## **TAX QUALIFIED (TQ):**

Policies that meet HIPAA's requirements for policy language and consumer protection standards. TQ policies are generally considered "health insurance" for tax purposes. They have guaranteed tax-free benefits (with limitations for INDEMNITY benefits), and the premiums may be deductible as a medical expense depending on the taxpayer's circumstances. [IRC 7702B]

## **TOILETING:**

An ACTIVITY OF DAILY LIVING. Using a toilet to relieve bowels or bladder, including getting to and from as well as on and off the toilet with a reasonable degree of hygiene.

Note that if assistance is needed just to get on and/or off the toilet that could qualify the client for the TOILETING ADL. This is similar to TRANSFERRING into/out of a chair. Therefore TOILETING and TRANSFERRING ADLs are commonly lost at the same time.

**TRANSFERRING:**

An ACTIVITY OF DAILY LIVING. The ability to get into or out of bed or a chair.

**WAIVER OF PREMIUM:**

When a policyholder is on claim, her premiums are “waived,” they do not have to be paid. Typically premiums are waived once benefit payments begin after the ELIMINATION PERIOD, though the premium waiver can start sooner or later depending on the policy. Future premiums are waived as long as the claim continues, and “unearned premiums”—premiums paid previously, in advance, that cover the time after the waiver starts—are usually refunded.

For example, Mary pays an annual premium of \$2,000 on January 1st, she needs care starting on April 1st, and after her 90-day EP her benefits begin on July 1st along with a Waiver of Premium. Because she paid for a full year in January and only six months have passed when the Waiver starts, she will receive a 6-month, pro-rata, refund along with her first benefits after July 1st.

Most policies automatically include Waiver of Premium, but it may be an optional rider. A policy may have different waiver of premium rules for nursing home and home care, or may waive the premium only for nursing-home care. A "joint waiver of premium" waives both spouses' (or partners') premiums if only one needs care.

**WEEKLY BENEFIT AMOUNT:**

If the home care BENEFIT AMOUNT is expressed as a Weekly Benefit, the policy will reimburse any covered amount per day until it reaches the Weekly Benefit maximum. A Weekly Benefit equals seven-times the DAILY BENEFIT AMOUNT.

For example, a policy with a \$100 DAILY BENEFIT AMOUNT will never reimburse more than \$100 in any one day. An equivalent WEEKLY BENEFIT of \$700 (\$100/day x 7 days) allows for higher reimbursements on high-usage days offset by days where little or no professional care is received. A Weekly Benefit policy of \$700 could therefore reimburse around \$175/day every other day.

A Weekly Benefit provides a similar home care benefit usage flexibility to a MONTHLY BENEFIT AMOUNT. MONTHLY BENEFIT is much more common than Weekly.

**WRITTEN PLAN OF CARE:**

See PLAN OF CARE



# Appendices

**Appendix 1 | State Medicaid Worksheet**

**Appendix 2 | State Tax Incentives for LTC Insurance**

**Appendix 3 | 2015 State Medicaid Asset and Income Limits**

**Appendix 4 | State Long-Term Care Supplements**

**Appendix 5 | CMS Medicaid Life Expectancy Table**

**Appendix 6 | CLTC Sample Exam**



# Appendix 1:

# State Medicaid

# Worksheet

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It's a good idea to be acquainted with the rules of your state's Medicaid program to understand how they affect the situations described in Part C. The following worksheet covers the most common state-specific information; please fill it out by contacting your state's Medicaid office. State asset and income limits are shown in Appendix 3.

## Countable Assets

### Assets Deemed Countable in Most States

	Status in your State	
Stocks	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable
Bonds	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable
Savings	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable
Money market accounts	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable
CDs	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable
Tax qualified pension plans	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable
Single premium deferred annuity	<input type="checkbox"/> Countable	<input type="checkbox"/> Non-Countable

- |  |                                    |  |
|--|------------------------------------|--|
| Life insurance with cash surrender value | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Vacation property                        | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Investment property                      | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |

Other assets deemed countable:

---

## Non-Countable Assets

### Assets Deemed Non-Countable in Most States

- |                            | Status in your State               |  |
|----------------------------|------------------------------------|--|
| Car                        | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Prepaid funeral            | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Principal residence        | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Business supporting family | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Burial account             | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Term life insurance        | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Cash                       | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Business property          | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |
| Household goods            | <input type="checkbox"/> Countable | <input type="checkbox"/> Non-Countable |

Other assets deemed non-countable:

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## Primary Residence

Policy on placing liens on the primary residence

## Income

### Cap state

A cap state will not grant Medicaid eligibility to anyone whose income exceeds a cap, typically \$2,199 per month in 2016. Those whose income exceed the cap do not qualify for Medicaid unless they establish a Miller Trust. See page #149 for additional information.

The following are income-cap states, but this list could change; verify your state's status and the amount of the cap. Non-cap states grant Medicaid eligibility to anyone otherwise eligible whose income is smaller than his extended care costs.

Alabama	Delaware	Kentucky	Oregon	Tennessee
Alaska	Florida	Mississippi	Oklahoma	Texas
Arizona	Georgia	Nevada	Oregon	Wyoming
Arkansas	Idaho	New Jersey	South Carolina	
Colorado	Iowa	New Mexico	South Dakota	

### **Are you in a cap state?**

Yes, the cap: \$ \_\_\_\_\_

No

## **Income and Asset Rules for Couples**

### **The minimum monthly maintenance needs allowance (MMMNA)**

Your state's MMMNA is \$ \_\_\_\_\_

### **The Community Spouse resource allowance (CSRA)**

Your state's CSRA is \$ \_\_\_\_\_

### **Interest Rates**

If the Community Spouse's monthly income is less than the monthly minimum maintenance needs allowance (MMMNA).

Annual return attributable to the CSRA \_\_\_\_\_%

The spend-down used to generate income \_\_\_\_\_%

# Appendix 2:

## State Tax Incentives for Long-Term Care Insurance

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<b>Alabama</b>	Deduction	Deduction of premiums for federally Tax-Qualified LTCI policies covering three or more years and meeting the requirements of <i>Alabama Code 27-47-3</i> .  <i>Alabama Code 40-18-15(27)(1996); Reg. 810-3-15.26</i>
<b>Arkansas</b>	Deduction	Deduction of federally Tax-Qualified LTCI premiums as medical expense as available in federal law.  Ark. Code Sec. 23-97-203; Reg. 1.26-51-423(a)(2)

<b>California</b>	Deduction	Deduction of federally tax-qualified LTCI premiums similar to that available in federal law. <i>Cal. Rev. &amp; Tax Code §17201</i>
<b>Colorado</b>	Credit	Tax credit for premiums paid for LTCI, to the lesser of: (A) 25% of the premiums, or (B) \$150 per policy, for tax years starting on or after January 1, 2000. The credit is available only to individual filers with federal taxable income less than \$50,000; joint filers with income less than \$50,000 claiming credit for one policy; or joint filers with income less than \$100,000 claiming credit for two policies. Policies must meet Colorado's definition of long-term care. <i>C.R.S. 39-22-122</i>
<b>District of Columbia</b>	Deduction	Since Jan. 21, 2005, permits a deduction from gross income of LTC insurance premiums up to \$500 per person per year, whether the person files individually or jointly. Section 47-7803.03 (b-1) of the DC Official Code
<b>Hawaii</b>	Deduction	Deduction of premiums for LTCI as a medical expense similar to that available in federal law. HRS Sec. 235-2.4
<b>Idaho</b>	Deduction	Deduction of premiums for long-term care policies that meet the requirements of <i>Idaho Code 41-4603</i> , purchased for the benefit of the taxpayer, or a dependent or an employee of the taxpayer. Idaho Code, 63-3022P

<b>Indiana</b>	Deduction	For qualified Partnership policies only, deduction of the eligible portion of premiums paid after January 1, 2000, for federally Tax-Qualified long-term care policies meeting the requirements of <i>IC 12-15-39.6-5</i> and insuring the taxpayer or his spouse.  <i>Section 2, IC 6-3-1-3.5</i>
<b>Iowa</b>	Deduction	Deduction of premiums for LTCI similar to that available in federal law as a medical expense.  <i>IAC Chapter 40, §701-40.48(422)</i>
<b>Kansas</b>	Deduction	Tax deduction for premiums of federally Tax-Qualified LTCI, up to \$1000.  <i>§79-32, 117(c)(xvi)</i>
<b>Kentucky</b>	Exclusion	Exclusion from Kentucky AGI of any amounts paid for LTCI as defined in the Kentucky code.  <i>KRS 140.010(10)(m); Reg. 304.14-600 &amp; 610</i>

<b>Louisiana</b>	Credit	10% state tax credit for eligible premiums
<b>Maine</b>	Deduction	<p>With effect from 1 Jan. 2004, a taxpayer may deduct any premiums for qualified LTCI, <i>reduced by</i> any premiums deducted from federal income tax and by premiums claimed as an itemized deduction pursuant to Title 24-A, Chapter 68.</p> <p><i>Rev. Stat. Title 36, Part 8, Chapter 805, Sec. 5122</i></p>
	Credit	<p>For employers, tax credit for federally Tax-qualified LTCI, equal to the lowest of: (A) \$5,000; (B) 20% of the costs of providing coverage; or (C) \$100 for each covered employee.</p> <p><i>Title 36, Part 4, Section 2525, Chapter 357</i></p>
<b>Maryland</b>	Credit	<p>A one-time-only tax credit of up to \$500 per insured (varying with the age of the insured and adjusted annually for inflation) for premiums of long-term care policies insuring the taxpayer, his spouse, parent, step-parent, child, or stepchild, if they reside in Maryland and were not covered by LTCI prior to July 1, 2000. Credit for the insured must not have been claimed by the taxpayer in any prior tax year. Credit in excess of the tax liability cannot be carried over.</p> <p><i>Chapter 242, Section 10-718</i></p>

	Credit	<p>For employers, tax credit of 5% for long-term care coverage as employee benefit, not to exceed the lower of: (A) a total of \$5,000; or (B) \$100 per covered employee.</p> <p><i>Chapter 242, Section 10-710; Ins. Art. 6-117, Chapter 7</i></p>
<b>Minnesota</b>	Credit	<p>Tax credit for LTCL premiums equal to the lesser of: (A) 25% of premiums paid to the extent not deducted from federal taxation; or (B) \$100 for individual filers or \$200 for married couples filing jointly.</p> <p><i>Sec. 21, Sec. 290.0672 subdivision 2</i></p>
<b>Mississippi</b>	Credit	<p>A credit against individual income taxes equal to 25% of the premium costs paid during the taxable year for a qualified LTCL policy covering the taxpayer, his spouse, parent, parent-in-law or dependent, but not to exceed the lesser of \$500 or the income tax liability. No carry-forward is allowed. No credit is allowed for any premium deducted, subtracted or excluded from the taxpayer's net taxable income. No credit is allowed for the same expenditures claimed by another taxpayer.</p> <p><i>Ms. Code Ann. §27-7-22.33</i></p>

<b>Missouri</b>	Deduction	<p>Taxpayer may deduct from each Missouri taxable income all non-reimbursed amounts paid for state-qualified LTCI premiums to the extent that such amounts are not included on the taxpayer's federal return. A married individual filing separately may only deduct the amount he personally paid for such premiums.</p> <p><i>Section 8 of R.S. Mo. 334660 (1999.) Mo. Rev Stat. Sec. 135.096. Secs. 376.951-376.958 of Mo. Long Term Care Insurance Act</i></p>
<b>Montana</b>	Deduction	<p>Deduction of premiums for LTCI policies covering both nursing-home and home care, and of premiums for policies insuring the taxpayer's parents or grandparents retroactively to 1997. A taxpayer may not claim both this deduction and the credit below for the same policy.</p> <p><i>Mont. Code. Ann. §15-30-121</i></p>
	Credit	<p>Tax credit for "qualified elderly care expenses" (including insurance premiums) made by the taxpayer for a "qualified family member." The credit is limited to \$5,000 per year for a single family member or \$10,000 for two or more family members and varies in accordance with the taxpayer's adjusted gross income. A tax-payer may not claim both this credit and the above deduction for the same policy.</p> <p><i>Mont. Code. Ann. §15-30-128</i></p>

<b>Nebraska</b>	Deduction	<p>With effect from Jan. 1, 2006, deduction for Nebraska Long-Term Care Savings Plan contributions of up to \$2,000 per married filing jointly return or \$1,000 for any other return, to the extent not deducted from federal income tax.</p> <p><i>Section 77-6102 of NE State Law</i></p>
<b>New Jersey</b>	Deduction	<p>Deduction of medical expenses, including LTCI premiums, to the extent that they exceed 2% of adjusted gross income.</p> <p><i>N.J. Stat. Sec. 54A:3-3</i></p>
<b>New Mexico</b>	Credit	<p>For ages 65+ 2,800 for taxpayer, spouse or dependents and unreimbursed medical expenses equal \$28,000 or more. LTC insurance premiums allowed as part of \$3000 medical care Exemption if all expenses exceed \$28,000.</p> <p><i>N.M. Stat. Ann. Sec. 7-2-35</i></p>

<p><b>New York</b></p>	<p>Credit</p>	<p>A credit is allowed equal to 20% of the premium paid during the taxable year for LTCI approved by the Superintendent of Insurance provided policy qualifies for such credit pursuant to Section 1117. If the amount of credit allowable under this subsection for any taxable year shall exceed the taxpayer's tax for such year, the excess may be carried over to the following year or years and may be deducted from the Taxpayer's tax from such year or years and applies to taxable years beginning on or after January 1, 2004.</p> <p><i>N.Y. Tax Law §606(aa)</i></p>
<p><b>North Carolina</b></p>	<p>NONE</p>	<p>Tax credit expired after 2013.</p> <p><i>N.C.G.S. §105-151.28(a)</i></p>
<p><b>North Dakota</b></p>	<p>Credit</p>	<p>Tax credit for premiums of long-term care policies insuring the taxpayer, his spouse, parents, step-parents or children, to the lesser of: (A) 25% of the premiums; or (B) \$100 per insured.</p> <p><i>N.D. Cent. Code Sec. 57-38-29.2; Reg. 26.1-45-01; Rule 81-03-02.1-11</i></p>

<b>Ohio</b>	Deduction	Deduction of federally Tax-Qualified LTCI premiums. <i>Ohio Rev. Stat. Section 5747.01(A)(11)</i>
<b>Oklahoma</b>	Deduction	Deduction of premiums for LTCI similar to that available in federal law for medical expenses. <i>68 Okl. Stat Sec. 2353</i>
<b>Oregon</b>	Credit	Tax credit for premiums of long-term care policies purchased on or after January 1, 2000, and insuring the taxpayer, his parents or dependents, to the lesser of: (A) 15% of the premium; or (B) \$500. Married taxpayers filing individually must divide the \$500 limit between them. Credit in excess of the tax liability cannot be carried over.  <i>Or. Rev. Stat Sec. 315.610; Sec. 743.652 (Definition for Secs. 743.650—743.656)</i>
	Credit	For employers, \$500 per employee tax credit for premiums of long-term care policies purchased on or after January 1, 2000.  <i>Or. Rev. Stat Sec. 315.610; Sec. 743.652 (Definition for Secs. 743.650—743.656)</i>



<b>Wisconsin</b>	Deduction	Deduction of premiums for long-term care policies insuring the taxpayer or his spouse. <i>Wis. Stat. §71.05(6)(b)26</i>
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Always refer your client to a qualified tax professional. CLTC® designees may not give tax advice unless properly qualified. Information deemed reliable as of 2/26/2016.



# Appendix 3:

## State Medicaid Asset and Income Limits

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Below are the limits that the state Medicaid programs place on the assets and income of applicants and their spouses. These amounts are for 2016 (the MMMNA is valid until July 1, 2016). CMS adjusts the CSRA and MMMNA annually for inflation.

State	Cap State	Cash Allowance	Community Spouse Resource Allowance Minimum	SNF Personal Monthly Needs Allowance	Minimum Monthly Maintenance Needs Allowance	Home Equity Limits
		(CA)	(CSRA)	(PMNA)	(MMMNA)	
AL	Y	\$2,000	\$27,000	\$30.00	\$1,991.25	\$552,000
AK	Y	\$2,000	\$119,220	\$200.00	\$2,457.50	\$552,000
AZ	Y	\$2,000	\$23,844	\$109.95	\$1,991.25	\$552,000
AR	Y	\$2,000	\$23,844	\$40.00	\$1,991.25	\$552,000

<b>State</b>	<b>Cap State</b>	<b>Cash Allowance</b>	<b>Community Spouse Resource Allowance Minimum</b>	<b>SNF Personal Monthly Needs Allowance</b>	<b>Minimum Monthly Maintenance Needs Allowance</b>	<b>Home Equity Limits</b>
<b>CA</b>		\$2,000	\$119,220	\$35.00	\$2,980.50	\$828,000
<b>CO</b>	Y	\$2,000	\$119,220	\$50.00	\$1,991.25	\$552,000
<b>CT</b>		\$1,600	\$119,220	\$60.00	\$1,991.25	\$828,000
<b>DE</b>	Y	\$2,000	\$25,000	\$44.00	\$1,991.25	\$552,000
<b>DC</b>		\$4,000	\$119,220	\$70.00	\$2,980.50	\$828,000
<b>FL</b>	Y	\$2,000	\$119,220	\$35.00	\$1,991.25	\$552,000
<b>GA</b>	Y	\$2,000	\$119,220	\$30.00	\$2,980.50	\$552,000
<b>HI</b>		\$2,000	\$119,220	\$30.00	\$2,261.25	\$828,000
<b>ID</b>	Y	\$2,000	\$23,844	\$40.00	\$1,991.25	\$828,000
<b>IL</b>		\$2,000	\$109,560	\$30.00	\$2,739.00	\$552,000
<b>IN</b>		\$2,000	\$23,844	\$52.00	\$1,991.25	\$552,000
<b>IA</b>	Y	\$2,000	\$24,000	\$50.00	\$2,980.50	\$552,000

<b>State</b>	<b>Cap State</b>	<b>Cash Allowance</b>	<b>Community Spouse Resource Allowance Minimum</b>	<b>SNF Personal Monthly Needs Allowance</b>	<b>Minimum Monthly Maintenance Needs Allowance</b>	<b>Home Equity Limits</b>
<b>KS</b>		\$2,000	\$23,844	\$62.00	\$1,991.25	\$552,000
<b>KY</b>	Y	\$2,000	\$23,844	\$40.00	\$1,991.25	\$552,000
<b>LA</b>		\$2,000	\$119,220	\$38.00	\$2,980.50	\$552,000
<b>ME</b>		\$2,000	\$119,220	\$70.00	\$1,991.25	\$828,000
<b>MD</b>		\$2,500	\$23,844	\$76.00	\$1,991.25	\$552,000
<b>MA</b>		\$2,000	\$119,220	\$72.80	\$1,991.25	\$828,000
<b>MI</b>		\$2,000	\$23,844	\$60.00	\$1,991.25	\$552,000
<b>MN</b>		\$3,000	\$33,851	\$97.00	\$1,991.25	\$552,000
<b>MS</b>	Y	\$2,000	\$119,220	\$44.00	\$2,980.50	\$552,000
<b>MO</b>		\$999.99	\$23,844	\$30.00	\$1,991.25	\$552,000
<b>MT</b>		\$2,000	\$23,844	\$50.00	\$1,991.25	\$552,000
<b>NE</b>		\$4,000	\$23,844	\$60.00	\$2,980.50	\$552,000

<b>State</b>	<b>Cap State</b>	<b>Cash Allowance</b>	<b>Community Spouse Resource Allowance Minimum</b>	<b>SNF Personal Monthly Needs Allowance</b>	<b>Minimum Monthly Maintenance Needs Allowance</b>	<b>Home Equity Limits</b>
<b>NV</b>		\$2,000	\$23,844	\$35.00	\$1,991.25	\$552,000
<b>NH</b>		\$2,500	\$23,844	\$70.00	\$1,991.25	\$552,000
<b>NJ</b>	Y	\$2,000	\$23,844	\$35.00	\$1,991.25	\$828,000
<b>NM</b>	Y	\$2,000	\$31,290	\$69.00	\$1,991.25	\$828,000
<b>NY</b>		\$14,850	\$74,820	\$50.00	\$2,980.50	\$828,000
<b>NC</b>		\$2,000	\$23,844	\$46.00	\$1,991.25	\$552,000
<b>ND</b>		\$3,000	\$23,844	\$60.00	\$2,267.00	\$552,000
<b>OH</b>		\$1,500	\$23,844	\$50.00	\$1,991.25	\$552,000
<b>OK</b>	Y	\$2,000	\$25,000	\$50.00	\$2,980.50	\$552,000
<b>OR</b>	Y	\$2,000	\$23,844	\$60.00	\$1,991.25	\$552,000
<b>PA</b>		\$2,400	\$23,844	\$45.00	\$1,991.25	\$552,000
<b>RI</b>		\$4,000	\$23,844	\$50.00	\$1,991.25	\$552,000

<b>State</b>	<b>Cap State</b>	<b>Cash Allowance</b>	<b>Community Spouse Resource Allowance Minimum</b>	<b>SNF Personal Monthly Needs Allowance</b>	<b>Minimum Monthly Maintenance Needs Allowance</b>	<b>Home Equity Limits</b>
<b>SC</b>	Y	\$2,000	\$66,480	\$30.00	\$2,980.50	\$552,000
<b>SD</b>	Y	\$2,000	\$23,844	\$60.00	\$1,991.25	\$552,000
<b>TN</b>	Y	\$2,000	\$23,844	\$40.00	\$1,991.25	\$552,000
<b>TX</b>	Y	\$2,000	\$23,844	\$60.00	\$2,980.50	\$552,000
<b>UT</b>		\$2,000	\$23,844	\$45.00	\$1,991.25	\$552,000
<b>VT</b>		\$2,000	\$119,220	\$47.66	\$1,991.25	\$552,000
<b>VA</b>		\$2,000	\$23,844	\$30.00	\$1,991.25	\$552,000
<b>WA</b>		\$2,000	\$54,726	\$57.28	\$1,991.25	\$552,000
<b>WV</b>		\$2,000	\$23,844	\$50.00	\$1,991.25	\$552,000
<b>WI</b>		\$2,000	\$50,000	\$65.00	\$2,655.00	\$828,000
<b>WY</b>	Y	\$2,000	\$119,220	\$50.00	\$2,980.50	\$552,000

Information and figures are current as of 2/26/2016 and based on at least two sources. Always work with and refer clients to a qualified elder law attorney.



# Appendix 4:

# State Long-Term Care Supplements

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## Georgia

### Medicaid Eligibility Overview

The Georgia Medicaid program is administered by the Department of Community Health, Division of Medical Assistance. The Medicaid program is funded by the federal and state governments. States administer the Medicaid program using federal regulations and guideline. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law.

### **CATEGORIAL RELATIONSHIP**

Many groups of people are covered by Medicaid. Even within these groups, certain requirements must be met. Every individual must be included in one of the following Medicaid categories:

- Family: Must be a child under age 21. or a pregnant woman
- Age: 65 years of age or older; or

- Blind: Under age 65 and visually impaired; or
- Disabled: Under age 65 and physically or mentally impaired.

## **BASIC ELIGIBILITY**

Every individual must meet all the following basic eligibility criteria:

- Must be a resident in Georgia.
- Must be a U.S. Citizen or a qualified alien.
- Must have income and resources below the prescribed limits.
- Must agree to assign to the State all rights to medical support and third party support payments (hospital and medical benefits).
- Must apply for all other benefits except Veterans Administration Improved Pension.
- Must apply for a Social Security Number.

## **LONG-TERM CARE MEDICAID COVERAGE GROUPS**

**Nursing Home** Aged, or disabled individuals needing long-term nursing care may be eligible for Medicaid benefits. Long term care is defined as nursing care provided for at least thirty (30) days, whether the nursing care is provided in a hospital, nursing home or at home through the home and community based health care program (i.e. Community Care Services Program).

**Community Care Waiver Services (CCSP)** Aged, blind or disabled individuals who are in need of nursing home care but remain at home with the aid of Community Care Services may be eligible for Medicaid benefits. Community Care Services are specific health care services rendered to an individual at home in lieu of nursing home placement. Services provided include: Home-delivered services; Homemaker Aide Services; Emergency Response Services; Respite Care; Adult Day Rehabilitation and Alternative Living Services.

**Katie Beckett or Deeming Waiver Coverage** Children under age eighteen (18) who are chronically sick and need nursing home care but could stay home with good

home care that costs less than nursing home care are eligible for this coverage. The parents of these children must have income or resources that make the children ineligible for SSI. The parents income and resources are not counted when determining these childrens eligibility.

**The Independent Care Medicaid Waiver Program** (ICWP) Severely disabled individual who are twenty-one (21) years of age or older, who are medically stable enough to leave the hospital but cannot do so without the support services available through this program, and who are at risk of out-of-state nursing home placement may be eligible for Medicaid benefits. The services available under this program are: Case Management, Homemaker, Personal Care Services, Environmental Modification, Skill Nursing, Transportation, Specialized Medical Equipment and Supplies, Personal Emergency Response Systems, Companion Services, Counseling and Occupational Therapy.

**Hospice Care** Available to individuals who are terminally ill; has a medical prognosis of six months or less life expectancy; and the individual receives hospice care from an approved hospice care provider. The services available under this program include but are not limited to; nursing care, medical social services, physician services, counseling services, respite care, and home health aide services.

**Mental Retardation Waiver Program and Community Habilitation Support Services** Designed to provide in-home and community based services to Medicaid eligible mentally retarded and developmentally disabled individuals who do not receive Medicaid benefits under a cash assistance program. **MRWP** Services include: Day Supports; Day Habilitation; Residential Training and Supervision; Natural Support Enhancements; Therapeutic Services; Respite Care; Supported Employment; Personal Support Services; Environmental Modifications; Vehicle Adaptations; Specialized Medical Equipment and Supplies.

**CHSS** Services include: Community Habilitation and Support Services; Specialized Medical Equipment and Supplies; Environmental Modifications.

## INCOME AND ASSETS LIMITATIONS

Financial need must exist in order for an individual to be eligible under all Medicaid programs including the long-term care coverage programs listed above. Financial criteria are divided into two groups, income and assets.

### Income

Income is any item an individual receives in cash or in-kind that can be used to meet his or her need for food or shelter. The income retirement for Medicaid states that gross monthly income of the applicant cannot exceed a certain figure. The 2008 figure has been set at \$1,911.00. The State of Georgia determines the income requirement, which changes each January. However, if an individual's income exceeds the income limit listed above the individual may establish an Irrevocable Qualified Income Trust (QIT), also known as a Miller Trust. (Contact your local county Department of Family and Children Services for additional information).

### Assets

**Assets include all income and resources** of the individual and of the individual's spouse, including income and resources which the individual or such individuals spouse is entitled to but does not receive. To meet the asset criteria, an individual must have countable resources of \$2,000 or less. Resources are those assets, both real and personal property, which an individual or couple owns and can apply, either directly or by sale or conversion, by meeting basic needs of food, clothing and shelter (like bank accounts, real property, or other items that can be sold for cash).

If the long-term care individual has a spouse who is not institutionalized or receiving home and community based services, the resources of the spouse **MUST** be considered in the eligibility determination. The **total combined** resources of the individual **and** the non-institutionalized spouse must be \$106,400 or less for 2008.

<u>Family Size</u>	<u>Monthly Income Limit</u>	<u>Resource Limit</u>
Individual	\$ 1,911.00	\$2,000
*Couple	\$3,822.00	\$3,000

*\*If both are receiving long-term services.*

## **ASSET PROTECTION UNDER THE LTCP PROGRAM**

Most people do not like to think about the fact they may one day need long-term care services. Most people are also surprised at the costs of long-term and do not think of having to use their entire life savings to pay for those needs and services.

The average private pay rate for a semi-private room in a Georgia nursing home in 2006 was \$147.34 a day, or over \$53,000 per year.

The Georgia Long-Term Care Partnership (Partnership) is designed to reward Georgians who plan ahead for future long-term care needs. The most unique aspect of a Georgia Partnership policy is the Medicaid **asset protection** feature. This feature provides **dollar-for-dollar asset protection**: for every dollar that a Partnership policy pays out in benefits, a dollar of assets can be protected from the long-term care Medicaid asset limit. When determining long-term care Medicaid eligibility, any assets you have up to the amount the Partnership insurance policy paid in benefits will be disregarded.

### EXAMPLE

If your Partnership policy paid \$200,000 in benefits, Georgia's Medicaid program would allow you to keep \$200,000 in assets and still qualify for Medicaid benefits. The amount of assets you are able to protect under the Partnership is in addition to the \$2,000 everyone is allowed to keep, including any assets your spouse may be

allowed to retain. The protected assets will also be exempted from estate recovery in an amount equal to the benefits paid by the long-term care insurance policy.

REMEMBER:

- The Partnerships Medicaid asset protection feature is not available under other long-term care insurance policies.
- The purchase of a Partnership Policy does not automatically qualify you for Medicaid.

# Kentucky

## Basic Long-Term Care Eligibility Criteria Relating To:

- **Resources**
- **Resource Assessment**
- **Look Back Period**
- **Estate Recovery**
- **Long Term Care Partnership Insurance**

**DISCLAIMER:** The Purpose of this document is to provide a general overview of eligibility for Medicaid Long Term Care (LTC) in Kentucky. It is intended to serve as a prerequisite to training required for insurance producers who sell, solicit or negotiate LTC Partnership insurance policies as part of the LTC partnership in Kentucky.

The document is not to be used to determine eligibility for Medicaid LTC services. Determining eligibility for Medicaid is the responsibility of the Kentucky Department of Community Based Services (DCBS), Division of Family Support. **All Medicaid eligibility determinations shall be made only by local DCBD offices. Producers should refer consumers to their local DCBS office for assistance with Medicaid eligibility determinations.**

The information in this document relates primarily to the rules to qualify for Medicaid eligibility rules and dollar limits that are correct at the time of the example. These rules and the dollar amounts change periodically.

## RESOURCES

### OVERVIEW OF RESOURCES

Resources are generally defined as those assets an individual or couple own and/or can convert to cash. Resources may be available money, real property, personal property or other assets and may have a lien or loan attached. They

may include homestead, and the cash surrender value of life insurance policies the individual has at the time of application for Medicaid. Savings, checking, stock accounts, retirement accounts, and vehicles are also examples of resources that are reviewed. Some resources may be countable and some may be excluded depending on the ownership or usage. Those issues are clarified during the application process. Although a resource may not be considered as available to the individual at application or may meet one of the exclusion criteria, it may still be subject to the Estate Recovery efforts.

### RESOURCE LIMITS

An institutionalized individual's current resource limit is \$2,000.

The community spouse's allowable resources are established at the resource assessment.

### RESOURCE ASSESSMENT

A resource assessment determines the amount of a couples assets which can be protected for the use and benefit of the community spouse. The couples' total assets are added together and compared to the resource allowance minimum and maximum limits in place at the time of assessment. The amount that can be protected for the community spouse is adjusted each January.

A couple or their representative can request a resource assessment when the individual is institutionalized. Once an assessment is completed it is valid unless it is discovered that all resources were not disclosed or the institutionalized spouse leaves long term care. The assessment requires the disclosure of all resources of the institutionalized spouse and community spouse. Once the resources are identified and the determination regarding countable versus excluded resources is made, the countable resources are totaled and each spouse is assigned  $\frac{1}{2}$ . If that  $\frac{1}{2}$  is not greater than the community spouses' resource maximum for that year, that figure becomes the amount the community spouse can keep. Any amount over the maximum is added to the institutionalized spouse's portion and must be spent down before Medicaid eligibility can be established. If the

½ is less than the minimum, additional resources from the institutionalized spouse can be transferred to the community spouse to bring her protected portion up to the resource minimum.

The portion that is determined to be protected for the benefit of the community spouse must be placed in the name of the community spouse **only** within six months of Medicaid approval.

RESOURCE ASSESSMENT EXAMPLES

**EXAMPLE 1:**

Sam and Sally have the following countable resources:

Checking.....	\$10,000
Savings.....	\$50,000
Boat.....	\$10,000
Annuity.....	\$50,000
<hr/>	
Total	\$120,000

Sam is in the nursing facility, Sally is the community spouse.

\$120,000 divided by 2 equals \$60,000 each which is below the maximum community spouse resource allowance.

Sally can protect \$60,000 and Sam must spend down to \$2,000. When a future application is made for Medicaid assistance the total countable resources must be equal to or less than \$62,000.

Sally has six months from the date of application to remove Sam’s name from the protected resources. Therefore, if Sally chooses to protect the boat and annuity she must have Sam’s name removed from those assets.

**EXAMPLE 2:**

John and Mary requested a resource assessment. They have the following countable resources:

Vacation home.....	\$ 50,000 .00
C.D.....	110,000.00
Life insurance policy with cash value.....	90,000.00
Building lot.....	25,000.00
Checking.....	30,000.00
Savings.....	60,000.00
<hr/>	
Total.....	365,000.00

\$365,000 divided by 2 equals \$182,500 each.

The maximum allowable in 2012 for the community spouse to protect was \$113,640.

\$182,500 minus \$113,640 equals \$68,860.

\$68,860 must be added to the institutionalized spouse's share of \$182,500 which results in his countable resource of \$251,360. The institutionalized spouse must spend this down to \$2,000 prior to Medicaid eligibility.

Therefore, when a reapplication is made the joint countable resources must not exceed \$115,640, the amount protected for the community spouse \$113,640 and the \$2,000 allowable for the institutionalized spouse.

**EXAMPLE 3:**

Tara and Cliff have the following countable resources during the resource assessment January 3, 2012:

CD.....	\$20,000
Checking.....	\$10,000
<hr/>	
Total	\$30,000

\$30,000 divided by 2 equals \$15,000 each. However, the community spouse minimum for 20 12 is \$22,728. Therefore the community spouse can protect \$22,728. The joint resources at the time of reapplication must be equal to or less than \$24,728. (The community spouses protected amount and the institutionalized spouses \$2,000). In this example only \$5,272 (\$30,000-\$24,729) must be spent down to obtain eligibility.

NOTE: All dollars spent after the resource assessment must be accounted for at the new application.

**LOOK BACK PERIOD AND PENALTIES**

Federal law requires that Medicaid eligibility workers determine that assets were not disposed of for less than fair market value in order to gain Medicaid eligibility. The Deficit Reduction Act (DRA) of 2006 strengthened the language requiring that all transfers of resources shall be presumed to be for the purpose of establishing Medicaid eligibility unless the applicant could prove otherwise. The DRA also required that this investigation cover the previous 60 months from application. To accomplish this, the application date becomes the base line date (starting point) and all transfers in the previous 60 months are investigated. Goods and/or services for fair market value must be received for any transfer that occurs during this time period. For example,

\$10,000 given to a daughter in the 32<sup>nd</sup> month from the baseline date would be investigated. If the applicant

could not demonstrate goods and/or services received for this amount, then this would be considered a prohibited transfer of resource and would be subject to a penalty period.

All resources disposed of during the "look back period" for less than fair market value are added and the total amount is used to determine an ineligibility period. The ineligibility period is based on the average daily cost of care and that factor is revised annually. The ineligibility period begins on either the date of transfer or the date the client would be otherwise eligible (had the transfer not occurred) – whichever date occurs last.

**The following is an example of calculating a transfer of resources ineligibility period for Long Term Care**

**Medicaid benefits:**

A Long-Term Care application was taken on August 1, 2012. There were multiple transfers that occurred prior to the application.

\$4,000 was given away on 3/1/2010

\$2,000 was given away on 5/15/2010

\$2,000 was given away on 7/19/2010

The eligibility worker would add all transfers together, in this situation, the total is \$8,000.

The worker would then determine the ineligibility period by dividing the total amount of the transfer by the current transfer of resource factor.

\$8,000 divided by \$194 (2012 factor) = 41.23 days, rounded down would be 41 days of ineligibility.

The ineligibility period would begin on the date of application, August 1, 2008.

The ineligibility period is for 41 days. On the 42<sup>nd</sup> day, the applicant can reapply and if all other eligibility criteria are met, the applicant would be eligible.

## **ESTATE RECOVERY**

Medicaid has the authority to seek recovery from the estate of a deceased Medicaid recipient in order to be reimbursed up to an amount equal to the total medical assistance paid for long term care benefits.

An estate is subject to estate recovery if the individual is at least 55 years of age AND if at any time the individual received medical assistance for any of the following:

- A. Nursing Facility (NF), not including institutionalized Hospice;
- B. Intermediate Care Facility (ICF);
- C. Mental Retardation/Developmentally Disabled (MR/DD) services;
- D. Long Term Care (LTC) services provided by a waiver.

The estates of individuals under 55 years of age are also subject to estate recovery if the individual has been receiving Medicaid for NF, ICF/MR/DD or LTC waiver services for a total of six consecutive months or more at the time of death.

**NOTE:** Resources that were excluded during the application process may still be subject to estate recovery.

## **EXEMPTION AND LIMITATIONS**

Estate Recovery shall not be made from the estate if the estate representative can verify that:

- A. There is a surviving spouse
- B. There is a surviving minor child (under 21) or disabled child
- C. The estate is valued at less than \$10,000
- D. Recovery would create a hardship for a surviving family member. This type of exception would require a request in writing with supporting documentation.

## **LONG-TERM CARE PARTNERSHIP INSURANCE**

A qualified Long-Term Care (LTC) Partnership Insurance policy will allow for an asset disregard at the time of the Medicaid application. The disregard is a one dollar (\$1) increase in protected assets for every one dollar (\$1) paid by the

insurance policy at the time of application. Any assets protected at the Medicaid application, shall also be protected from estate recovery.

At the time of application an individual with a qualified LTC partnership policy must produce documentation of the dollar amount paid by the insurance as a direct reimbursement of LTC expenses, as well as benefits paid on a per diem or other periodic basis, for periods during which the individual received LTC services. It is not required that the partnership policy funds be fully exhausted. However, the resource protection is based on the amount actually paid at the time of application.

The applicant must identify the assets they wish to protect as a result of the LTC Partnership payments. The applicant **cannot** change the selection after Medicaid approval. The eligibility worker will then disregard the assets chosen when determining Medicaid eligibility and those assets will also be protected from estate recovery.

The applicant may wish to apply their LTC Partnership insurance protection to an asset that was excluded in the eligibility determination process. They may choose to apply their protection to that asset in order to insure protection from estate recovery.

**NOTE:** Applicants without a community spouse or a minor dependent child in the home equity greater than \$525,000 (2012) are technically ineligible for Medicaid. Due to this technical ineligibility, LTC Partnership insurance cannot apply in this situation.

## **EXAMPLES OF THE BENEFIT OF LTC PARTNERSHIP INSURANCE**

If an applicant has purchased a qualified LTC partnership insurance policy and that policy paid out \$100,000 as of the month of application for Medicaid, that applicant could protect an additional \$100,000 of assets.

**EXAMPLE 1:**

Bob, a single individual, has been in the nursing facility for three years. He has homestead property valued at \$85,000 and a CD valued at \$20,000. On the date of his application, his LTC Partnership policy has paid out \$103,000. He can protect \$103,000 of resources. He is allowed to have \$2,000 in resources; therefore, he can gain eligibility and protect his homestead property and CD from estate recovery.

In order to understand how LTC Partnership insurance can affect applicants with a community spouse, below are the original examples we listed in the resource assessment section. In each example, we will consider that the LTC partnership insurance has paid \$50,000 benefits as of the month of application for Medicaid.

**EXAMPLE 2:**

Sam and Sally have the following countable resources:

Checking.....	\$10,000
Savings.....	\$50,000
Boat.....	\$10,000
Annuity.....	\$50,000
<hr/>	
Total	\$120,000

Sam is in the nursing facility, Sally is the community spouse.

\$120,000 divided by 2 equals \$60,000 each which is below the maximum community spouse resource allowance.

Sally can protect \$60,000 and Sam can apply his LTC partnership policy payout of \$50,000 at the time of application.

The couple could protect up to \$112,000 (\$60,000 + 50,000 + 2,000).

Sam will need to determine when to make his second application based on the dollar amount he was over resource limit at the original application. He will need to take into consideration the monthly benefits from his LTC Partnership insurance policy and the amount he is paying for his cost of care, reducing his resources. For example, if Sam's LTC Partnership policy is paying \$4,000 per month to the facility and Sam is also paying \$4,000 privately he can apply the following month.

**EXAMPLE 3:**

John and Mary requested a resource assessment in November 20 11. They have the following countable resources:

Vacation home.....	\$ 50,000.00
C.D.....	110,000.00
Life insurance policy with cash value.....	90,000.00
Building lot.....	25,000.00
Checking.....	30,000.00
Savings.....	60,000.00
Total.....	365,000.00

\$365,000 divided by 2 equals \$182,500 each.

The maximum allowable in 2012 for the community spouse to protect was \$113,640.

\$182,500 minus \$113,640 equals \$68,860.

\$68,860 must be added to the institutionalized spouse's share of \$182,500 which results in his countable resource of \$251,360. The LTC Partnership policy has paid out \$50,000, he is only over the resource limit by \$201,360.

The community spouse's protected assets remain the same as long as the institutionalization remains unchanged. John needs to determine the appropriate time to reapply based on the monthly benefit of his LTC Partnership policy and the rate at which his cost of care is reducing his resources.

**EXAMPLE 4:**

Tara and Cliff have the following countable resources during the resource assessment January 3, 2009:

CD.....	\$20,000
Checking.....	\$10,000
<hr/>	
Total	\$30,000

\$30,000 divided by 2 equals \$15,000 each. However, the community spouse minimum for 2012 is \$22,728. Therefore the community spouse can protect \$22,728. The joint resources at the time of reapplication must be equal to or less than \$24,728 (the community spouses protected amount and the institutionalized spouses \$2,000). In this example, since Cliff's LTC Partnership policy has spent more than the couple's countable Resources, all resources can be protected and Cliff is financially eligible.

**NOTE:** All dollars spent after the resource assessment must be accounted for at the new application.

# Massachusetts

## MassHealth General Eligibility Rules

There are special eligibility rules for persons who need long-term-care services at home, or who are waiting to go into a long-term-care facility.

A long-term-care facility is a type of medical institution that includes:

- licensed nursing facilities;
- chronic-disease and rehabilitation hospitals;
- state hospitals and state schools specifically designated as long-term-care facilities; and
- intermediate-care facilities for the mentally retarded (ICFs/MR).

Long-term-care services are the types of services needed if you are frequently ill and/or permanently disabled and need help, or cannot take care of yourself. These include medical and personal services. Generally, people get long-term-care services while they are in a long-term-care facility.

To be eligible for payment of long-term-care services in a long-term-care facility, you must be eligible for MassHealth Standard as a person who is:

- aged 65 or older;
- aged 19 through 65 and disabled according to the Social Security Administration's disability rules; or
- under age 19;
- meet the requirements of citizenship and identity;
  - **Citizenship Documentation Requirements:**  
*(Please see Annex A for actual copy of announcement in .pdf file)*

## **New Citizenship Documentation Requirements:**

**Due to a change in Federal law, effective July 1, 2006, MassHealth now requires individuals who state they are U.S. citizens or nationals** to provide acceptable documentation of their citizenship and identity when first applying for MassHealth or upon MassHealth redetermination.

- ✓ **Verification of citizenship and identity is a one-time activity.**  
Members who have verified citizenship and identity satisfactorily will not be asked to do so again.
- ✓ **The new Federal Law does not include changes for documented immigrants,** who must continue to provide proof of their status when they apply for MassHealth.
- ✓ **MassHealth will use electronic data matching to the greatest extent possible and allowable** to assist members with fulfilling this new requirement.

### **Timeframes:**

- **Applicants:** **MassHealth coverage will not begin until all necessary documentation**, including proof of citizenship and identity, are submitted within the necessary timeframes. MassHealth will inform applicants when documents are due - either 60 or 30 days, depending on coverage type.
  - **Time-limited presumptive coverage for pregnant women and children will not be delayed** pending documentation of citizenship and identity, but this documentation must still be submitted within 60 days of application in order for MassHealth benefits to continue.
  
- **Current members:** MassHealth requires a redetermination of eligibility at least once each year. When a member's redetermination is due, the member will be notified that they have either 60 or 30 days, depending on coverage type, to provide documentation of citizenship and identity. These timeframes may be extended if the member indicates to MassHealth that he or she is making a good faith effort to submit the documentation.

**Phone Numbers for Assistance in Obtaining Necessary Documentation:**

- **To receive or renew a Passport:** National Passport Information Center, U.S. Department of State: 1-877-487-2778
- **For Certificate of Naturalization or Certificate of U.S. Citizenship:** U.S. Department of Homeland Security: 1-800-375-5283 / TTY 1-800-767-1833
- **For Massachusetts Birth Certificates:** Registry of Vital Records and Statistics, Massachusetts Department of Public Health: 150 Mount Vernon Street, 1<sup>st</sup> Floor, Dorchester, MA 02125-3105, 617-740-2600
- **For a Massachusetts Driver's License or Massachusetts ID card:** Massachusetts Registry of Motor Vehicles: 617-351-4500 / TTY 617-536-7534 or 1-877-768-8833
- **General questions:** MassHealth Customer Service: 1-800-841-2900 / TTY 1-800-497-4648

- **US Citizenship/National Status and Identity Requirements for MassHealth [C+I (03/10)]**

A form that provides complete information about acceptable proofs of U.S. citizenship/national status and identity.

*(Please see Annex B for actual copy of the form in .pdf file)*

**U.S. Citizenship/National Status and Identity Requirements for  
MassHealth / Commonwealth Care**

**Effective 7/1/06 from the Federal Deficit Reduction Act of 2005**

**Proof of both U.S. Citizenship/National Status and Identity\***

- **Exception:** Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI) do NOT have to give proof of their U.S. citizenship/national status and identity. A child born to a mother who was getting MassHealth on the date of the child's birth does not have to give proof of U.S. citizenship/national status and identity.

The following **FIRST-LEVEL DOCUMENTS** may be accepted as proof of BOTH U.S. citizenship/national status AND identity. (No other documentation is required.) Individuals born outside the U.S. who were not U.S. citizens/nationals at birth must submit first-level documents or appropriate second-level documents (where applicable for a birth abroad) or, if such documents are not available, affidavits of citizenship. Adopted children born outside the U.S. may establish citizenship under the Child Citizenship Act.

1. a U.S. passport; or
2. a Certificate of Naturalization (DHS Form N-550 or N-570); or
3. a Certificate of U.S. Citizenship (DHS Form N-560 or N-561); or
4. a document issued by a federally recognized American Indian tribe showing membership or enrollment in, or affiliation with, such tribe



**Proof of U.S. Citizenship/National Status Only plus Proof of Identity Only**

<p style="text-align: center;"><b>Proof of U.S. Citizenship/National Status Only</b></p> <p><b>(Submit documentation from the highest level possible!)</b></p> <p>The following <b>SECOND-LEVEL DOCUMENTS</b> may be accepted as proof of U.S. citizenship/national status only.</p> <ul style="list-style-type: none"> <li>• A U.S. public record of birth (including the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The individual may also be collectively naturalized under federal regulations. The birth record must have been recorded within 5 years of birth.</li> <li>• A Report of Birth Abroad of a U.S. Citizen (Form FS-545, Form FS-240, or Form DS-1350)</li> <li>• A U.S. Citizen ID card (INS Form I-197 or I-179)</li> <li>• An American Indian Card (I-872 with the classification code KIC) issued by the Department of Homeland Security (DHS) to identify U.S. citizen members of the Texas Band of Kickapoos living</li> </ul>	<p style="text-align: center;"><b>Proof of Identity Only</b></p> <p>The following documents may be accepted as proof of identity only.</p> <ol style="list-style-type: none"> <li>1. A state driver's license containing the individual's photo or other identifying information</li> <li>2. A government-issued identity card containing the individual's photo or other identifying information</li> <li>3. Certificate of Indian Blood or other U.S. tribal document with photo or other identifying information</li> <li>4. U.S. military card or draft record</li> <li>5. Three or more of the following documents, such as, marriage licenses, divorce decrees, high school diplomas, employer ID cards, and property deeds/titles (This documentation cannot be used if fourth-level documents were submitted as proof of U.S. citizenship/national status.)</li> <li>6. School identity card with photo, except for children under age 16</li> <li>7. Military dependent's identity card</li> </ol>
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<p>near the U.S./Mexican border</p> <ul style="list-style-type: none"> <li>• Final adoption decree showing the child's name and U.S. place of birth (if adoption is not finalized, a statement from a state-approved adoption agency)</li> <li>• Evidence of U.S. civil service employment before June 1, 1976</li> <li>• An official military record showing a U.S. place of birth</li> <li>• A Northern Mariana Identification Card (I-873) issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986</li> <li>• Documentary evidence under the Child Citizenship Act for adopted children born outside the U.S</li> </ul> <p>The following <b>THIRD-LEVEL DOCUMENTS</b> may be accepted as proof of U.S. citizenship/national status only.</p> <ul style="list-style-type: none"> <li>• Extract of U.S. hospital record of birth on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth.</li> </ul>	<p>8. U.S. Coast Guard Merchant Mariner card</p> <p>9. For children under age 16: a clinic, doctor, or hospital record, or a school record, or a daycare or nursery school record that is verified with the school, or a parental, guardian, or caretaker relative affidavit attesting to the child's date and place of birth that is signed under penalty of perjury (cannot be used if an affidavit for citizenship/national status was provided). For children between the ages of 16 and 18, the affidavit can be used where a school photo ID or driver's license with photo is not available in that area until that age.</p> <p>10. For disabled individuals in residential care facilities: an affidavit signed under penalty of perjury by the facility director or administrator when the disabled individual does not have or cannot get any identity document listed in 1 through 9 above.</p>
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For children under age 16, the hospital record must have been created near the time of birth or 5 years before the application date. A souvenir birth certificate is not acceptable.

- Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth.

For children under age 16, the document must have been created near the time of birth or 5 years before the application date.

- An official religious record recorded with the religious organization in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of birth or the individual's age at the time the record was made. Entries in a family bible are not considered religious records.

- An early school record showing the child's name, U.S. place of birth, date of admission, and date of birth

The following **FOURTH-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

<ul style="list-style-type: none"><li>• Birth records recorded after the person turned age 5</li><li>• Federal or state census record showing U.S. citizenship or a U.S. place of birth and person's age</li><li>• Admission papers from a nursing home, skilled-care facility, or other institution that were created at least 5 years before the initial application date and that indicate a U.S. place of birth</li><li>• Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth that was created at least 5 years before the initial application date. For children under age 16, the medical record must have been created near the time of birth or 5 years before the application date.</li><li>• Other documents that show a U.S. place of birth that were created at least 5 years before the application for MassHealth (For children under age 16, the document must have been created near the time of birth or 5 years before the application date.): Seneca or Navajo Indian tribal census records, U.S. State Vital Statistics official notification of birth registration, an amended U.S. public birth record that was amended more than 5 years after the person's birth, a statement from a physician/midwife</li></ul>	
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<p>who was in attendance at the birth, or the Bureau of Indian Affairs Roll of Alaska Natives</p> <ul style="list-style-type: none"> <li>• Written affidavit**</li> </ul>	
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**\*\*Affidavits (written statements) of U.S. citizenship/national status should be used only in rare circumstances when the applicant or member is unable to provide evidence of U.S. citizenship/national status from any other source listed.** Two affidavits must be submitted. One of the two affidavits must be from an individual who is not related to the applicant or member. Each individual providing an affidavit must have personal knowledge of

the event(s) establishing the applicant's or member's claim of U.S. citizenship/national status; for example, the date and place of the applicant's birth in the United States, if applicable. The individuals providing the affidavits must also provide proof of both their own U.S. citizenship/national status and identity for the affidavit to be accepted. If these individuals also know why documentary evidence of the applicant's or member's claim of U.S. citizenship/national status cannot be provided, this should be included in the affidavit. The applicant or member (or other knowledgeable individual) must also provide a separate affidavit explaining why this evidence cannot be provided. Different requirements apply to affidavits of identity for children and institutionalized individuals.

- be determined by Mass Healthy as medically needing long-term-care services; and
- prove that you (and your spouse) meet certain income and asset rules

To decide if you can get Mass Health, we look at your income and assets and, in some cases, your immigration status.

## **U.S. Citizenship and Immigration Rules**

When deciding if you are eligible for MassHealth, we look at all of the requirements described under each coverage type and program. We also look at your U.S. citizenship/national status and immigration status to decide if you may get a certain coverage type.

People who are U.S. citizens/nationals or qualified aliens who meet one of the following statuses may be eligible for MassHealth Standard, CommonHealth, Family Assistance, Basic, Essential, or Prenatal.

### Qualified Aliens

1. \*People admitted for legal permanent residence (LPR) under the Immigration and Nationality Act (INA). But see starred (\*) paragraph below.
2. \*People granted parole for at least one year under section 212(d)(5) of the INA. But see starred (\*) paragraph below.
3. \*Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980. But see starred (\*) paragraph below.
4. People granted asylum under section 208 of the INA.
5. Refugees admitted under section 207 of the INA.
6. People whose deportation has been withheld under section 243(h), or 241(b)(3) of the INA, as provided by section 5562 of the federal Balanced Budget Act of 1997.
7. People who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980.
8. Native Americans with at least 50 percent American Indian blood who were born in Canada pursuant to section 289 of the INA or other tribal members born in territories outside of the United States pursuant to 25 U.S.C. 450b(e).

9. Amerasians admitted pursuant to section 584 of Public Law 100-202.
10. Veterans of the United States (U.S.) Armed Forces with an honorable discharge not related to their alien status. (b) Filipino war veterans who fought under U.S. command during WWII. (c) Hmong and Highland Lao veterans who are admitted for legal permanent residence (LPR) and who fought under U.S. command during the Vietnam War. (d) Persons with alien status on active duty in the U.S. Armed Forces, other than active duty for training. (e) The spouse, surviving un-remarried spouse, or unmarried dependent child of the alien described in (a) through (d).
11. Aliens or their unmarried dependent children, as defined in federal law, who have been subjected to battery or extreme cruelty by their spouse, parent, sponsor, or a member of their household, and who no longer live in the same household as the batterer.
12. Victims of severe forms of trafficking.
13. Iraqi Special Immigrants granted special immigrant status under Section 101(a)(27) of the Immigration and Nationality Act pursuant to section 1244 of Public Law 110-181 or section 525 of Public Law 110-161, for a period not to exceed eight months.
14. Afghan Special Immigrants granted special immigrant status under Section 101(a)(27) of the Immigration and Nationality Act pursuant to section 525 of Public Law 110-161, for a period not to exceed six months.

\*People described in 1, 2, and 3 above must have entered the United States before August 22, 1996, or have entered the United States on or after August 22, 1996, and completed the five-year bar, to be eligible for MassHealth Standard, unless they also meet a status in 4 through 14 above.

### Aliens with Special Status

People who entered the United States on or after August 22, 1996, and have a status described in 1, 2, or 3 below, and have not completed the five-year bar, or who have entered at any time and are permanently living in the United States under color of

law (PRUCOLs) as described in 4 below, cannot get MassHealth Standard. However, they may be eligible for any coverage type except Standard if they meet the rules and income limits for that coverage type, and they may get MassHealth Family Assistance if they meet the rules and income limits for Standard.

In addition, people who meet the rules and income limits of MassHealth Standard and are under the age of 19, or the parent of a child under age 19, or pregnant, can get MassHealth Family Assistance instead of MassHealth Standard. If they are disabled according to the standards set by federal and state law, they can get MassHealth CommonHealth.

- People admitted for legal permanent residence (LPR) under the INA.
- People granted parole for at least one year under section 212(d)(5) of the INA.
- Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980.
- People permanently living in the United States under color of law (PRUCOLs) as described below:
  - a. aliens living in the United States in accordance with an indefinite stay of deportation;
  - b. aliens living in the United States in accordance with an indefinite voluntary departure;
  - c. aliens and their families who are covered by an approved immediate relative petition, who are entitled to voluntary departure, and whose departure the United States Immigration and Naturalization Service (INS) does not contemplate enforcing;
  - d. aliens who have filed applications for adjustment of status that the INS has accepted as "properly filed," and whose departure the INS does not contemplate enforcing;
  - e. aliens granted stays of deportation by court order, statute, or regulation, by individual determination of the INS, or relevant INS instructions, and whose departure INS does not contemplate enforcing;
  - f. aliens granted voluntary departure by the INS or an Immigration Judge, and whose deportation the INS does not contemplate enforcing;
  - g. aliens granted deferred action status;

- h. aliens living under orders of supervision;
- i. aliens who have entered and continuously lived in the United States since before January 1, 1972;
- j. aliens granted suspension of deportation, and whose departure the INS does not contemplate enforcing;
- k. aliens granted temporary protected status (TPS);
- l. aliens who are asylum applicants; and
- m. any other aliens living in the United States with the knowledge and consent of the INS, and whose departure the INS does not contemplate enforcing. (These include permanent nonimmigrants as established by Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a determination by the Secretary of State.)

If your immigration status is not described above, you may be eligible for MassHealth Limited.

Note: People who were getting MassHealth, formerly known as Medical Assistance, or CommonHealth on June 30, 1997, may continue to get benefits regardless of immigration status if otherwise eligible.

## ANNEX A.



### Important Announcement from MassHealth



#### New Citizenship Documentation Requirements

**New!**

**Due to a change in Federal law, effective July 1, 2006, MassHealth now requires individuals who state they are U.S. citizens or nationals** to provide acceptable documentation of their citizenship and identity when first applying for MassHealth or upon MassHealth redetermination.

- ✓ **Verification of citizenship and identity is a one-time activity.** Members who have verified citizenship and identity satisfactorily will not be asked to do so again.
- ✓ **The new Federal Law does not include changes for documented immigrants,** who must continue to provide proof of their status when they apply for MassHealth.
- ✓ MassHealth will use electronic data matching to the greatest extent possible and allowable to assist members with fulfilling this new requirement.

#### **Timeframes:**

⇒ **Applicants:** MassHealth coverage will not begin until all necessary **documentation**, including proof of citizenship and identity, are submitted within the necessary timeframes.

MassHealth will inform applicants when documents are due - either 60 or 30 days, depending on coverage type.

- **Time-limited presumptive coverage for pregnant women and children will not be delayed** pending documentation of citizenship and identity, but this documentation must still be submitted within 60 days of application in order for MassHealth benefits to continue.

⇒ **Current members:** MassHealth requires a redetermination of eligibility at least once each year. When a member's redetermination is due, the member will be notified that they have either 60 or 30 days, depending on coverage type, to provide documentation of citizenship and identity. These timeframes may be extended if the member indicates to MassHealth that he or she is making a good faith effort to submit the documentation.

## **Phone Numbers for Assistance in Obtaining Necessary Documentation:**

- ⇒ **To receive or renew a Passport:** National Passport Information Center, U.S. Department of State: 1-877-487-2778
- ⇒ **For Certificate of Naturalization or Certificate of U.S. Citizenship:** U.S. Department of Homeland Security: 1-800-375-5283 / TTY 1-800-767-1833
- ⇒ **For Massachusetts Birth Certificates:** Registry of Vital Records and Statistics, Massachusetts Department of Public Health: 150 Mount Vernon Street, 1<sup>st</sup> Floor, Dorchester, MA 02125-3105, 617-740-2600
- ⇒ **For a Massachusetts Driver's License or Massachusetts ID card:** Massachusetts Registry of Motor Vehicles: 617-351-4500 / TTY 617-536-7534 or 1-877-768-8833
- ⇒ **General questions:** MassHealth Customer Service: 1-800-841-2900 / TTY 1-800-497-4648

*Please see next page for acceptable documentation to verify*

## ANNEX B.

### **U.S. Citizenship/National Status and Identity Requirements for MassHealth/Commonwealth Care Effective 7/1/06 from the Federal Deficit Reduction Act of 2005**

#### **Proof of both U.S. Citizenship/National Status and Identity\***

\* **Exception:** Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI) do NOT have to give proof of their U.S. citizenship/national status and identity. A child born to a mother who was getting MassHealth on the date of the child's birth does not have to give proof of U.S. citizenship/national status and identity.

The following **FIRST-LEVEL DOCUMENTS** may be accepted as proof of **BOTH U.S. citizenship/national status AND identity**. (No other documentation is required.) Individuals born outside the U.S. who were not U.S. citizens/nationals at birth must submit first-level documents or appropriate second-level documents (where applicable for a birth abroad) or, if such documents are not available, affidavits of citizenship. Adopted children born outside the U.S. may establish citizenship under the Child Citizenship Act.

- 1. a U.S. passport; or**
- 2. a Certificate of Naturalization (DHS Form N-550 or N-570); or**
- 3. a Certificate of U.S. Citizenship (DHS Form N-560 or N-561); or**
- 4. a document issued by a federally recognized American Indian tribe showing membership or enrollment in, or affiliation with, such tribe.**

**OR**

**PLUS**

#### **Proof of U.S. Citizenship/National Status Only**

#### **Proof of Identity Only**

##### **(Submit documentation from the highest level possible!)**

**The following documents may be accepted as proof of identity only.**

The following **SECOND-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- A U.S. public record of birth (including the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The individual may also be collectively naturalized under federal regulations. The birth record must have been recorded within 5 years of birth.
- A Report of Birth Abroad of a U.S. Citizen (Form FS-545, Form FS-240, or Form DS-1350)
- A U.S. Citizen ID card (INS Form I-197 or I-179)
- An American Indian Card (I-872 with the classification code KIC) issued by the Department of Homeland Security (DHS) to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border
- Final adoption decree showing the child's name and U.S. place of birth (if adoption)

1. A state driver's license containing the individual's photo or other identifying information
2. A government-issued identity card containing the individual's photo or other identifying information
3. Certificate of Indian Blood or other U.S. tribal document with photo or other identifying information
4. U.S. military card or draft record

- is not finalized, a statement from a state-approved adoption agency)
- Evidence of U.S. civil service employment before June 1, 1976
- An official military record showing a U.S. place of birth
- A Northern Mariana Identification Card (I-873) issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986
- Documentary evidence under the Child Citizenship Act for adopted children born outside the U.S.

The following **THIRD-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- Extract of U.S. hospital record of birth on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth. For children under age 16, the hospital record must have been created near the time of birth or 5 years before the application date. A souvenir birth certificate is not acceptable.
- Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth. For children under age 16, the document must have been created near the time of birth or 5 years before the application date.
- An official religious record recorded with the religious organization in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of birth or the individual's age at the time the record was made. Entries in a family bible are not considered religious records.
- An early school record showing the child's name, U.S. place of birth, date of admission, and date of birth

The following **FOURTH-LEVEL DOCUMENTS** may be accepted as proof of U.S. citizenship/national status only.

- Birth records recorded after the person turned age 5
- Federal or state census record showing U.S. citizenship or a U.S. place of birth and person's age
- Admission papers from a nursing home, skilled-care facility, or other institution that were created at least 5 years before the initial application date and that indicate a U.S. place of birth
- Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth that was created at least 5 years before the initial application date. For children under age 16, the medical record must have been created near the time of birth or 5 years before the application date.
- Other documents that show a U.S. place of birth that were created at least 5 years before the application for MassHealth (For children under age 16, the document must have been created near the time of birth or 5 years before the application date.): Seneca or Navajo Indian tribal census records, U.S. State Vital Statistics official notification of birth registration, an amended U.S. public birth record that was amended more than 5 years after the person's birth, a statement from a physician/midwife who was in attendance at the birth, or the Bureau of Indian Affairs Roll of Alaska Natives

5. Three or more of the following documents, such as, marriage licenses, divorce decrees, high school diplomas, employer ID cards, and property deeds/titles (This documentation cannot be used if fourth-level documents were submitted as proof of U.S. citizenship/ national status.)
6. School identity card with photo, except for children under age 16
7. Military dependent's identity card
8. U.S. Coast Guard Merchant Mariner card
9. For children under age 16: a clinic, doctor, or hospital record, or a school record, or a day-care or nursery school record that is verified with the school, or a parental, guardian, or caretaker relative affidavit attesting to the child's date and place of birth that is signed under penalty of perjury (cannot be used if an affidavit for citizenship/national status was provided). For children between the ages of 16 and 18, the affidavit can be used where a school photo ID or driver's license with photo is not available in that area until that age.
10. For disabled individuals in residential-care facilities: an affidavit signed under penalty of perjury by the facility director or administrator when the disabled individual does not have or cannot get any identity document listed in 1 through 9 above.

**\*\*Affidavits (written statements) of U.S. citizenship/national status should be used only in rare circumstances when the applicant or member is unable to provide evidence of U.S. citizenship/national status from any other source listed.** Two affidavits must be submitted. One of the two affidavits must be from an individual who is **not** related to the applicant or member. Each individual providing an affidavit must have personal knowledge of the event(s) establishing the applicant's or member's claim of U.S. citizenship/national status; for example, the date and place of the applicant's birth in the United States, if applicable. The individuals providing the affidavits must also provide proof of both their own U.S. citizenship/national status and identity for the affidavit to be accepted. If these individuals also know why documentary evidence of the applicant's or member's claim of U.S. citizenship/national status cannot be provided, this should be included in the affidavit. The applicant or member (or other knowledgeable individual) must also provide a separate affidavit explaining why this evidence cannot be provided. Different requirements apply to affidavits of identity for children and institutionalized individuals.

# Michigan

## Legislation Regarding Adult Financial Exploitation

Michigan takes adult financial exploitation very seriously. The following legislation lays out the prohibited conduct, definitions of victims and abusers, and the penalties that can occur.

### From

[http://www.legislature.mi.gov/\(S\(oke4opyzremprcmh34nb42o5\)\)/mileg.aspx?page=GetObject&objectname=mcl-750-174a](http://www.legislature.mi.gov/(S(oke4opyzremprcmh34nb42o5))/mileg.aspx?page=GetObject&objectname=mcl-750-174a)

## THE MICHIGAN PENAL CODE (EXCERPT) Act 328 of 1931

**750.174a Vulnerable adult; prohibited conduct; violation; penalty; enhanced sentence; exceptions; consecutive sentence; definitions; report by office of services to the aging to department of human services.**

Sec. 174a.

(1) A person shall not through fraud, deceit, misrepresentation, coercion, or unjust enrichment obtain or use or attempt to obtain or use a vulnerable adult's money or property to directly or indirectly benefit that person knowing or having reason to know the vulnerable adult is a vulnerable adult.

(2) If the money or property used or obtained, or attempted to be used or obtained, has a value of less than \$200.00, the person is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than \$500.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine.

(3) If any of the following apply, the person is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than \$2,000.00 or 3

times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of \$200.00 or more but less than \$1,000.00.

(b) The person violates subsection (2) and has 1 or more prior convictions for committing or attempting to commit an offense under this section.

(4) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 5 years or a fine of not more than \$10,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of \$1,000.00 or more but less than \$20,000.00.

(b) The person violates subsection (3)(a) and has 1 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(5) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 10 years or a fine of not more than \$15,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of \$20,000.00 or more but less than \$50,000.00.

(b) The person violates subsection (4)(a) and has 2 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(6) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 15 years or a fine of not more than \$15,000.00 or 3

times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of \$50,000.00 or more but less than \$100,000.00.

(b) The person violates subsection (5)(a) and has 2 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(7) If any of the following apply, the person is guilty of a felony punishable by imprisonment for not more than 20 years or a fine of not more than \$50,000.00 or 3 times the value of the money or property used or obtained or attempted to be used or obtained, whichever is greater, or both imprisonment and a fine:

(a) The money or property used or obtained, or attempted to be used or obtained, has a value of \$100,000.00 or more.

(b) The person violates subsection (6)(a) and has 2 or more prior convictions for committing or attempting to commit an offense under this section. For purposes of this subdivision, however, a prior conviction does not include a conviction for a violation or attempted violation of subsection (2) or (3)(b).

(8) Except as otherwise provided in this subsection, the values of money or property used or obtained or attempted to be used or obtained in separate incidents pursuant to a scheme or course of conduct within any 12-month period may be aggregated to determine the total value of money or personal property used or obtained or attempted to be used or obtained. If the scheme or course of conduct is directed against only 1 person, no time limit applies to aggregation under this subsection.

(9) If the prosecuting attorney intends to seek an enhanced sentence based upon the defendant having 1 or more prior convictions, the prosecuting attorney shall include on the complaint and information a statement listing the prior conviction or convictions. The existence of the defendant's prior conviction or convictions shall be determined by the court, without a jury, at sentencing or at a separate hearing for that purpose before sentencing. The existence of a prior conviction may be

established by any evidence relevant for that purpose, including, but not limited to, 1 or more of the following:

- (a) A copy of the judgment of conviction.
- (b) A transcript of a prior trial, plea-taking, or sentencing.
- (c) Information contained in a presentence report.
- (d) The defendant's statement.

(10) If the sentence for a conviction under this section is enhanced by 1 or more prior convictions, those prior convictions shall not be used to further enhance the sentence for the conviction under section 10, 11, or 12 of chapter IX of the code of criminal procedure, 1927 PA 175, MCL 769.10, 769.11, and 769.12.

(11) A financial institution or a broker or a director, officer, employee, or agent of a financial institution or broker is not in violation of this section while performing duties in the normal course of business of a financial institution or broker or a director, officer, employee, or agent of a financial institution or broker.

(13) The court may order a sentence imposed for a violation of subsection (4), (5), (6), or (7) to be served consecutively to any other sentence imposed for a violation of this section.

(14) This section does not prohibit a person from being charged with, convicted of, or punished for any other violation of law the person commits while violating this section.

(15) As used in this section:

(a) "Broker" means that term as defined in section 8102 of the uniform commercial code, 1962 PA 174, MCL 440.8102.

(b) "Financial institution" means a bank, credit union, saving bank, or a savings and loan chartered under state or federal law or an affiliate of a bank,

credit union, saving bank, or savings and loan chartered under state or federal law.

(c) "Vulnerable adult" means that term as defined in section 145m, whether or not the individual has been determined by the court to be incapacitated.

(16) If the office of services to the aging becomes aware of a violation of this section, the office of services to the aging shall promptly report the violation to the department of human services.

**History:** Add. 2000, Act 222, Eff. Sept. 25, 2000 ;-- Am. 2004, Act 255, Eff. Sept. 1, 2004 ;-- Am. 2012, Act 172, Imd. Eff. June 19, 2012 ;-- Am. 2013, Act 34, Imd. Eff. May 21, 2013

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# Minnesota

## MA Eligibility and the LTC Partnership Program

### Understanding Minnesota Long-Term Care

The following section is specific to Minnesota MA Eligibility and the Minnesota LTCP Program. Information for this section has been found in the following MN Publications:

“Medical Assistance Eligibility and the Long Term Care Partnership in Minnesota”, September 2008.

“Minnesota Long Term Care Partnership”, [www.dhs.state.mn.us](http://www.dhs.state.mn.us)

Bulletin 2007-10, State of Minnesota Department of Commerce, October 8, 2007.

Minnesota Statute 60K.365

### Producer Training

An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness insurance or life insurance and has completed an initial training course and ongoing training every 24 months thereafter. Insurance producers are required to successfully complete training that has been approved by the Minnesota Department of Commerce. The training includes basic information about Medical Assistance (MA) eligibility and asset protection as it relates to the Long Term Care Partnership (LTCP). The initial training course must be no less than eight hours, and the ongoing training course must be no less than four hours every 24 months.

It is important to understand that MA eligibility policy is very complex. It incorporates special regulation and exceptions for certain situations, and regulations change when state and federal legislation is amended. This section of the course provides general

eligibility information. This information should not be considered enough to be able to determine if someone may be eligible for MA benefits in Minnesota.

In order to understand how MA eligibility policy would be applied to someone's particular circumstances, the person must submit an application to the county agency and provide all information and verifications necessary to determine eligibility. Inquiries about the MA status of current enrollees must be requested by enrollees or their authorized representatives, or third parties with written consent.

MA regulations vary from state to state. The rules that apply in Minnesota may not apply in other states.

**Nonresident Producers:** selling partnership policies shall be expected to demonstrate knowledge about unique aspects of the Minnesota medical assistance system. An insurer offering partnership products in Minnesota shall maintain records verifying that its nonresident producers have attained the required training and make that verification available to the commissioner upon request.

## MA Eligibility and the Minnesota LTCP Program

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### Long Term Care Partnership (LTCP)

LTCP is a joint effort between the federal Medicaid Program and LTC insurers. LTCP was developed to encourage people to plan for their future Long-term care(LTC) needs, such as residing in a nursing facility or receiving LTC waiver services in a home or community-based setting.

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The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the Department of Human Services (DHS) and the Department of Commerce. Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In Minnesota, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements established by state and federal law.

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### Medical Assistance (MA)

MA is Minnesota's name for the federal Medicaid program. It provides health care services, including long-term care. A person who requests MA payment of LTC services after using some benefits of a qualified LTCP policy may protect assets equal to the amount paid by the policy. More detailed information will be provided about the relationship between MA asset eligibility and how assets can be protected by a LTCP policy.

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## What Qualifies as Partnership in Minnesota

Unlike earlier Partnership programs in other states, Minnesota's program does not require minimum lifetime or daily maximums. To qualify as Minnesota Partnership, long-term care insurance coverage must:

- Meet the requirements for being "tax qualified" as defined in Section 7702B(b) of the Internal Revenue Code
- Meet certain consumer protection requirements in Section 6021(a)(1)(B)(5)(A) of the Deficit Reduction Act, which are taken from the NAIC model act of 2000
- Provide coverage to a person who was a resident of Minnesota when coverage first became effective
- Provide inflation protection if the person is under age 76:
  - For issue ages under 61: If a policy is sold to a person under the age of 61, it must provide compound annual inflation protection. Inflation protection must be continued until at least age 66 to be considered meaningful protection allowing the policy to maintain Partnership status.
  - For issue ages 61 through 75: If a policy is sold to a person aged 61 through 75, the policy must provide some level of inflation protection. Inflation protection must continue for the first five consecutive years following the date of purchase, or until age 76, whichever occurs first, to be considered meaningful protection allowing the policy to maintain Partnership status. After the first five years, a policy sold to a person aged 61 through 75 may, but is not required to, provide inflation protection to maintain Partnership status.
  - For issue ages 76 and over: If a policy is sold to a person aged 76 or older, the policy may, but is not required to, provide some level of inflation protection.

Further details are contained in the Inflation, exchange and notification bulletin issued 10/8/07.

## **Tax Qualified**

The term "qualified long-term care insurance contract" means any insurance contract if—

- (A) the only insurance protection provided under such contract is coverage of qualified long-term care services,
- (B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such 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,
- (C) such contract is guaranteed renewable,
- (D) such contract does not provide for a cash surrender value or other money that can be—
  - (i) paid, assigned, or pledged as collateral for a loan, or
  - (ii) borrowed,
- other than as provided in subparagraph (E) or paragraph (2)(C) which describes that subparagraph (E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be included in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.
- (E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and
- (F) such contract meets the requirements of subsection (g).

## Consumer Protection Requirements

All policies sold in Minnesota must contain the following consumer protection features:

- At least one year of nursing home or home health care coverage, including intermediate and custodial care. Health care benefits cannot be limited to “skilled care” only.
- Coverage for Alzheimer’s disease.
- An inflation protection option.
- An “outline of coverage” that clearly describes a policy’s benefits, limitations, and exclusions, allowing the client to compare the coverage with that of other providers. This must be given to clients at the time of initial solicitation and before they complete the application for insurance.
- If the client purchases a policy that was approved in 2002 or later, it will contain “rate stabilization” provisions that are intended to make rate increases less likely
- If the client purchases a “qualified” policy they must be given the long-term care insurance “shopper’s guide” that helps them decide whether long-term care insurance is appropriate for them.
- A “guaranteed renewable” clause, meaning that the policy cannot be cancelled, non-renewed, or otherwise terminated except for non-payment of premium.
- A statement that the client has the right to return the policy for any reason within 30 days after the purchase and to receive a full premium refund.

## Inflation Protection

Minnesota law requires that Minnesota Long Term Care Partnership coverage provide inflation protection based on an insured’s age at the time the policy is issued. The prior section described the age breakdown when inflation protection must apply. For the years where inflation protection is required, the protection within the long-term

care policy must meet with the following requirements in order to qualify for partnership status:

**Adequate Level of Inflation Protection:** there must be inflation protection which increases policy benefits at a rate of at least 5% compounded annually to be considered meaningful to allow for reasonably anticipated increases in the costs of LTC services under Minn. Stat. §62S.23

**Other Levels of Inflation Protection Subject to Review:** Inflation protection in an amount less than 5% compounded annually and/or inflation protection that is tied to a particular index value will be subject to review by the Minnesota Department of Commerce before it will be considered adequate to qualify for Partnership status. The Minnesota Department of Commerce considers the age range of purchasers and the type of long-term care services covered by policy when making its determination whether or not the protection is meaningful to allow for reasonably anticipated increases in the costs of LTC services under Minn. Stat. §62S.23

**Schedule of Business Increases:** benefit increases for inflation protection must occur no less frequently than annually.

**Inflation Protection Increases NOT Subject to Underwriting:** increases cannot be contingent on the insured providing evidence of insurability or health status information. This, however, does not alter the ability of an insurer to consider evidence of insurability or health status information at the time the policy or the inflation protection rider is initially underwritten.

**Flexibility in Premium Structure:** The premium associated with the policy may be;

- Level premium,
- Premium that increases annually, or
- Other premium arrangement set forth by contract.

The additional premium must be no higher than the rate based on the insured's attained age at the time of each offer.

**Illustration Requirement if Not Level Premium:** If the insured elects a premium other than level premiums, a personalized illustration must be provided at the point of sale that demonstrates the expected pattern of future annual premiums needed to maintain Partnership status until at least age 100. This illustration must include yearly comparison to the premium and the benefits for a policy that includes automatic compound annual inflation protection with level premiums.

**Inflation Protection Offers, Disclosure Requirements & Discontinuation of Inflation Protection:** The inflation protection may be automatic or the inflation protection may be provided as the result of an annual guaranteed offer by the company. During the previously outlined time frames for which inflation protection is required, each annual guaranteed offer of inflation protection must include disclosure language notifying the insured person of the effect on the policy's Partnership status if the insured fails to maintain inflation protection. Guaranteed offers must be structured so that the inflation protection required for Partnership status is maintained unless the insured formally declines an offer of inflation protection in a written statement or on a form developed by the company for such purpose. In the written statement or form, the insured must acknowledge understanding that the decision to decline inflation protection will result in the loss of the policy's Partnership status, including the asset protections provided by a Partnership policy. A similar written acknowledgment is required if an individual elects to drop a rider that provides automatic inflation protection if such a change would result in the loss of Partnership status.

## **General Eligibility Criteria for Persons Requesting MA Payment for LTC Services**

To be eligible for MA, a person must first fit into an eligibility group, then must meet specific requirements relating to residency, citizenship, immigration status, third party liability, income and asset guidelines. General information about each item is included below, with special emphasis on people who reside in a Long-term Care Facility (LTCF) or receive home and community-based services through a waiver program.

**MA eligibility groups** in Minnesota include the following:

- Children under the age of 21.
- Parents or relative caretakers of dependent children.
- Pregnant women.
- People age 65 or older.
- People who are blind.
- People with a certified disability.
- Women in need of treatment for certain cancers.

People in a LTCF or receiving home or community-based waiver services are generally either certified as disabled or are age 65 or over. They would be eligible for MA benefits if they meet all other requirements, such as those noted below.

## **Residency**

Residency rules require that a person lives in Minnesota and intends to remain in the state. However, those rules do not necessarily apply to everyone. A person in an LTCF is considered a resident of the state in which he or she was physically present on the date of the MA application. In addition, MN is not considered the state of residence for:

- A child under 18 whose parent or legal guardian lives in another state.
- A person of any age placed in the LTCF by another state.
- A person who resided in North Dakota prior to nursing home admission. (Per an agreement between the two states, the person remains a North Dakota resident for the first 2 years in a Minnesota nursing facility, and vice versa.)

## **Citizenship and Immigration Status**

A person is required to be either a U.S. citizen or a non-citizen with a qualified immigration status. The following must be verified:

- U.S. citizenship and identity when a person declares that he or she is a U.S. citizen.
- Immigration status when the person states that he or she has a non-citizen status. Sponsored non-citizens must also provide information about their sponsors.

## **Third-Party Liability**

The rules state that MA is the payor of last resort. People must provide information about other payment sources, such as other health insurance, Medicare, long-term care insurance, or a liable third party. The other payment source pays their portion of medical expenses before MA payments are made.

## **Coverage for Persons Requesting MA Payment of LTC Services**

The following information will help you see the complexity of MA eligibility rules that are evaluated for each person's circumstances. To be eligible for MA payment of LTC services in Minnesota, a person must:

- Have a **Long Term Care Consultation (LTCC)** which determines he or she needs a level of care provided in either:
  - One of these medical facilities:
    - Nursing facility.
    - Medical hospital.
    - Intermediate care facility for people with mental retardation or related condition (ICF-MR).
    - MA-covered bed in a psychiatric hospital or nursing home.

Or, through

- One of these home and community-based services for elderly or disabled people:

- Elderly Waiver (EW) program.
  - Community Alternative Care (CAC).
  - Community Alternatives for Disabled Individuals (CADI).
  - Developmental Disabilities (DD) (formerly called Mental Retardation and Related Conditions-MR/RC).
  - Traumatic Brain Injury (TBI).
- Begin receiving LTC services within 60 days of the LTCC.
- Reside in an MA-certified LTCF or receive services under an MA home and community-based waiver services program. This does **not** include placements in facilities that are not Medicaid-certified, such as a Veteran's Administration facility. Also, note that MA does not consider assisted living facilities to be LTCFs. For MA, people in non-Medicaid-certified facilities are considered community residents.
- Have home equity of \$500,000 or less. (Note: Special rules apply when home equity is over \$500,000 or when the person or certain dependent family members do not live in the home.)
- Disclose any interest in an annuity for self and for spouse, if married. The state must be named as a remainder beneficiary of all annuities owned by the person or spouse.
- Not be in a penalty period for an uncompensated transfer of income or assets. During a penalty period, MA will not pay the cost of LTC services.
  - Penalty periods are caused when a person or spouse makes an uncompensated transfer while receiving MA or during a "lookback period" before applying for MA.
  - The lookback period is currently 36 months for most uncompensated transfers. Due to the Federal Deficit Reduction Act of 2005 (DRA), the lookback period for all transfers will be increased to 60 months by January 2011.
  - A specific formula is used to determine the length of a penalty period.

- The penalty period begin date depends on when the transfer was made. For transfers made before 2/8/06, the penalty begins the month after the month of the transfer.
- For transfers made on or after 2/8/06, the penalty begins when the person requests MA payment of LTC services and would have been eligible if there was no penalty.

## **Income**

People who receive MA benefits do not all have the same income limits or use the same MA budget. A person's MA eligibility group determines the income and budgeting rules, such as the person's:

- Income limits (which are adjusted annually).
- Countable income.
- Excluded income.
- Deductions allowed from total gross countable income.
- Potential MA eligibility if the person's income is over the allowable limit.

This basic budgeting information relates specifically to people in an LTCF or receiving EW services. People who receive home and community-based services through other waiver programs (such as CAC, CADI, DD or TBI) may be eligible for asset protection under the Partnership, but have different MA eligibility rules not addressed in this document. Refer them to their county agencies for information relating to their specific situations.

When looking at MA eligibility, income of just the LTC or EW person is counted in his or her MA-LTC budget. Income of that person's spouse or parent is not counted.

Deductions allowed in an MA budget depend on the person's specific situation, and everyone does not necessarily get the same deductions. General deductions allowed in Minnesota on LTC or EW budgets include:

- Medicare premiums and health insurance premiums not paid by MA.

- An income allocation to a spouse who is living in community and not receiving LTC services if it is determined that the spouse has a financial need.
- Income allocations to certain other family members (subject to very specific limitations).
- Personal needs allowance, which changes annually.
- Home maintenance allowance if a doctor certifies that the person is expected to return to the home in a specific time period.
- Health care expenses that will not be paid by MA or by a third party.

The result of the calculation is the amount that a person must contribute toward the cost of his or her monthly LTC services and is typically paid to the LTCF or EW provider. MA will pay for other covered medical services received by the person.

## **Assets**

A person's MA asset limit is determined by his or her eligibility group and household size. In Minnesota, someone in an LTCF or receiving EW services is considered to be an MA household of one with an asset limit of \$3,000 in countable assets. People in other eligibility groups or with larger household sizes may have different asset limits.

**Excluded assets** are not counted towards the MA asset limit. Some excluded assets are one vehicle, some types of trusts, certain funds set aside for burial expenses, some federal payments, household goods, and personal items such as clothing and jewelry. Homestead property is excluded if the person or spouse or certain other family members live there. The homestead is excluded for 6 months from date of permanent LTCF admittance when no spouse or certain other family members live in the home.

**Countable assets** are available to the person and are counted towards the MA asset limit. Some countable assets are cash, bank accounts, stocks, bonds, non-homestead real property, property agreements like contracts-for-deed, life estate interests, and other liquid assets. The homestead becomes a countable asset 6 months after the person was admitted to the LTCF for a permanent stay when no spouse or certain other family members live in the home.

The county agency must review all verified assets and will determine which assets are:

- Counted toward MA eligibility.
- Excluded and not counted toward MA eligibility.
- Considered protected for a community spouse, if married.
- Protected because the person's LTCP policy has paid some LTC benefits. (This will be explained later)

The county will determine if the person needs to reduce countable assets to the \$3,000 asset limit to be eligible for MA payment of LTC services.

## **Assets of Married Couples**

A person in an LTCF or receiving EW services is considered a household of one for MA, even if married. He or she has an asset limit of \$3,000 in countable assets. However, evaluating assets of a married person is very complicated and several questions need to be addressed.

- Is the spouse also receiving or requesting MA payment of LTC services? If Yes, then each one is treated as a single individual for purposes of the MA eligibility. Each has an asset limit of \$3,000 in countable assets.
- Is the spouse living independently in the community and is not requesting or receiving MA payment of LTC services? If Yes, then that spouse is considered a **community spouse**. An asset assessment must be completed for the married couple (the LTC spouse and the community spouse).

## **Asset Assessment**

In the asset assessment process:

- The married couple reports all assets owned solely by each spouse and jointly by both spouses. This should be done as soon as one spouse requires LTC services that are expected to last at least 30 days, whether or not they are requesting MA at that time.

- The county evaluates all verified assets to determine the amount of countable assets that can be kept by the community spouse. A community spouse may keep either the minimum asset allowance for that year or one-half the total countable marital assets (up to a maximum amount). The minimum and maximum amounts are adjusted annually.
- The county also estimates when the LTC spouse may possibly be eligible to receive MA payment for LTC services.

**Two important points to remember:**

- Reporting all assets for the assessment ensures that the greatest amount possible will be protected for the community spouse in the future.
- A married couple's asset assessment must be completed before assets are protected under the LTCP. This allows the couple to protect only those assets that are considered available to the LTC spouse.

## **Pablo and Tasha Example**

Pablo and Tasha are married. Pablo moved into a LTCF on December 1 and was expected to stay there for longer than 30 consecutive days. They asked the county agency for an asset assessment and completed the required form, verifying all assets in which Pablo and/or Tasha had an ownership interest on the day he entered the LTCF.

The county worker completed the asset assessment calculation and determined that they owned \$120,000 in countable assets on December 1 (Pablo's first day of 30+ days in the LTCF). It was estimated that \$60,000 (one-half of their marital assets) would be protected for Tasha if Pablo ever applies for MA payment of LTC services.

Pablo therefore privately paid for the first six months of his stay in the LTCF. On July 8 of the following year, he applies for MA payment of LTC services. They verify that they have \$65,000 of countable assets.

Of the \$65,000:

- Tasha, the community spouse, may keep \$60,000 (the amount calculated on the date of the asset assessment).
- Pablo, the LTC spouse, has \$5,000 in assets available to meet his needs. He must spend \$2,000 in order to meet his \$3,000 MA asset limit. The county worker would suggest ways he can spend that amount without creating an uncompensated transfer.

## **Long-Term Care (LTC Partnership Program and MA Eligibility)**

### Asset Protection

An LTCP participant in Minnesota:

- Requests MA payment of LTC services either as an elderly or certified disabled person **and**
- Meets all eligibility requirements for MA-LTC **or** meets all the requirements except for the asset limit **and**
- Has a qualified LTCP policy that paid for some LTC costs since July 1, 2006.

**Note that MA benefits are not automatic for people with LTCP insurance. Even with asset protection, people must meet all MA-LTC requirements, including the asset limit of \$3000 in countable assets.**

To help attain the \$3000 asset limit, an LTCP participant may designate a certain amount of assets for protection. Protected asset(s) will be listed on a form provided by the county agency and the value of each protected asset must be verified.

- Designated assets do not count toward the person's MA asset limit.
- The amount of protected assets equals the amount that the Partnership policy paid for LTC services since July 1, 2006.
- The LTCP participant can protect \$1 of assets for every \$1 paid by the LTCP insurance.

- The full amount that a person can protect is called his **Protected Asset Limit (PAL)**.

After a person protects an asset, he or she can:

- Keep it. The value will have to be reported each year and will count towards the PAL.
- Give it away. A designated asset may be transferred to any other person without penalty. The value of the asset on the day it is given away will usually count towards the PAL.
- Use it to get another asset. Then the new asset becomes protected and its value will count towards the PAL.
- Spend it on goods or services. For instance, John spends \$6,000 from a protected bank account to go on a cruise. That \$6,000 will still count towards his PAL.

A person cannot change his mind about what assets he has protected. For example, Marie has a bank account and owns a home. Her PAL allows her to protect just one of them, and she decides to protect her bank account. Marie cannot later change her mind and protect the home instead.

Note that two types of assets cannot be protected under the LTCP. Federal Medicaid rules state that when a person dies, the following assets must be available to reimburse DHS for the amount of MA benefits paid during his or her lifetime:

- Resources in a Special Needs Trust or a Pooled Trust and
- Annuity interests in which Minnesota must be named as a preferred remainder beneficiary.

The Liens and Estate Recovery section will explain what happens to protected assets when the LTCP Participant dies.

## **Decisions about Protecting Assets**

When a person requests MA payment of LTC services, he or she may:

- Be eligible without having to protect any assets.
- Have assets worth less than his or her PAL.
- Have assets worth more than his or her PAL.

A person does not have to use the maximum amount of asset protection right away. The person who is eligible for MA by protecting just part of the PAL may have options in the future. He or she may choose to protect:

- The increased value of a protected asset.
- A newly acquired asset, such as an inheritance.
- An asset that is normally excluded for MA, such as a home in which a person or spouse lives.
- An asset that was formerly excluded, but became countable. For example, when an excluded home is sold, proceeds from the sale are counted as an asset.

The person whose assets are worth more than the PAL will have to make some decisions. The county will explain which assets are excluded for MA, what amount is considered the spouse's based on the asset assessment, and what amount is counted towards the MA asset limit. The person whose assets exceed the MA limit may either:

- Re-apply for MA-LTC after the LTCP insurance has paid for more care.
- Re-apply for MA-LTC after reducing assets in the future.
- Reduce countable assets right away to become eligible for MA-LTC. The county agency can suggest ways to reduce assets without creating an uncompensated transfer. For example, the person may purchase a TV or new clothing.

## **When Protected Assets Increase in Value**

Some protected assets will increase in value due to interest or dividends, etc. What happens then depends on the person's PAL and the value of all the protected assets.

- The increase in value will also be protected if total value of all protected assets is still below the PAL.
- If the total value of protected assets is greater than the PAL, the person may have to reduce some assets so countable assets go under the MA asset limit.

## **When an MA Client's LTCP Continues to Pay Benefits**

A person's PAL will increase as long as the LTCP insurance continues to pay benefits.

Once a year:

- The person will have to report the status and value of all protected assets.
- With the person's permission, the agency will contact the insurance company to find out the value of benefits paid over the past year.
- The county agency will tell the LTCP person if his or her PAL has increased.
- Any increase in the value of protected assets over the past year will be applied to the PAL.
- If additional asset protection remains, the person may protect more assets.

## **Inheritance, liens, and Estate Recovery**

Assets protected during a person's lifetime will stay protected after he or she dies.

The state or county will not file a claim against a person's protected assets to repay MA for that person's health care. However, as explained below, MA claims may be filed against assets that are not protected.

A lien is usually placed against a person's home or other real property when a person gets MA benefits. A lien may be filed against:

- An interest in a life estate.
- Real property owned solely by one person.
- Real property owned jointly with other person or persons.
- The portion of real property that is not protected because of LTCP insurance.

Liens are not filed if:

- The person is in a long-term care facility nursing home and will return to his own home or
- The person's spouse is residing in the home or
- The home or other property was fully protected because of LTCP insurance.

Sometimes property is worth more than the person is allowed to protect. In that situation, a lien may be filed against the value of property that is higher than the PAL amount. For example, David's property is valued at \$200,000. His PAL amount is \$150,000 and he chooses to protect \$150,000 of his property. When David dies, the \$150,000 amount that he protected will stay protected. However, a claim or a lien may be filed against the other \$50,000 worth of property.

After an LTCP client dies:

- Assets which were protected during his lifetime are also protected from estate recovery. The state or county will not file a claim against his protected assets to repay MA. However, they may file an MA claim against any assets that were not protected.
- When the person does not protect assets during his lifetime, or when he protects less than his PAL, his personal representative may protect assets during the estate recovery process - up to the total amount of his PAL. See the Anna example below.

What about the protected assets of someone who is married? We know what happens to a protected asset when the person dies, but what happens to that asset when his surviving spouse dies? The answer to this question depends on whether the surviving spouse:

- Had an LTCP policy and
- Received MA-LTC benefits.

Review the Jack and Jill example below.

## **Estate Recovery Examples**

### Anna Example

Anna's LTCP insurance paid for her LTC for one year before she applied for MA payment of LTC services. At that time her countable assets were below the MA asset limit and she was eligible for MA without protecting any assets. When Anna died, she had received MA-LTC benefits for three years and never designated an asset for protection.

So did Anna or her family lose out on asset protection completely? No. When Anna died, her personal representative was able to protect assets from MA estate recovery, up to her PAL amount.

### Jack and Jill Example

Jack and Jill were married. Jack received MA payment for LTC services and protected an asset because of his LTCP. Jack's protected asset remained protected when he died.

Several years after Jack died, Jill entered an LTCF and received MA-LTC benefits. What happens to Jack's protected asset when Jill dies? That depends on whether Jill also protected the asset because of her own LTCP.

- If Jill did not protect the asset because of her own LTCP, a lien or estate recovery claim may be filed against Jack's protected asset to repay Jill's MA costs.
- However, a lien or estate recovery claim will not be filed if Jill also protected that asset because of her own LTCP.

### Mabel and Wilma Examples

Mabel and Wilma have similar stories. Both women receive LTC services in their own homes. The services are partially covered by a qualified \$20,000 LTCP policy. Each woman has used \$10,000 of policy benefits. Neither one has resources to pay for services not covered by LTCP insurance.

Both Mabel and Wilma are found eligible for MA payment of LTC services through the Elderly Waiver (EW) program. Their LTCP policies are treated as third party liability and MA pays for services not covered by the LTCP.

When applying for MA, they each own the following assets:

- \$2,500 savings account.
- House with an equity value of \$50,000.
- Insurance-funded burial.

Each woman's assets are evaluated for MA as follows:

- The savings account is a countable asset, with a value less than her MA-LTC asset limit.
- The insurance-funded burial meets specific guidelines and is excluded for MA.
- The home is excluded because she lives there.

Mabel and Wilma were both found to be eligible for MA payment of LTC services. When MA opened, neither woman chose to protect any assets.

**Now their stories become different.** Remember, their LTCP policies had a maximum lifetime benefit of \$20,000.

**Mabel** dies after using another \$5,000 of LTCP benefits, for total LTC insurance payments of \$15,000. Although she could not benefit from the full value of the policy, her personal representative may designate \$15,000 of Mabel's assets so they are protected from estate recovery.

**Wilma** exhausts the remaining \$10,000 of her LTCP policy benefits during her first six months of receiving MA payment of LTC services. Although the full \$20,000 of her LTCP benefits have been used, Wilma still does not feel a need to designate any assets for protection.

A few months later Wilma's brother dies, leaving her a \$10,000 inheritance. Adding her \$3,000 savings account to the inheritance gives her countable assets of \$13,000. Because this puts her over the \$3,000 limit, she designates the \$10,000 inheritance as protected under LTCP. Wilma remains eligible for MA payment of LTC services.

One month later she gives the \$10,000 protected asset to her granddaughter for college tuition. There is no uncompensated transfer because the \$10,000 was an LTCP protected asset. That \$10,000 is still counted as a protected asset, even though she gave it away.

When Wilma dies two years later, she owns the insurance-funded burial and her home. Remember, Wilma's \$20,000 LTCP policy paid the full amount of benefits for her. So what could happen with her remaining assets?

- Her insurance-funded burial was used in full to cover funeral costs.
- Wilma had protected the \$10,000 inheritance during her lifetime.
- So another \$10,000 could be protected after she dies.
- Since the home is the sole asset in her estate, her personal representative could protect \$10,000 of the home's equity value from estate recovery.
- A claim or a lien could be filed against the remaining equity value of the home.

## **How to Apply for Minnesota Health Care Programs**

A person may apply for any of the Minnesota health care programs by completing a Minnesota Health Care Programs Application, also known as the HCAPP (Form DHS-3417).

- The HCAPP allows people to apply for any or all of Minnesota Health Care Programs on one form.
- People may request an application form by:
  - Calling the Department of Human Services (DHS) at (651) 431-2670 or (800) 657-3739.

- Visiting or calling their county office. Agency addresses and phone numbers are listed in the application.
- A complete signed and dated HCAPP can be faxed or mailed to the county agency. Agency addresses are listed in the application.
- People may ask the county agency to help them complete the application and contact third parties for required information and/or verifications.
- Health Care coverage generally begins in the month that the county receives a completed, signed and dated application.
- People may ask that Medical Assistance coverage begin up to three months before the date they apply.

## **General Differences in Medicaid Eligibility between Minnesota and Neighboring States**

Medicaid is a federal/state health care program and eligibility regulations differ from state to state. It may be helpful to briefly review the areas of difference, especially if you sell LTC insurance in states other than Minnesota.

### Household Size

In Minnesota a person in an LTCF is considered a household of one for MA purposes, even if that person's spouse is also a resident of that facility. A person receiving home and community-based waiver services is also considered a household of one, even if the person has a spouse.

Other states may consider a married person receiving waiver services as a household of two, and both spouses in an LTCF are considered to be a household of two.

### Assets

In Minnesota a person's asset limit for MA-LTC in Minnesota is \$3,000. Other states, such as South Dakota and Wisconsin, follow SSI guidelines, allowing countable assets of \$2,000.

In Minnesota a homestead is excluded for a person's first six months in an LTCF unless a physician's statement verifies that the person is expected to return home and/or certain other family members reside in the home. The exclusion begins on the person's date of admission into the facility, not on the date the person applies for MA-LTC. Other states exclude the homestead indefinitely while a person is in a nursing home.

A community spouse's asset allowance is the amount of assets that a community spouse can keep when the LTC spouse applies for MA payment of LTC. Minnesota's minimum allowance for 2008 is \$29,389. North Dakota's minimum is lower than Minnesota's and Wisconsin's minimum is higher. Also, some states have no minimum community spouse asset allowance.

The MA-LTC home equity limit in Minnesota is \$500,000. Other states have home equity limits as high as \$750,000.

### MA-LTC Screening

In Minnesota, people must have a Long-Term Care Consultation (LTCC) to determine their needed level of care. For MA payment, they must begin LTC services within 60 days of the LTCC.

Screening requirements and processes differ from state to state.

### Income and Deductions

Minnesota provides health care programs for medically needy people whose income is higher than their MA income limit, but their medical costs allow them to spend down to the income standard. Some people may not be eligible for MA in the community because of their income, but may be eligible for MA-LTC because they can spend down by deducting nursing home costs.

Some states do not allow an income spenddown provision.

A Personal Needs Allowance is the amount of monthly income a person receiving MA-LTC can keep for personal needs. The amount of this allowance differs significantly between states with a range from \$45 to \$84.

In Minnesota the Personal Needs Allowance is adjusted annually. In other states it is a fixed amount that is not adjusted on a regular basis.

Minnesota allows some people in an LTCF to deduct a Home Maintenance Allowance for three full calendar months to help maintain their homes in the community. A doctor must certify that the LTCF stay is temporary and the person is expected to return home.

Many other states do not allow this deduction.

#### LTCP Asset Protection

Minnesota allows a person with LTCP to protect an amount of assets equal to the benefits paid by the LTCP since July 1, 2006.

Other states have different rules about which benefits paid by LTCP will determine the amount of assets a person can protect under the Partnership.

Minnesota allows MA-LTC clients to accrue asset protection as additional payments are made by their LTCP insurance.

Some states do not allow additional asset protection after a person is enrolled in Medicaid.

# Ohio

## Long-Term Care Insurance

### ORC 5111.18 Qualified LTC Insurance Program Establishment

The medicaid director shall establish a qualified state long-term care insurance partnership program consistent with the definition of that term in the "Social Security Act," section 1917(b)(1)(C)(iii), 42 U.S.C. 1396p(b)(1)(C)(iii). An individual participating in the program who is subject to the medicaid estate recovery program instituted under section 5162.21 of the Revised Code shall be eligible for the reduced adjustment or recovery under division (D) of that section.

Renumbered from § 5111.18 by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Effective Date: 06-30-2006

## **ORC 3923.41–48 Long-term Care Insurance**

### 3923.41 LONG-TERM CARE INSURANCE DEFINITIONS.

(A) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, 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. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care benefits, and policies or riders that provide for payment of benefits based on cognitive impairment or the loss of functional capacity. "Long-term care insurance" includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, or health insuring corporations. "Long-term care insurance" includes qualified long-term care insurance contracts. "Long-term care insurance" does not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital

confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to life insurance, "long-term care insurance" does not include life insurance policies that accelerate the death benefits specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement; that 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 in sections 3923.41 to 3923.48 of the Revised Code, any product advertised, marketed, or offered as long-term care insurance shall be subject to sections 3923.41 to 3923.48 of the Revised Code.

(B) "Applicant" means either of the following:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

(C) "Certificate" means any certificate issued under a group long-term care insurance policy that has been delivered, issued for delivery, or used in or outside this state.

(D) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state to any of the following:

(1) One or more employers or labor organizations, or a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, established for either of the following:

(a) Employees or former employees or a combination thereof;

(b) Members of the labor organization, or former members of the labor organization, or a combination thereof.

(2) Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if the association satisfies both of the following requirements:

(a) It is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation.

(b) It is maintained in good faith for purposes other than obtaining insurance.

(3) An association or trust of the trustees of a fund established, created, or maintained for the benefit of members of one or more associations that meets the requirements of section 3923.43 of the Revised Code;

(4) A group other than as described in divisions (D)(1), (2), and (3) of this section about whom the superintendent of insurance finds that all of the following are true:

(a) The issuance of the group policy is not contrary to the best interest of the public.

(b) The issuance of the group policy would result in economies of acquisition or administration.

(c) The benefits of the group policy are reasonable in relation to the premiums charged.

(E) "Policy" means any policy, contract, rider, or endorsement delivered, issued for delivery, or used in or outside this state by an insurer, fraternal benefit society, or health insuring corporation.

(F)

(1) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract of which all of the following are true pursuant to division (b) of section 7702B of the "Internal Revenue Code of 1986," 26 U.S.C. 7702B, as amended:

(a) The only insurance protection provided under the contract is coverage of qualified long-term care services including payments made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq., as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The contract may pay or reimburse expenses that are reimbursable under Title XVIII of the Social Security Act as a secondary payer. A contract may allow payments to be made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(c) The contract is guaranteed renewable, within the meaning of division (b)(1)(C) of section 7702B of the "Internal Revenue Code of 1986," 26 U.S.C. 7702B, as amended.

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in division (F)(1)(e) of this section.

(e) All refunds of premiums, and all policy holder dividends or similar amounts, under the contract shall be applied to a reduction in future premiums or to increase future benefits, except that a refund in the event of death of the insured or in the event of a complete surrender or cancellation of the contract shall not exceed the aggregate premiums paid under the contract.

(f) The contract meets the consumer protection provisions set forth in division (g) of section 7702B of the "Internal Revenue Code of 1986," 26 U.S.C. 7702B, as amended.

(2) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by a rider or as part of the contract and that satisfies the requirements of divisions (b) and (e) of section 7702B of the Internal Revenue Code of 1986, 26 U.S.C. 7702B, as amended.

(G) "State long-term care partnership program" or "partnership program" means a program established under division (b) of section 1917 of the "Social Security Act," 42 U.S.C. 1396p, as amended.

(H) "Insurance agent" or "agent" means a person licensed under Chapter 3905. of the Revised Code to sell, solicit, or negotiate insurance.

(l) "Insurer" means any person authorized under Title XXXIX of the Revised Code to engage in the business of insurance in this state or any health insuring corporation authorized under Chapter 1751. of the Revised Code to do business in this state that issues long-term care insurance policies or certificates.

Effective Date: 06-04-1997; 2007 HB100 09-10-2007

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#### 3923.42 Citing Provisions—Applicability.

(A) Sections 3923.41 to 3923.48 of the Revised Code may be cited as the "long-term care insurance act."

(B) Sections 3923.41 to 3923.48 of the Revised Code do not supersede the obligations of entities subject to these sections to comply with the substance of other applicable insurance laws insofar as they do not conflict with these sections, except that section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code and rules intended to apply to medicare supplement insurance policies do not apply to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance need not meet the requirements of sections 3923.41 to 3923.48 of the Revised Code.

Effective Date: 01-31-1992

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#### 3923.43 Evidence to be filed by long-term care insurance association.

(A) Prior to advertising, marketing, or offering a policy within this state, the association or the insurer of the association described in division (D)(3) of section 3923.41 of the Revised Code, shall file evidence with the superintendent of insurance that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws that provide all of the following:

(1) The association holds regular meetings not less than annually to further the purposes of the members;

(2) Except for credit unions, the association collects dues or solicits contributions from members;

(3) The association's members have voting privileges and representation on the governing board and committees of the association.

(B) Thirty days after the evidence filing, the association is deemed to satisfy the organizational requirements listed in division (A) of this section unless the superintendent makes a specific finding that the association does not satisfy the organizational requirements.

Effective Date: 2007 HB100 09-10-2007

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3923.44 Standards for full and fair disclosure for sale of long-term care insurance policies.

(A) The superintendent of insurance, pursuant to Chapter 119. of the Revised Code, may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of coverage, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. Such rules may include provisions related to the state long-term care partnership program, including, but not limited to, requirements related to offers to exchange partnership program policies for previously issued policies and for consumer disclosures related to the state long-term care partnership program.

(B) No long-term care insurance policy shall:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period if 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 policyholder;

(3) 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;

(4) Use a definition of "preexisting condition" that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(5) Exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(C) The superintendent may extend the limitation periods set forth in divisions (B)(4) and (5) of this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(D) "Preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in division (B)(5) of this section 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 described in division (B)(5) of this section.

(E)

(1) No long-term care insurance policy shall do any of the following:

(a) Condition eligibility for any institutional benefits on a requirement of prior hospitalization;

(b) Condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;

(c) Condition eligibility for any institutional benefits, other than waiver of premium or post-confinement, post-acute care, or recuperative benefits, on a requirement of prior institutionalization.

(2) Every long-term care insurance policy that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care is subject to both of the following:

(a) The policy shall not require a prior institutional stay of more than thirty days.

(b) The policy shall provide that eligibility for noninstitutional benefits shall be established by the alternative of a period of hospitalization of not more than three days.

(3) No long-term care insurance policy, except for the policy described in division (E)(2) of this section, shall condition eligibility for noninstitutional benefits on the requirement of prior hospitalization.

(4) No long-term care insurance policy that provides benefits only following institutionalization shall condition the benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

(F) A long-term care insurance policy that provides post-confinement, post-acute care, or recuperative benefits shall state any limitations or conditions on eligibility for benefits, including any required period of prior institutionalization as permitted in division (E)(1)(c) of this section, in a separate paragraph of the policy or certificate and shall label that paragraph "Limitations or Conditions on Eligibility for Benefits."

(G) The superintendent, pursuant to Chapter 119. of the Revised Code, may adopt rules establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the rule.

(H)

(1) A person insured under a long-term care insurance policy may return the policy or certificate in accordance with the procedures and requirements provided for individual policyholders under section 3923.31 of the Revised Code, except that the person has thirty days from the date of delivery to return the policy or certificate and have the premium refunded.

(2) A notice of the policyholder's or certificate holder's rights under division (H)(1) of this section and section 3923.31 of the Revised Code shall be printed prominently on the first page of the policy or certificate or attached to the policy or certificate.

(l) Except as provided in division (M) of this section, an outline of coverage and a notice that consumer information is available from the department of insurance under section 3923.49 of the Revised Code shall be delivered to a prospective applicant for long-term care insurance at the time of the initial solicitation through means that prominently direct the attention of the prospective applicant to the outline of coverage, the purpose of the outline of coverage, and the notice. In the case of agent solicitations, the agent shall deliver the outline of coverage and notice prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the insurer shall deliver the outline of coverage and notice in conjunction with any application or enrollment form. The superintendent shall prescribe by rule the content and format of the outline of coverage and notice, including the style, overall appearance, size, color and prominence of type, and the arrangement of text and captions. The outline of coverage shall include all of the following:

(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;

(3) A statement of the terms under which the individual policy or certificate or the group policy or certificate may be renewed and the terms under which cancellation is permitted, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group long-term care insurance shall be specifically described.

(4) A description of the terms under which the policy or certificate may be returned and the premium refunded;

(5) A brief description of the relationship of the cost of care and benefits;

(6) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy or group master policy should be consulted to determine governing contractual provisions;

(7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract.

(J) A certificate issued pursuant to a group long-term care insurance policy that is delivered, issued for delivery, or used in or outside this state shall include all of the following:

(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;

(3) A statement that the group master policy determines governing contractual provisions.

(K) If an individual life insurance policy provides long-term care benefits within the policy or by rider, a policy summary shall be delivered to an applicant for the policy at the time of policy delivery. In the case of direct response solicitations, the insurer shall deliver the policy summary to the applicant upon the applicant's request. If no such request is made, the insurer shall deliver the policy summary no later than at the time of policy delivery. In addition to any other information required by this section, the policy summary shall include all of the following:

(1) A statement that explains how the terms of the policy that provide benefits for long-term care insurance affect the other terms of the policy, including how the payment of these benefits would reduce the death benefits payable by the policy;

(2) A description of the amount of benefits for long-term care insurance that is available under the policy, the length of time these benefits could be paid by the policy, and any guaranteed lifetime benefits provided by the policy, for each insured under the policy;

(3) A statement of the exclusions, reductions, and limitations on benefits for long-term care insurance that are contained in the policy;

(4) A statement of the effects of exercising other rights under the policy;

(5) A statement of the guarantees, if any, with respect to the policy costs of providing benefits for long-term care insurance;

(6) A statement of all current and projected maximum lifetime benefits;

(7) A statement of whether long-term care inflation protection is available under the policy.

(L) During the time when a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, the insurer shall provide a monthly report to the policyholder. The report shall include all of the following:

(1) A description of all benefits for long-term care insurance that were paid by the policy during that month;

(2) An explanation of any changes in the policy, including death benefits or cash values due to the payout of long-term care benefits;

(3) A statement of the amount of benefits for long-term care insurance that is still available under the policy.

(M) In case of a policy issued to a group defined in division (D)(1) of section 3923.41 of the Revised Code, an outline of coverage shall not be required to be delivered, provided that the information described in division (I) of this section is contained in other materials relating to enrollment and, upon request, these other materials are made available to the superintendent.

(N)

(1) Policies that are intended to qualify under the state long-term care partnership program shall comply with all state and federal requirements applicable to policies issued in connection with the state long-term care partnership program.

(2)

(a) For policies intended to qualify under the state long-term care partnership program, the agent or insurer shall deliver to the applicant a long-term care partnership policy disclosure form along with the outline of coverage specified in division (I) of this section.

(b) In the case of a policy issued to a group where an outline of coverage is not delivered, the long-term care partnership policy disclosure form is delivered with enrollment forms.

(c) In the case of a life insurance policy that offers long-term care insurance within the policy or as a rider, the disclosure form is provided with the policy summary.

(O) No insurer shall issue a policy intended to qualify as a state partnership program policy that fails to satisfy the following inflation protection requirements:

(1) For a person who is less than sixty-one years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three per cent compounded annually per year or a rate, compounded annually, that is equal to the annual consumer price index.

(2) For a person who is at least sixty-one years of age but less than seventy-six years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three per cent simple or a rate equal to the annual consumer price index.

(3) For a person who is at least seventy-six years of age as of the date of purchase of the policy, the policy may provide inflation protection.

(P) As used in this section, "consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the bureau of labor statistics of the United States department of labor.

(Q) For purposes of division (O) of this section, the superintendent may approve an alternative index to be used in place of the consumer price index.

(R) The superintendent shall prescribe by rule pursuant to Chapter 119. of the Revised Code the content and format of the state long-term care partnership program policy disclosure form required by division (N)(2) of this section.

(S) No policy may be advertised, marketed, or offered as long-term care insurance unless it complies with sections 3923.41 to 3923.48 of the Revised Code.

(T) The superintendent may adopt rules in accordance with Chapter 119. of the Revised Code to establish minimum standards for marketing practices, agent compensation, agent testing, and reporting practices for long-term care insurance.

Effective Date: 07-01-1993; 2007 HB100 09-10-2007

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3923.441 Rescission of long-term care policy for misrepresentation.

(A) Except as otherwise provided in division (C) of this section and notwithstanding division (B) of section 3923.04 of the Revised Code, no insurer shall rescind a long-term care insurance policy or certificate or deny an otherwise valid claim based upon a misrepresentation by the applicant without adhering to one of the following:

(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the insurer can demonstrate that the insured misrepresented facts that were material to the insurer's offer of coverage to the insured.

(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the insurer can demonstrate that the insured misrepresented facts that were both material to the insurer's offer of coverage to the insured and that pertain to the condition for which the insured sought benefits.

(3) After a policy or certificate has been in force for at least two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the insurer can demonstrate that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health in the insured's application for the policy.

(B) No insurer shall recover from the insured benefits that were paid under a long-term care insurance policy or certificate prior to the rescission of the policy or certificate pursuant to this section.

(C) In the event of the death of the insured, the remaining death benefits under a life insurance policy that accelerates benefits for long-term care are governed by section 3923.04 of the Revised Code.

Effective Date: 2007 HB100 09-10-2007

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3923.442 Offer of nonforfeiture benefit option with long-term care policy.

(A)

(1) Except as provided in division (B) of this section, no insurer shall deliver or issue for delivery a long-term care insurance policy or certificate in this state without offering the policyholder or certificate holder the option of purchasing a nonforfeiture benefit.

(2) An insurer's offer of a nonforfeiture benefit pursuant to this section may be in the form of a rider that is attached to the policy.

(3) If the policyholder or certificate holder declines the nonforfeiture benefit offered pursuant to this section, the insurer shall provide a contingent benefit upon lapse that shall be available for a period of time specified in the policy or certificate following a substantial increase in premium rates.

(B)

(1) For a group long-term care insurance policy, the insurer shall make the offer required by division (A) of this section to the group policyholder.

(2) For a group long-term care insurance policy as defined by division (D)(4) of section 3923.41 of the Revised Code, other than to a continuing care retirement community or other similar entity, the insurer shall make the offer required by division (A) of this section to each proposed certificate holder.

(C) The superintendent of insurance may adopt rules specifying the type of nonforfeiture benefits insurers may offer as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in division (A) of this section.

Effective Date: 2007 HB100 09-10-2007

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3923.443 Training required for agents selling long-term care policies.

(A)

(1) No agent shall sell, solicit, or negotiate long-term care insurance on or after September 1, 2008, without completing an initial eight-hour partnership program training course as described in division (B) of this section.

(2)

(a) Any agent that sells, solicits, or negotiates any long-term care insurance shall complete at least four hours of continuing education in every twenty-four-month period commencing on the first day of January of the year immediately following the year of the issuance of the agent's license.

(b) No agent shall fail to complete the continuing education requirements in division (A)(2)(a) of this section in the twenty-four-month period described in that division.

(B) The initial training course and continuing education required under division (A) of this section may be approved by the superintendent of insurance as continuing education courses under sections 3905.481 to 3905.486 of the Revised Code and shall consist of combined topics related to long-term care insurance, long-term care services, and state long-term care insurance partnership programs, including all of the following:

(1) State and federal regulations and requirements and the relationship between state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(2) Available long-term care services and providers;

(3) Changes or improvements in long-term care services or providers;

(4) Alternatives to the purchase of private long-term care insurance;

(5) The effect of inflation on benefits and the importance of inflation protection;

(6) Consumer suitability standards and guidelines;

(7) Any other topics required by the superintendent.

(C) The initial training and continuing education required by division (A) of this section shall not include training that is specific to a particular insurer or company product or that includes any sales or marketing information, materials, or training other than those required by state or federal law.

(D) A resident agent shall satisfy the training and continuing education required by division (A) of this section by completing long-term care courses that are approved by the superintendent. A nonresident agent may satisfy the training and continuing education required by division (A) of this section by completing the training requirements in any other state, provided that the course is approved for credit by the insurance department of that state prior to the agent taking the course.

(E) Each insurer shall obtain records of the initial training and continuing education completed by agents of that insurer pursuant to division (A) of this section as well as the training completed by the insurer's agents concerning the distribution of the insurer's partnership program policies and shall make those records available to the superintendent upon request.

(F) Each insurer shall maintain records with respect to the training of its agents concerning the distribution of the insurer's partnership program policies. Each insurer shall provide documentation to the superintendent that will allow the superintendent to provide assurance to the medicaid director that agents have received the training required by this section and that agents have demonstrated an understanding of the partnership program policies and their relationship to public and private coverage of long-term care in this state, including medicaid. The superintendent may audit each insurer's records annually to verify that the insurer is maintaining the records required by this division. The superintendent shall make the records provided to the superintendent pursuant to division (E) of this section available to the director.

Amended by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Effective Date: 2007 HB100 09-10-2007; 2008 HB562 09-22-2008

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3923.444 Compensation of agents selling long-term care policies.

(A) No agent or third-party administrator shall field issue a long-term care insurance policy or certificate if the compensation to the agent or third-party administrator is not based on the number of policies or certificates issued.

(B) As used in this section, "field issue" means to issue a policy or certificate pursuant to the underwriting authority granted to an agent or third-party administrator by an insurer using the insurer's underwriting guidelines.

Effective Date: 2007 HB100 09-10-2007

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3923.45 Forms.

The form of all long-term care insurance policies and applications shall be filed and approved in accordance with section 3923.02 of the Revised Code.

Effective Date: 09-14-1988

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3923.46 Rates for individual policy.

Premium rates for any individual policy of long-term care insurance shall be filed in accordance with section 3923.021 of the Revised Code.

Effective Date: 09-14-1988

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3923.47 Rules.

The superintendent of insurance shall, pursuant to Chapter 119. of the Revised Code, adopt rules to carry out the purposes of sections 3923.41 to 3923.48 of the Revised Code including rules related to the state long-term care partnership program.

Effective Date: 09-14-1988; 2007 HB100 09-10-2007

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3923.48 Violation is unfair and deceptive insurance practice.

Any violation of sections 3923.44 to 3923.46 of the Revised Code is an unfair and deceptive insurance practice under sections 3901.19 to 3901.23 of the Revised Code.

Effective Date: 08-14-1992

## **Ohio Administrative Code Section 3901-4-01 Long-Term Care Insurance**

(A) Purpose. The purpose of this rule is to implement sections 3923.41 to 3923.49 of the Revised Code to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

(B) Authority. This regulation is issued pursuant to the authority vested in the superintendent under sections 3901.041, 3923.44 and 3923.47 of the Revised Code.

(C) Applicability. Except as otherwise specifically provided, this rule applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) Benefits under the policy may commence after the policyholder has reached social security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

(D) Definitions. For the purpose of this rule, the terms "long-term care insurance," "group long-term care insurance," "applicant," "policy" and "certificate" shall have the meanings set forth in section 3923.41 of the Revised Code. In addition, the following definitions apply.

(1) "Association" shall mean any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance.

(2)

(a) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the superintendent determines the need for the premium rate increase is justified:

(i) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(ii) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in paragraph (T) of this rule, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(c) The superintendent may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

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

(3) "Incidental," as used in paragraph (T)(10) of this rule, means that the value of the long-term care benefits provided is less than ten per cent 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.

(4) "Qualified actuary" means a member in good standing of the American academy of actuaries.

(5) "Similar policy forms" means 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 section 3923.41 of the Revised Code 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.

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

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(2) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

(4) "Bathing" 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.

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

(6) "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 caring for catheter or colostomy bag).

(7) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(8) "Eating" 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.

(9) "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(10) "Home health care services" means medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(11) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(12) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(15) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(16) "Transferring" means moving into or out of a bed, chair or wheelchair.

(17) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

(F) Policy practices and provisions

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of paragraph (I) of this rule.

(a) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

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

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

(d) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this paragraph, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

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

(a) Preexisting conditions or diseases;

(b) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease;

(c) Alcoholism and drug addiction;

(d) Illness, treatment or medical condition arising out of:

(i) War or act of war (whether declared or undeclared);

(ii) Participation in a felony, riot or insurrection;

(iii) Service in the armed forces or units auxiliary thereto;

(iv) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(v) Aviation (this exclusion applies only to non-fare-paying passengers).

(e) 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;

(f) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(g) 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.

(h)

(i) This subparagraph is not intended to prohibit exclusions and limitations by type of provider. However, no long term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

(a) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

(b) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(ii) For purposes of this paragraph, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(i) This subparagraph is not intended to prohibit territorial limitations.

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

(4) Continuation or conversion

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

(b) For the purposes of this paragraph, a "basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The superintendent 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.

(c) For the purposes of this paragraph, 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.

(d) For the purposes of this paragraph, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the superintendent to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the superintendent, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty 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.

(f) 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.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(i) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(ii) The termination coverage is replaced not later than thirty-one days after termination, by group coverage effective on the day following the termination of coverage:

(a) Providing benefits identical to or benefits determined by the superintendent to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b) The premium for which is calculated in a manner consistent with the requirements of paragraph (F)(4)(f) of this rule.

(h) Notwithstanding any other provisions of this paragraph, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that 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 one hundred per cent of incurred expenses. The 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.

(i) 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.

(j) Notwithstanding any provision of this paragraph, an 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.

(k) For the purposes of this paragraph 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.

(5) Discontinuance and replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(a) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

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

(6)

(a) The premium charged to an insured shall not increase due to either:

(i) The increasing age of the insured at ages beyond sixty-five; or

(ii) The duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under paragraph (AA) of this rule, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under paragraph (AA) of this rule, the initial annual premium shall be based on the reduced benefits.

(7) Electronic enrollment for group policies

(a) In the case of a group defined in division (D) of section 3923.41 of the Revised Code, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by division (U) of section 3904.01 of the Revised Code, is maintained.

(b) The insurer shall make available, upon request of the superintendent, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

(G) Unintentional lapse. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1)

(a) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I

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

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

(b) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (G)(1)(a) of this rule need not be met until sixty 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.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (G)(1)(a) of this rule, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirement in paragraph (G)(1) of this rule, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

(H) Required disclosure provisions

(1) Renewability. Individual long-term care insurance policies shall contain a renewability provision.

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

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

(2) 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 that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing 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, the premium charge shall be set forth in the policy, rider or endorsement.

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

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

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in divisions (E)(2) and (F) of section 3923.44 of the Revised Code shall set forth

a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Disclosure of tax consequences. With regard to life insurance policies that 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 subparagraph shall not apply to qualified long-term care insurance contracts.

(7) Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate 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.

(8) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in paragraph (DD)(5) of this rule that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in paragraph (DD)(5) of this rule that the policy is not intended to be a qualified long-term care insurance contract.

(I) Required disclosure of rating practices to consumers

(1) This paragraph shall apply as follows:

(a) Except as provided in paragraph (I)(1)(b) of this rule, this paragraph applies to any long-term care policy or certificate issued in this state on or after one hundred eighty days after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule became effective, the provisions of this paragraph shall apply on the policy anniversary following three hundred sixty-five days after the effective date of this rule.

(2) 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 subparagraph 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 paragraph to the applicant no later than at the time of delivery of the policy or certificate.

(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 certificateholder'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:

(i) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(ii) The right to a revised premium rate or rate schedule as provided in paragraph (l)(2) of this rule if the premium rate or rate schedule is changed;

(e)

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

(a) The policy forms for which premium rates have been increased;

(b) The calendar years when the form was available for purchase; and

(c) The amount or per cent 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.

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

(iii) 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.

(iv) 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 paragraph 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 in accordance with paragraph (l)(2)(e)(i) of this rule.

(v) If the acquiring insurer in paragraph (l)(2)(e)(iv) of this rule files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block policy forms acquired from nonaffiliated insurers referenced in paragraph (l)(2)(e)(iv) of this rule, the acquiring insurer shall make all disclosures required by paragraph (l)(2) of this rule, including disclosure of the earlier rate increase referenced in paragraph (l)(2)(e)(iv) of this rule.

(3) An applicant shall 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 under paragraphs (l)(2)(a) and (l)(2)(e) of this rule. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the forms in appendices B and F to this rule to comply with the requirements of paragraphs (I)(1) and (I)(2) of this rule.

(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (I)(2) of this rule when the rate increase is implemented.

(J) Initial filing requirements

(1) This paragraph applies to any long-term care policy issued in this state on or after one hundred eighty days after the effective date of this rule.

(2) An insurer shall provide the information listed in this subparagraph to the superintendent thirty days prior to making a long-term care insurance form available for sale.

(a) A copy of the disclosure documents required in paragraph (I) of this rule; and

(b) An actuarial certification consisting of at least the following:

(i) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(iv) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(b) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(c) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(d) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(i) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(ii) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the superintendent may request a demonstration under paragraph (J)(3) of this rule based on a standard age distribution; and

(v)

(a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(3)

(a) The superintendent may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(b) In the event the superintendent asks for additional information under this provision, the period in paragraph (J)(2) of this rule does not include the period during which the insurer is preparing the requested information.

(K) Prohibition against post-claims underwriting

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

(2)

(a) If an application for long-term care insurance contains a question that 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.

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

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

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

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

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application][enrollment form][is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or

rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

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

(i) A report of a physical examination;

(ii) An assessment of functional capacity;

(iii) An attending physician's statement; or

(iv) Copies of medical records.

(4) 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.

(5) 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 that the insured voluntarily effectuated and shall annually furnish this information to the superintendent in the format prescribed by the national association of insurance commissioners in appendix A to this rule.

(L) Minimum standards for home health and community care benefits in long-term care insurance policies

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

(a) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) 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;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) 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;

(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) By limiting benefits to services provided by medicare-certified agencies or providers;  
or

(i) By excluding coverage for adult day care services.

(2) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(M) Requirement to offer inflation protection

(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each

policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five per cent;

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five per cent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the policy is issued to a group, the required offer in paragraph (M)(1) of this rule shall be made to the group policyholder; except, if the policy is issued to a group defined in division (D) of section 3923.41 of the Revised Code other than an employer, labor organization or trust established by one or more employers or labor organizations or a combination thereof, or an association group, and the group is not a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(3) The offer in paragraph (M)(1) of this rule shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4)

(a) Insurers shall include the following information in or with the outline of coverage:

(i) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

(5) Inflation protection benefit increases under a policy which contains these 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.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7)

(a) Inflation protection as provided in paragraph (M)(1)(a) of this rule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subparagraph. The rejection may be either in the application or on a separate form.

(b) The rejection shall be considered a part of the application and shall state:

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

(N) Requirements for application forms and replacement coverage

(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by division (D) of section 3923.41 of the Revised Code, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(a) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(b) Did you have another long-term care insurance policy or certificate in force during the last twelve months?

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(c) Are you covered by medicaid?

(d) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(2) Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold that are still in force.

(b) List policies sold in the past five years that are no longer in force.

(3) 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; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided as shown in appendix I to this rule.

(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided as shown in appendix I to this rule.

(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice

shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(6) Life insurance policies that accelerate benefits for long-term care shall comply with this paragraph 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 rule 3901-6-05 of the Administrative Code. 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.

(O) Reporting requirements

(1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a per cent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a per cent of the agent's total annual sales.

(2) Every insurer shall report annually by June thirtieth the ten per cent of its agents with the greatest percentages of lapses and replacements as measured by paragraph (O)(1) of this rule (appendix G to this rule).

(3) 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.

(4) Every insurer shall report annually by June thirtieth the number of lapsed policies as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the end of the preceding calendar year (appendix G to this rule).

(5) Every insurer shall report annually by June thirtieth the number of replacement policies sold as a per cent of its total annual sales and as a per cent of its total number of policies in force as of the preceding calendar year (appendix G to this rule).

(6) Every insurer shall report annually by June thirtieth, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied (appendix E to this rule).

(7) For purposes of this paragraph:

(a) "Policy" means only long-term care insurance;

(b) Subject to paragraph (O)(7)(c) of this rule, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means the insurer refused to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this paragraph shall be filed with the superintendent.

(P) Licensing: A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by Chapter 3905. of the Revised Code.

(Q) Discretionary powers of superintendent: The superintendent may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3)

(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

(R) Reserve standards

(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with division (D)(7) of section 3903.72 of the Revised Code. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this paragraph should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this paragraph, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following;

- (a) Definition of insured events;
- (b) Covered long-term care facilities;
- (c) Existence of home convalescence care coverage;
- (d) Definition of facilities;
- (e) Existence or absence of barriers to eligibility;
- (f) Premium waiver provision;
- (g) Renewability;

- (h) Ability to raise premiums;
- (i) Marketing method;
- (j) Underwriting procedures;
- (k) Claims adjustment procedures;
- (l) Waiting period;
- (m) Maximum benefit;
- (n) Availability of eligible facilities;
- (o) Margins in claim costs;
- (p) Optional nature of benefit;
- (q) Delay in eligibility for benefit;
- (r) Inflation protection provisions; and
- (s) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(2) When long-term care benefits are provided other than as in paragraph (R)(1) of this rule, reserves shall be determined in accordance with rule 3901-3-13 of the Administrative Code.

(S) Loss ratio

(1) This paragraph shall apply to all long-term care insurance policies or certificates except those covered under paragraphs (J) and (T) of this rule.

(2) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty per cent, 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:

(a) Statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) Concentration of experience within early policy duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) Experimental nature of the coverage;

(k) Policy reserves;

(l) Mix of business by risk classification; and

(m) Product features such as long elimination periods, high deductibles and high maximum limits.

(3) Paragraph (S)(2) of this rule 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:

(a) 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;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of sections 3915.071 and 3915.072 of the Revised Code;

(c) The policy meets the disclosure requirements of divisions (K), (L), and (M) of section 3923.44 of the Revised Code.

(d) Any policy illustration that meets the applicable requirements of the rule 3901-6-04 of the Administrative Code; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, an insurer must include per cent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) 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

(viii) 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.

(T) Premium rate schedule increases

(1) This paragraph shall apply as follows:

(a) Except as provided in paragraph (T)(1)(b) of this rule, this paragraph applies to any long-term care policy or certificate issued in this state on or after one hundred eighty days after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule became effective, the provisions of this paragraph shall apply on the policy anniversary following three hundred sixty-five days after the effective date of this rule.

(2) An insurer shall provide notice of a pending premium rate schedule increase for a group long-term care policy, including an exceptional increase, to the superintendent at least thirty days prior to the notice to the policyholders. An insurer shall request approval of a pending premium rate schedule increase for an individual long-term care policy, including an exceptional increase, from the superintendent at least thirty days prior to the notice to the policyholders. The notice or request for approval shall include:

(a) Information required by paragraph (l) of this rule;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(ii) The premium rate filing is in compliance with the provisions of this paragraph;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(a) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(b) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(c) The projections shall demonstrate compliance with paragraph (T)(3) of this rule; and

(d) For exceptional increases,

(i) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(ii) In the event the superintendent determines as provided in paragraph (D)(2)(d) of this rule that offsets may exist, the insurer shall use appropriate net projected experience;

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the superintendent; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the superintendent.

(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that seventy per cent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight per cent;

(ii) Eighty-five per cent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight per cent; and

(iv) Eighty-five per cent of the present value of future projected premiums not in paragraph (T)(3)(c) of this rule on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in paragraphs (T)(3)(b)(ii) and (T)(3)(b)(iv) of this rule will also include seventy per cent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in rule 3901-3-13 of the Administrative Code. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(4) For each rate increase that is implemented, the insurer shall file with the superintendent updated projections, as defined in paragraph (T)(2)(c)(i) of this rule, annually for the next three years and include a comparison of actual results to projected

values. The superintendent may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in paragraph (T)(11) of this rule, the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the superintendent.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred per cent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph (T)(2)(c)(i) of this rule, shall be filed with the superintendent every five years following the end of the required period in paragraph (T)(4) of this rule. For group insurance policies that meet the conditions in paragraph (T)(11) of this rule, the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the superintendent.

(6)

(a) If the superintendent has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in paragraph (T)(3) of this rule, the superintendent may require the insurer to implement any of the following:

(i) Premium rate schedule adjustments; or

(ii) Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph (T)(2)(c)(v) of this rule, if applicable.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to superintendent approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in

effect; otherwise the superintendent may impose the condition in paragraph (T)(8) of this rule; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to paragraph (T)(3) of this rule had the greater of the original anticipated lifetime loss ratio or fifty-eight per cent been used in the calculations described in paragraphs (T)(3)(a) and (T)(3)(c) of this rule.

(8)

(a) For a rate increase filing that meets the following criteria, the superintendent shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

(iii) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the superintendent may determine that a rate spiral exists. Following the determination that a rate spiral exists, the superintendent may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(i) The offer shall:

(a) Be subject to the approval of the superintendent;

(b) Be based on actuarially sound principles, but not be based on attained age; and

(c) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(ii) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(a) The maximum rate increase determined based on the combined experience; and

(b) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten per cent.

(9) If the superintendent determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the superintendent may, in addition to the provisions of paragraph (T)(8) of this rule, prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Paragraphs (T)(1) to (T)(9) of this rule shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in paragraph (D)(3) of this rule, if the policy complies with all of the following provisions:

(a) 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;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) Sections 3915.071 and 3915.072 of the Revised Code, and

(ii) Section 3915.073 of the Revised Code;

- (c) The policy meets the disclosure requirements of divisions (K), (L) and (M) of section 3923.44 of the Revised Code;
- (d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
- (i) Policy illustrations as required by rule 3901-6-04 of the Administrative Code;
- (e) An actuarial memorandum is filed with the insurance department that includes:
- (i) A description of the basis on which the long-term care rates were determined;
- (ii) A description of the basis for the reserves;
- (iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
- (iv) A description and a table of each actuarial assumption used. For expenses, an insurer must include per cent of premium dollars per policy and dollars per unit of benefits, if any;
- (v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- (vi) The estimated average annual premium per policy and the average issue age;
- (vii) 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
- (viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Paragraphs (T)(6) and (T)(8) of this rule shall not apply to group insurance policies as defined in division (D) of section 3923.41 of the Revised Code, which are issued to an employer, labor organization or trust established by one or more employers or labor organizations or a combination thereof where:

(a) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(b) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty per cent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(U) Filing requirements for advertising

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

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

(V) Standards for marketing

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

(a) Establish marketing procedures and agent training requirements to assure that:

(i) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(ii) Excessive insurance is not sold or issued.

(b) 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."

(c) Provide copies of the disclosure forms required in paragraph (I)(3) of this rule (appendices B and F to this rule) to the applicant.

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

(e) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this paragraph (V)(1) of this rule.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the superintendent, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

(g) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph (F)(1)(c) of this rule.

(h) Provide an explanation of contingent benefit upon lapse provided for in paragraph (AA)(4)(c) of this rule and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in paragraph (AA)(4)(d) of this rule.

(2) In addition to the practices prohibited in sections 3901.20 and 3901.21 of the Revised Code, the following acts and practices are prohibited:

(a) 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.

(b) 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.

(c) 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.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3)

(a) With respect to the obligations set forth in this paragraph, the primary responsibility of an association, as defined in paragraph (D)(1) of this rule, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The insurer shall file with the insurance department the following material:

(i) The policy and certificate,

(ii) A corresponding outline of coverage, and

(iii) All advertisements requested by the insurance department.

(c) The association shall disclose in any long-term care insurance solicitation:

(i) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(ii) A brief description of the process under which the policies and the insurer issuing the policies were selected.

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

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

(f) The association shall also:

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

(ii) Actively monitor the marketing efforts of the insurer and its agents; and

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

(iv) Paragraphs (V)(3)(f)(i) to (V)(3)(f)(iii) of this rule shall not apply to qualified long-term care insurance contracts.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this paragraph.

(h) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this paragraph.

(i) Failure to comply with the filing and certification requirements of this paragraph constitutes an unfair trade practice.

(W) Suitability

(1) This paragraph shall not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") 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) Train its agents in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the superintendent.

(3)

(a) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) 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

(iii) 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.

(b) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in paragraph (W)(3)(a) of this rule. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a

minimum, the information in the format contained in appendix B to this rule, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the superintendent.

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

(d) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in appendix B to this rule is prohibited.

(4) The issuer shall use the suitability standards it has developed pursuant to this paragraph in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(5) Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

(6) 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 to this rule, in not less than twelve point type.

(7) 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 to this rule. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(8) The issuer shall report annually to the superintendent 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.

(X) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates: If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

(Y) Availability of new services or providers

(1) An insurer shall notify policyholders of the availability of a new long-term care policy series that provides coverage of new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within three hundred sixty-five days of the date the new policy series is made available for sale in this state.

(2) Notwithstanding paragraph (Y)(1) of this rule, notification is not required for any policy issued prior to the effective date of paragraph (Y) of this rule or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(3) The insurer shall make the new coverage available in one of the following ways:

(a) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(b) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(c) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the

new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(d) By an alternative program developed by the insurer that meets the intent of paragraph (Y) of this rule if the program is filed with and approved by the superintendent.

(4) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subparagraph, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(5) Policies issued pursuant to this paragraph shall be considered exchanges and not replacements. These exchanges shall not be subject to paragraphs (N) and (W) of this rule, and the reporting requirements of paragraphs (O)(1) to (O)(5) of this rule.

(6) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in paragraph (Y)(1) of this rule shall be made to the offering entity. However, if the policy is issued to a group defined in division (D)(4) of section 3923.41 of the Revised Code, the notification shall be made to each certificateholder.

(7) Nothing in this paragraph shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(8) Paragraph (Y) of this rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(9) Paragraph (Y) of this rule shall become effective on or after three hundred sixty-five days after the effective date of this amended rule.

(Z) Right to reduce coverage and lower premiums

(1)

(a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways;

(i) Reducing the maximum benefit; or

(ii) Reducing the daily, weekly or monthly benefit amount.

(b) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. An example of a policy design would be a partnership policy which maintains its partnership status by containing certain features as required by state or federal law.

(2) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(3) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(4) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(5) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by paragraph (G)(1)(c) of this rule.

(6) Paragraph (Z) of this rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(7) The requirements of paragraph (Z) of this rule shall apply to any long-term care policy issued in this state on or after three hundred sixty-five days after the effective date of this amended rule.

(AA) Nonforfeiture benefit requirement

(1) This paragraph does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(2) A nonforfeiture benefit shall be offered that complies with the following:

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in paragraph (AA)(5) of this rule; and

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

(3) If the offer is rejected, the insurer shall provide the contingent benefit upon lapse described in this paragraph. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit upon lapse in paragraph (AA)(4)(d) of this rule shall still apply.

(4)

(a) After rejection of the offer, for individual and group policies without nonforfeiture benefits issued after the effective date of this paragraph, the insurer shall provide a contingent benefit upon lapse.

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

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

## Triggers for a substantial premium 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%

(d) A contingent benefit upon lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased, and the ratio in paragraph (AA)(4)(f)(ii) of this rule is forty per cent or more. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

#### Triggers for a Substantial Premium Increase

##### Issue Age/Percent Increase Over Initial Premium

Under 65            50%

65-80                30%

Over 80             10%

This provision shall be in addition to the contingent benefit provided by paragraph (AA)(4)(c) of this rule and where both are triggered, the benefit provided shall be at the option of the insured.

(e) On or before the effective date of a substantial premium increase as defined in paragraph (AA)(4)(c) of this rule, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of paragraph (AA)(5) of this rule. This option may be elected at

any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(c) of this rule; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(c) of this rule shall be deemed to be the election of the offer to convert in paragraph (AA)(4)(e)(ii) of this rule unless the automatic option in paragraph (AA)(4)(f)(iii) of this rule applies.

(f) On or before the effective date of a substantial premium increase as defined in paragraph (AA)(4)(d) of this rule, the insurer shall:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety per cent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(d) of this rule; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in paragraph (AA)(4)(d) of this rule shall be deemed to be the election of the offer to convert in paragraph (AA)(4)(f)(ii) of this rule if the ratio is forty per cent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with paragraph (AA)(4)(c) of this rule but not paragraph (AA)(4)(d) of this rule, are described in this subparagraph:

(a) For purposes of paragraph (AA)(5)(a) of this rule, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one per cent per year prior to age fifty, and at least three per cent per year beyond age fifty.

(b) For purposes of this subparagraph, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased

thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (AA)(5)(c) of this rule.

(c) The standard nonforfeiture credit will be equal to one hundred per cent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of paragraph (AA)(6) of this rule.

(d)

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

(ii) Notwithstanding paragraph (AA)(5)(d)(i) of this rule, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(a) The end of the tenth year following the policy or certificate issue date; or

(b) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) 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.

(6) 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 be payable if the policy or certificate had remained in premium paying status.

(7) There shall be no difference in the minimum nonforfeiture benefits as required under this paragraph for group and individual policies.

(8) The requirements set forth in this paragraph shall become effective three hundred sixty-five days after the effective date of this provision and shall apply as follows:

(a) Except as provided in paragraphs (AA)(8)(b) and (AA)(8)(c) of this rule, the provisions of paragraph (AA) of this rule apply to any long-term care policy issued in this state on or after the effective date of this rule.

(b) For certificates issued on or after the effective date of paragraph (AA) of this rule, under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code, which policy was in force at the time this amended rule becomes effective, the provisions of paragraph (AA) of this rule shall not apply.

(c) The last sentence in paragraph (AA)(3) and paragraphs (AA)(4)(d) and (AA)(4)(f) of this rule shall apply to any long-term care insurance policy or certificate issued in this state after one hundred eighty days after the effective date of this rule adopting those provisions, except new certificates on a group policy as defined in division (D)(1) of section 3923.41 of the Revised Code, three hundred sixty-five days after the effective date of this rule adopting those provisions.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the loss ratio requirements of paragraph (S) or paragraph (T) of this rule, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph (AA)(4)(c) or (AA)(4)(d) of this rule, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

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

(a) The nonforfeiture provision shall be appropriately captioned;

(b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall 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 superintendent for the same contract form; and

(c) The nonforfeiture provision shall provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the superintendent.

(BB) Standards for benefit triggers

(1) 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.

(2)

(a) Activities of daily living shall include at least the following as defined in paragraph (E) of this rule and in the policy:

(i) Bathing;

(ii) Continence;

(iii) Dressing;

(iv) Eating;

(v) Toileting; and

(vi) Transferring;

(b) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in paragraph (BB)(2)(a) of this rule as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in paragraphs (BB)(1) and (BB)(2) of this rule.

(4) For purposes of this paragraph the determination of a deficiency shall not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

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

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

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

(7) The requirements set forth in this paragraph shall be effective three hundred sixty-five days after the effective date of this provision and shall apply as follows:

(a) Except as provided in paragraph (BB)(7)(b) of this rule, the provisions of this paragraph apply to a long-term care policy issued in this state on or after the effective date of this amended rule.

(b) For certificates issued on or after the effective date of paragraph (BB)(7) of this rule, under a group long-term care insurance policy as defined in division (D) of section 3923.41 of the Revised Code that was in force at the time this amended rule became effective, the provisions of this paragraph shall not apply.

(CC) Additional standards for benefit triggers for qualified long-term care insurance contracts.

(1) For purposes of this paragraph the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows:

necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b)

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

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

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

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

(d) "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).

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

(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an

expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to paragraph (CC)(3) of this rule shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

(5) Certifications required pursuant to paragraph (CC)(3) of this rule may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

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

(DD) Standard format outline of coverage: This paragraph of the rule implements, interprets and makes specific, the provisions of division (I) of section 3923.44 of the Revised Code in prescribing a standard format and the content of an outline of coverage.

(1) The outline of coverage shall be a free-standing document, using no smaller than twelve-point type.

(2) The outline of coverage shall contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) Format for outline of coverage is shown in appendix H to this rule.

(EE) Requirement to deliver shopper's guide

(1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the superintendent, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

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

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

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-reference guide, but shall furnish the policy summary required under division (K) of section 3923.44 of the Revised Code.

(FF) Penalties: In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated 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 times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

**APPENDIX A**

**RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES**

FOR THE STATE OF \_\_\_\_\_

FOR THE REPORTING YEAR []

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.

Date of Date/s

Policy Policy and Name of Policy Claim/s Date of

Form # Certificate # Insured Issuance Submitted Rescission

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Detailed reason for rescission: \_\_\_\_\_

\_\_\_\_\_

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Signature

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Name and Title (please type)

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Date

## **APPENDIX B**

### **LONG-TERM CARE INSURANCE PERSONAL WORKSHEET**

People buy long-term care insurance for many 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 (noncancellable/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 form 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.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

#### 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%?

Drafting Note: The insurer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

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 how 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

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days \_\_\_\_\_ Approximate cost \$\_\_\_\_\_ for that period of care.

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

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your 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

The answers to the questions above describe my financial situation. Or

I choose not to complete this information. (Check one.)

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed: \_\_\_\_\_

(Applicant) (Date)

I explained to the applicant the importance of completing this information..]

Signed: \_\_\_\_\_

(Agent) (Date)

Agent's Printed Name: \_\_\_\_\_]

[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 seem 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 insurance, 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.

## **Facilities**

-- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

## **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

See Form at <http://www.registerofohio.state.oh.us/pdfs/3901/0/4/3901-4-01 PH FF A APP4 20081104 1545.pdf>

## **APPENDIX F**

See Form at [http://www.registerofohio.state.oh.us/pdfs/3901/0/4/3901-4-01\\_PH\\_FF\\_A\\_APP9\\_20081104\\_1545.pdf](http://www.registerofohio.state.oh.us/pdfs/3901/0/4/3901-4-01_PH_FF_A_APP9_20081104_1545.pdf)

## **APPENDIX G**

### **LONG-TERM CARE INSURANCE REPLACEMENT AND LAPSE REPORTING FORM**

See Form at [http://www.registerofohio.state.oh.us/pdfs/3901/0/4/3901-4-01\\_PH\\_FF\\_A\\_APP5\\_20081104\\_1545.pdf](http://www.registerofohio.state.oh.us/pdfs/3901/0/4/3901-4-01_PH_FF_A_APP5_20081104_1545.pdf)

## **APPENDIX H**

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[POLICY NUMBER OR GROUP MASTER POLICY AND CERTIFICATE NUMBER]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

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]

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. Purpose of outline of coverage. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you read your policy (or certificate) carefully!

3. 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.

4. 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.]

5. 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.]

6. 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.]

7. 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.

8. 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.]

9. 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 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.]

10. 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.

11. 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.]

12. 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.]

13. 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.]

14. 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.

## **APPENDIX I**

### **FOR AGENT SOLICITATION**

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

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy

only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY 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 that 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. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its 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 any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

---

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

---

(Applicant's Signature)

(Date)

## **FOR DIRECT SOLICITATION**

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

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in

payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its 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 thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

R.C. 119.032 review dates: 01/08/2014 and 08/31/2018

Promulgated Under: 119.03

Statutory Authority: 3901.041, 3923.44, 3924.47

Rule Amplifies: 3923.41 to 3923.50

Prior Effective Dates: 1/1/1994; 8/12/2002; 11/14/2008

## **Ohio Administrative Code Section 3901-4-02 Long-Term Care Partnership Program**

(A) Purpose. The purpose of this rule is to implement a state long-term care partnership program in Ohio in accordance with sections 3923.41 to 3923.49 and 5111.18 of the Revised Code.

(B) Authority. This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041, 3923.44, and 3923.47 of the Revised Code.

(C) Applicability. This rule applies to long-term care insurance that is intended to qualify under the state's long-term care partnership program.

(D) Definitions. For purposes of this rule, the definitions set forth in section 3923.41 of the Revised Code and in rule 3901-4-01 of the Administrative Code shall have the same meaning as if such definitions were fully set forth herein. The term "policy" shall also include a certificate issued as evidence of coverage under a group insurance policy.

(E) Offers of exchange

(1) Within one hundred eighty days of the date that an insurer begins to advertise, market, offer, sell or issue policies that qualify under the state long-term care partnership program, the insurer shall offer, on a one time basis, in writing, to all existing policyholders and certificate holders that were issued long-term care coverage by the insurer on or after August 12, 2002, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under the state's long-term care partnership program (partnership plan). The written offer of exchange shall include a long-term care partnership program exchange notification, appendix A to this rule, or a form that is substantially similar in content.

(2) An exchange occurs when an insurer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a partnership plan, and the insured accepts the offer to terminate the existing policy and accepts the new policy. In making an offer to exchange, an insurer shall comply with all of the following requirements:

(a) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured;

(b) The offer shall remain open for a minimum of ninety days from the date of mailing by the insurer; and

(c) At the time the offer is made, the insurer shall provide the insured a copy of appendix A to this rule or a form that is substantially similar in content.

(3) Notwithstanding paragraphs (E)(1) and (E)(2) of this rule,

(a) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(b) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the insurer's new business, long-term care, underwriting guidelines.

(4) If the new policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then all of the following apply:

(a) The new policy shall not be underwritten; and

(b) The rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(5) If the new policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then all of the following apply:

(a) The insurer shall apply its new business, long-term care, underwriting guidelines to the increased benefits only; and

(b) The rate charged for the new policy shall be determined using the method set forth in paragraph (E)(4)(b) of this rule for the existing benefits, increased by the rate for the

increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(6)

(a) The new policy offered in an exchange shall be on a form that is currently offered for sale by the insurer in the general market and the effective date of the partnership plan policy shall be the same as the new policy.

(b) For purposes of implementing the exchange requirement set forth in paragraph (E)(1) of this rule, an insurer may also implement exchanges via any policy form that the superintendent has approved as being partnership-qualified, even if that long-term care insurance policy form is no longer offered or marketed. The superintendent may, at the superintendent's sole discretion, extend the one hundred eighty day time period referenced in paragraph (E)(1) of this rule to allow for implementation of exchanges on a long-term care insurance policy form no longer offered or marketed.

(7) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

(8) Insurers may complete an exchange by : issuing a new policy ; amending an existing policy with an endorsement or rider; or revising the schedule of benefits.

(9) The requirements of rule 3901-4-01 of the Administrative Code shall apply to exchanges including, but not limited to, the requirements relating to suitability. However, policies issued pursuant to this rule shall not be considered replacements if issued by the same insurer that issued the existing policy and shall therefore not be subject to paragraphs (N) and (O) in rule 3901-4-01 of the Administrative Code replacement standards.

(10) The offer of exchange required by paragraph (E) of this rule only applies to products issued by an insurer that are comparable to the types of policy forms (e.g. group policies or individual policies) offered by the insurer which are qualified as partnership plans. For example, if an insurer offers a comprehensive individual long-term care insurance policy qualified as a partnership plan, it is only required to offer exchanges to comprehensive

individual long-term care insurance policyholders who were issued coverage on or after August 12, 2002. In this example, since only an individual policy is qualified as a partnership plan, exchange offers would not be required to be made to group certificate holders under a group policy.

(11) For those insureds with long-term care insurance policies issued before August 12, 2002, any insurer may offer any insured an option to exchange an existing policy for a policy that qualifies as a state long-term care insurance partnership plan. The requirements set forth in paragraphs (E)(2) to (E)(9) of this rule shall apply to any such exchange.

(F) Filing requirements for long-term care insurance partnership program policies.

(1) Any policy that is intended to qualify as a partnership plan must be filed with the superintendent in accordance with section 3923.02 of the Revised Code prior to use, and such filing shall include the partnership program certification form attached as appendix B to this rule, signed by an officer of the company.

(2) Insurers intending to make use of a previously filed qualifying partnership policy shall submit to the superintendent a partnership program certification form (appendix B to this rule) signed by an officer of the company with respect to each such policy form filed. For each policy form, the partnership program certification form (appendix B to this rule) shall identify the policy by the original form number and filing date.

(3) If an insurer intends to amend a previously filed policy with an endorsement or rider in order to bring the policy into compliance with the partnership program, the insurer shall file the endorsement or rider with the superintendent prior to use, and the filing shall include a partnership program certification form (appendix B to this rule) signed by an officer of the company for each policy to be amended by the endorsement or rider, which shall include the original form number and filing date of the previously filed policy.

(4) Insurers using appendix A or appendix C to this rule do not have to file the forms with the superintendent before use. However, if the insurer modifies the content of appendix A or appendix C to this rule or intends to use another form, even though substantially similar in content, the form must be filed with the superintendent before use.

(G) The partnership program disclosure form

For policies intended to qualify under the partnership program,

(1) The agent or insurer shall give the consumer a partnership disclosure notice, either using appendix C to this rule or a notice substantially similar in content, along with the outline of coverage required by division (I) of section 3923.44 of the Revised Code at the time of solicitation;

(2) In the case of a policy issued to a group where an outline of coverage is not delivered, the agent or insurer shall deliver copies of a partnership disclosure notice, either using appendix C to this rule or a notice substantially similar in content, along with the enrollment forms; or

(3) In the case of a life insurance policy that offers long-term care insurance as a term of the policy or in a rider, the agent or insurer shall give the consumer a partnership disclosure notice, either using appendix C to this rule or a notice substantially similar in content, along with the policy summary at the time of solicitation.

(4) In addition to assuring that either a copy of appendix C to this rule or a notice substantially similar in content is provided to the consumer at the time of the initial solicitation, or to the group at the time the enrollment forms are delivered, the insurer shall also assure that a copy of appendix C to this rule or a notice substantially similar in content, is provided no later than partnership policy delivery.

#### (H) Data reporting

Each insurer offering partnership program policies in this state shall make regular reports to the United States secretary of health and human services that include such information as required by law or as the secretary determines is appropriate for the administration of the partnership program.

#### (I) Severability

If any paragraph, term, or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term, or provision of this rule, but the remaining paragraphs, terms, and provisions shall be and continue in full force and effect.

R.C. 119.032 review dates: 01/08/2014 and 08/31/2018

Promulgated Under: 119.03

Statutory Authority: 3901.041, 3923.41, 3923.44, 3923.47

Rule Amplifies: 3923.41 to 3923.49

Prior Effective Dates: 9/10/2007, 1/1/2009, 4/5/2013

# Pennsylvania

## Medicaid Long-Term Care Services

### DISCLAIMER

The purpose of this document is to provide a general overview of eligibility for Medicaid Long Term Care (LTC) in Pennsylvania. It is intended to serve as a prerequisite to training required for insurance producers who sell, solicit or negotiate LTC Partnership (LTCP) insurance policies as part of the LTCP Program in Pennsylvania.

This document is **not** to be used to determine eligibility for Medicaid LTC services. Determining eligibility for Medicaid is the responsibility of the Department of Public Welfare (DPW) through the local County Assistance Office (CAO). **All Medicaid eligibility determinations shall be made only by the CAOs. Producers should refer consumers to the local CAO or the toll-free Welfare Helpline at 1-800-692-7462 for assistance with Medicaid eligibility determinations.**

The information in this document relates primarily to the rules to qualify for Medicaid LTC and the interface with the LTCP program. This document includes Medicaid eligibility rules and dollar limits that are correct at the time of publication. These rules and the dollar amounts change periodically.

## OVERVIEW OF MEDICAID

The Medicaid Program provides health care coverage to low income families and certain categories of aged and disabled individuals. Enacted in 1965, the program is jointly financed by Federal and State government. The Federal government through Health and Human Services establishes guidelines for its operation and each State administers its own program and determines eligibility criteria; the type, amount and duration of services; and the rates for payment for services.

Medicaid LTC Services includes services received in an institutional setting or services received under one of the Home and Community Based Services (HCBS) programs.

**NOTE:** The phrase “Medicaid LTC Services” used in this document refers to individuals receiving Medicaid benefits in either setting unless otherwise noted.

Over the past decade, Medicaid has become a major payer of health care services for the elderly and disabled. As the population ages, the cost of providing these services continues to soar. In 2004, the Medicaid Program accounted for approximately 47% of the payment for LTC services.

## **LONG-TERM CARE PARTNERSHIP (LTCP) PROGRAM**

The LTCP program empowers individuals to plan for and finance for future LTC while reducing the financial strain on the Medicaid Program.

The Pennsylvania LTCP Program is a cooperative effort between private LTC insurers and Medicaid designed to encourage individuals to plan ahead and provide for their long term health needs. The LTCP Program benefits an individual by allowing the individual to retain resources in an amount equal to the insurance benefits paid under a qualified LTCP insurance policy that they would normally be required to spend on LTC. If the individual needs assistance in paying for LTC and applies for Medicaid, resources protected under Medicaid and Estate Recovery are equivalent to the amount of LTC insurance benefits paid under a LTCP policy.

**An individual must still meet other eligibility criteria referenced below (non-financial, financial and medical) to qualify for Medicaid LTC.** It is important to note that only resources are protected under a LTCP policy not income. Any pension, Social Security or other income must be used to help pay for LTC costs. An individual does not have to exhaust their qualified LTCP insurance policy benefits prior to applying for Medicaid LTC Services.

The LTCP program works like this: An individual buys a qualified LTCP policy. If LTC services are needed, the policy helps pay for care and the individual does not have to rely on Medicaid. If she continues to receive LTC services and eventually needs help paying for her care, she can apply for Medicaid LTC to help pay; however, she is not required to spend all her resources in order to qualify for Medicaid. When determining eligibility for Medicaid LTC, resources up to the amount the LTCP policy has paid in benefits will be excluded and the same amount of resources will also be excluded from estate recovery after the individual passes away.

EXAMPLES: Below are three examples illustrating how a LTCP policy works for an individual and interfaces with Medicaid (1) when the policy has exhausted benefits and (2) when the policy is still in force and paying benefits, and (3) when an individual does not own a LTCP policy.

1. Mr. Jones buys a qualified LTC insurance policy that meets the requirements of the LTCP Program. The policy provides for \$100,000 in coverage. Several years later, Mr. Jones needs nursing home care following a stroke. The LTCP policy covers most of the costs for three years but the benefits payable under the policy have been exhausted and paid \$100,000 for his care.

Mr. Jones applies for Medicaid LTC at the local CAO. Applicants normally must spend down most of their available resources to qualify for Medicaid LTC but Mr. Jones is able to preserve \$100,000 of his resources and still qualify for Medicaid to help pay for his LTC if he meets the other eligibility criteria (discussed below).

2. Mr. Smith buys a qualified LTC insurance policy that meets the requirements of the LTCP Program. The policy provides for \$100,000 in coverage. Several years later, Mr. Smith needs LTC services but also applies for Medicaid to “supplement” payment for his care along with the LTCP insurance benefits. Mr. Smith currently has \$100,000 in resources which is the amount of assets he wants to protect. The policy paid out \$92,000 in benefits with \$8,000 remaining. Mr. Smith meets all the Medicaid LTC eligibility criteria therefore Medicaid along with his LTCP insurance will pay for his monthly long term care needs. Mr. Smith is able to preserve \$92,000 in assets because the LTCP policy he purchased paid \$92,000 in benefits.

3. Mr. Miller does not own a LTCP policy but needs LTC services due to an extended illness. Mr. Miller has \$100,000 in resources accumulated over the years and would like to preserve his resources to pass on to his heirs. Mr.

Miller applies for Medicaid and is determined ineligible for Medicaid LTC until he reduces or spends his resources down to an amount of \$8,000 or less.

## **LONG-TERM CARE INSURANCE POLICIES AND “QUALIFIED PARTNERSHIP” POLICIES**

Long-term care insurance policies (LTC) are generally designed to provide coverage for long-term care services. However, the benefits provided under each LTC policy may vary due to the options available and benefits selected by the individual purchaser. For example, coverage under a LTC policy may vary based on the setting or services received, reimbursement method or benefit levels.

LTC policies may also be either federally tax-qualified or non-tax-qualified policies. The Health Insurance Portability and Accountability

Act of 1996 (HIPAA) established federally “tax-qualified” LTC policies.

Therefore, LTC policies meeting HIPAA requirements are deemed to be “tax-qualified” and are given favorable tax treatment. Insurers may offer both federally tax-qualified and non-tax-qualified LTC policies.

The Deficit Reduction Act (DRA) of 2005 facilitated the development of LTCP programs in states. The DRA also sets forth conditions that a policy must meet before it can be deemed a “Qualified Partnership” policy. Following are a few key requirements for a Qualified Partnership policy:

- The policy must cover an individual who was a resident of a Qualified Partnership State when coverage first becomes effective.
- The policy must be a federally tax-qualified LTC policy
- The policy must include inflation protection based on the individual’s age at the time of purchase:
  - Individuals under age 61 must have annual compound inflation protection
  - Individuals age 61 to 76 must have some level of inflation protection.
  - Individuals age 76 or older must be offered an inflation protection option.

It is important to note that the purchase of a Qualified Partnership policy does **not** guarantee Medicaid eligibility or benefits. Individuals who have Qualified Partnership

policies must still meet Medicaid eligibility requirements before they can qualify and receive benefits under Medicaid.

## **ELIGIBILITY CRITERIA—MEDICAID LTC**

An individual applying for Medicaid LTC Services must submit an application to DPW through the local CAO. An individual must meet non-financial and financial criteria requirements and be certified medically eligible to receive LTC payments. DPW determines nonfinancial and financial eligibility. The Pennsylvania Department of Aging through the local Area Agency on Aging (AAA) certifies that an individual is medically eligible for LTC Services.

### **Non-Financial Criteria (includes but is not limited to):**

- Age
- Social Security Number (Enumeration)
- Residence-No requirement to the length of time an individual resides in PA to be considered a resident. If an individual is admitted to a LTC facility in Pennsylvania and intends to remain in PA, the individual is considered to be a resident of PA. If the individual intends to return to another state he/she is not a resident of PA.
- Citizenship/Identity
- Medical Certification – A Medical Assessment to determine if an individual is in need of LTC Services. This includes a DPW medical assessment form completed by a qualified medical professional usually at the Hospital and/or in the LTC facility and completed by the local AAA which is then forwarded to the CAO.

## **Financial Criteria**

There are two types of Medicaid LTC eligibility:

Categorically Needy Non-Money Payment (NMP) which covers individuals with low income (up to 300% of Federal Benefit Rate) and limited resources.

Medically Needy Only (MNO) covers individuals with slightly higher income and resources and who have incurred high medical or LTC expenses.

## **Categorically Needy NMP**

**Income Limit:** \$1,869 monthly gross (adjusted annually)

**Resource Limit:** \$2,000 limit with an additional \$6,000 resource disregard. With the disregard an individual may have up to \$8,000.

**NOTE:** Individuals requesting HCBS are evaluated only under the Categorically Needy NMP criteria.

## **Medically Needy Only MNO**

**Income Limit:**

- \$2,550 semi-annual net
- Eligibility for the MNO category includes unearned and earned income deductions plus medical expense deductions from an individual's gross income.
- Medical expense deductions include the six month projected cost of nursing facility care at the private rate.

**Resource Limit:** \$2,400

## **Income—Payment towards the Cost of Care**

An individual receiving HCBS is not required to make a payment towards the cost of care.

An individual receiving Medicaid LTC Services in a LTC facility is required to make a monthly payment towards the cost of care to the facility. The payment is based on gross monthly income minus certain deductions.

The CAO computes the payment towards the cost of care as follows:

Gross monthly income

- Minus \$45/month personal needs allowance (Standard)

- Minus potential deductions:

- Home Maintenance Deduction (amount in 2007 is \$650.40/month),
- Spousal/Dependent Maintenance Allowance (specific to each case).
- Guardian Fee (up to \$100/month).

= Resulting amount is paid monthly by the individual.

**NOTE:** Certain medical expenses not covered by Medicaid are deducted by the LTC Facility.

Example:

Individual's gross monthly income includes monthly Social Security income in the amount of \$800 and a monthly pension in the amount of \$500. Individual has total gross income of \$1,300.

Gross income	\$1,300
Personal needs allowance	- <u>    \$45</u>
Individual's cost of care payment	\$1,255/month

**NOTE:** The individual may be entitled to other deductions that may include one or more of the deductions listed above.

## **RESOURCES**

The CAO will evaluate each resource owned by the applicant and the spouse of an applicant if a married individual is applying for Medicaid LTC services. The CAO will determine if the resource can be obtained and if the resource should be counted or excluded.

### **Countable Resources:**

Countable resources include but are not limited to:

- Personal property that includes cash, all bank accounts that can be liquidated such as checking, savings and Certificate of Deposit accounts, mutual funds, IRAs and investment accounts, savings bonds etc.
- Life Insurance-applicant and/or a spouse of a married applicant must own policy for the policy to be counted. If the total face value of all insurance policies owned by the same individual is more than \$1500, then the cash

value of the policy and/or policies is/are countable. The first \$1000 of the cash value of countable policy/policies is exempt for each insured individual.

- Vehicles (one vehicle is excluded). All vehicles are considered whether they are inspected, licensed, unlicensed or inoperable.
- Real Property Residential. Ownership will have to be reviewed by the CAO. If the applicant intends to return to the residential property, the residential property is excluded at application but may be subject to Medicaid Estate Recovery.

## **Non-Countable Resources:**

Non-countable or exempt resources include but are not limited to:

- Household goods, jewelry, furniture
- One vehicle
- 1 home (if there is intent to return and Equity Value is less than \$500,000 or if a spouse, dependent or disabled child lives in the home).
- Burial spaces/plots (subject to limits)
- Cash surrender value of life insurance up to \$1,000 if face value of policy is more than \$1,500.

## **Trusts:**

Trusts can be counted and/or excluded as a resource and/or income. Trust documents will be reviewed by the CAO. Trusts are often reviewed by DPW legal counsel if a decision can not be made by the CAO.

## **Annuities:**

In determining Medicaid LTC eligibility, an annuity is evaluated as either qualified or non-qualified.

1. Medicaid Qualified - employer established account or individual retirement plan such as an IRA.
2. Medicaid Non-Qualified – annuity purchased outright by an individual and not part of a retirement plan.

A Medicaid qualified annuity belonging to the community spouse (CS) is not considered an available resource. Medicaid non-qualified annuities belonging to the CS may or may not be treated as an available resource depending on if the income generated from the annuity meets the Community Spouse's Monthly Maintenance Needs Allowance (CSMMNA to be discussed under Spousal Impoverishment section)

As of March 5, 2007, a change in Federal law required that if an applicant or a recipient of Medicaid LTC Services owns an annuity that was purchased on or after February 8, 2006, it must meet the following requirements:

- Is irrevocable and non-assignable;
- Is actuarially sound;
- Provides for payments in equal amounts, with no deferral and no balloon payments made; and
- Names DPW as primary beneficiary for at least the total amount of Medicaid paid on the behalf of the applicant or recipient.

Or

When a CS, minor child or disabled child exist and are named as the primary beneficiary, DPW is named as the beneficiary in the second position.

## **TRANSFER OF ASSETS**

Assets include all income and resources of the individual and of the individual's spouse if the individual applying for Medicaid LTC Services is married.

### **Transfer of Assets for less than fair market value (FMV):**

If assets were transferred by a Medicaid applicant or the spouse of the applicant or a recipient within the look-back period, the transfer is reviewed to determine if FMV was received. If FMV was not received, the transfer could result in a period of ineligibility. The individual would be ineligible for payment of Medicaid LTC Services during this period. The individual would, however, qualify for other Medicaid benefits if otherwise eligible.

- This policy applies to applicants who submit a Medicaid LTC application on or after March 5, 2007 **and** who transferred assets on or after February 8, 2006. It also applies to recipients who transferred assets on or after March 5, 2007.

- The period of ineligibility is calculated as follows:
  - All periods of ineligibility are calculated in days. Currently the daily rate is \$222.17 (adjusted annually)

Example: Applicant gives a \$5,000 cash gift to their child.

5,000 divided by \$222.17 results in 22 days of ineligibility

for payment of Medicaid LTC Services.

- Look-Back Period

Asset transfers that occur during a certain period of time prior to an application for Medicaid LTC are evaluated by the CAO. This period is called the Look-Back Period.

- The look-back period for transfer of assets for less than FMV made on or after February 8, 2006 has increased from 36 months to 60 months beginning 02/08/2006.
  - There will be no impact of this policy until February 9, 2009. Beginning 02/09/2009 it will be a month by month increase in the look-back period. A full 60 month look-back will be in effect February 9, 2011.
- Begin date for the period of ineligibility.
    - If the asset transfer occurred on or after February 8, 2006 and the Medicaid LTC application was submitted on or after March 5, 2007, the period of ineligibility begins the first date that Medicaid LTC Services are needed.

Example: Mr. and Mrs. S transfer \$10,000 to their child in August 2006. Mr. S submits a Medicaid LTC application on or after March 5, 2007. Their income and resources are within the Medicaid limits on April 1<sup>st</sup> of 2007. The period of ineligibility is determined for 45 days (\$10,000 divided by \$222.17) beginning April 1, 2007 through May 15, 2007. Mr. S would not be eligible for payment of Medicaid LTC Services until May 16, 2007.

**NOTE:** Mr. S would be eligible for other services provided by the Medicaid Program during the period of ineligibility. Mr. S would be responsible for paying the cost of care services charged by the LTC facility.

## **Spousal Impoverishment Protection Provisions**

Special Medicaid rules apply to couples to ensure that the CS who does not need LTC Services does not become impoverished when the other spouse needs Medicaid to help pay for the cost of LTC services.

The CS may retain an amount equal to one-half of the couple's combined countable resources, up to a maximum of \$101,640. If one-half of the couple's combined countable resources are less than the minimum resource level of \$20,328, then the CS may retain resources up to \$20,328. The amount that the CS is allowed to retain is known as the "protected share."

The couple must submit a Resource Assessment Form in order for the CAO to compute the total resources owned by the couple.

**NOTE:** The minimum and maximum resource standards change annually in January.

### **Examples:**

- If a couple owns a total of \$210,000 in countable resources on the day of admission to the LTC facility, the CS can protect the maximum resource standard amount of \$101,640.

- If a couple owns a total of \$150,000 in countable resources on the day of admission to the LTC facility, the CS can protect one-half of the total resources in the amount of \$75,000.
- If a couple owns a total of \$35,000 in countable resources on the day of admission to the LTC facility, the CS can protect the minimum resource standard of \$20,328.

**NOTE:** A Resource Assessment Form is not required if both spouses are applying for or receiving Medicaid LTC Services. In this situation, both spouses are evaluated as individual applicants.

The monthly amount of income that the CS needs for food, clothing, shelter and personal needs is known as the Community Spouse Monthly Maintenance Needs Allowance (CSMMNA). The minimum monthly amount of income that the CS is permitted to prevent impoverishment is \$1,650 and the maximum amount is \$2,541.

The CS does not have to use his or her income to help pay for the LTC Services received by the spouse applying for or receiving LTC Services.

In some cases, additional resources above the protected share of resources may be protected for the CS in order to provide additional monthly income for the CS. Effective March 5, 2007 the Institutionalized Spouse (IS) must first make available his/her monthly income to the CS to meet the CSMMNA. If the CS still does not have sufficient monthly income to meet the CSMMNA, additional resources above the protected share may be used to generate monthly income for the CS.

**If a consumer has questions related to Medicaid LTC eligibility and the current financial limits, they should contact the Welfare Helpline at 1-800-692-7462.**

## **MEDICAID ESTATE RECOVERY PROGRAM**

The Medicaid Estate Recovery Program was established under Federal law and requires the DPW to recover specific Medicaid payments from the probate estates of certain Medicaid recipients who have died.

An estate of an individual includes property or assets owned entirely or in part by the deceased. Estate Recovery will only recover property and/or assets belonging to the estate of the deceased.

Medicaid Estate Recovery applies only to the estates of deceased Medicaid recipients:

- age 55 and over
- who received Medicaid LTC Services after August 15, 1994 including nursing facility care, HCBS, hospital and prescription drug services provided while receiving nursing facility care and/or HCBS.

Medicaid Estate Recovery occurs **only** after the death of an individual who meets the criteria above.

Questions may also be directed to the Medicaid Estate Recovery hotline at 1-800-528-3708.

**NOTE:** Insurance benefits paid under a LTCP policy are excluded from Medicaid Estate Recovery.

# South Carolina

## Long-Term Care Partnership Agent Training Guidelines

### Disclaimer

This document is intended to help readers understand:

- General eligibility policy relating to Medicaid payment of long-term care services in South Carolina, and
- The interaction between South Carolina Medicaid policy and the Long Term Care

Partnership Program in South Carolina

**Insurance Producers:** To sell Long Term Care Partnership policies in South Carolina, insurance producers must successfully complete training that had been approved by the South Carolina Department of Insurance. The training must include basic information about South Carolina Healthy Connections Medicaid eligibility as it relates to the Long Term Care Partnership Program.

An individual may not sell, solicit, or negotiate long term insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life. Previously licensed may continue to sell long term care products, but must complete a one-time training course by or before June 30, 2009 and ongoing training every 24 months thereafter. Those who were not yet licensed producers as of July 2008 must obtain the initial course before beginning to sell long term insurance products. The one- time training shall be no less than eight hours and the ongoing training shall be no less than four hours. Training can occur in the classroom or online.

South Carolina Medicaid eligibility policy is very complex. It incorporates special regulations and exceptions for various situations, and changes frequently due to legislative regulations. As a result, this document provides basic eligibility information, but not enough for readers to determine if someone may be eligible for Medicaid benefits.

To see how South Carolina Medicaid eligibility policy would be applied to someone's particular circumstances, the person must submit an application to their South Carolina Department of Health and Human Services (SCDHHS) Local Medicaid Eligibility office and provide all information and verifications necessary to determine eligibility. Inquiries about the eligibility status of current beneficiaries must be requested by the beneficiaries or their authorized representatives, or third parties with written consent of the beneficiary.

**Training curriculum developers:** Information provided in this document may be used as a guide when developing the Long Term Care insurance producer training. It is not necessary to use this information verbatim, but the training should address the basic elements contained in this document.

This document provides information on one of the subjects that must be included in the training required of individuals seeking approval to sell long-term care insurance policies in South Carolina. Training courses must include all of the topics listed in SC Code 123345.

Information in this document is up-to-date as of September 7, 2012.

## **Introduction to the Long-Term Care Partnership Program**

The Long Term Care Partnership (LTCP) Program is a joint effort between the federal Medicaid Program and Long Term Care (LTC) insurers. The Long Term Care Partnership was developed to encourage people to plan for their future Long-Term Care (CLTC) needs, such as residing in a nursing facility or receiving CLTC waived services in a home or community-based setting.

The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the South Carolina Department of Health and Human Services (SCDHHS) and the Department of Insurance (DOI). Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In South Carolina, qualified LTCP policies must provide a specific amount of inflation protection based on the

person's age when the policy is purchased and must meet other requirements determined by the Department of Insurance.

A person who requests Medicaid assistance of LTC services after exhausting some or all benefits of a qualified LTCP policy may have certain assets "disregarded" equal to the benefits paid by the qualified LTCP policy at the time the person is determined eligible for Medicaid. These assets are not counted when the person's Medicaid eligibility is determined and will not be recovered during estate recovery when the person dies.

## **General Criteria for Medicaid Eligibility**

To be eligible for Medicaid, a person must fit into an eligibility group and meet specific requirements relating to residency, citizenship, immigration status, third party liability, income, and asset guidelines. General information about each item is included below, with special emphasis on people who reside in a long-term care facility (LTCF) or receive home and community-based services through a waiver program.

**Medicaid eligibility groups** in South Carolina include the following:

- Children under the age of 21
- Parents or relative caretakers of dependent children
- Pregnant women
- People age 65 or older
- People who are blind
- People with a certified disability
- Women in need of treatment for certain cancers.

People living in a Long Term Care Facility or receiving Home and Community-Based Services (HCBS) are generally either disabled or are age 65 or over.

**Medicaid Residency** rules require that a person be a resident of South Carolina and intend to remain in South Carolina. With some exceptions the state of residency for someone in a Long Term Care Facility is the state in which the

person is physically present on the date of application. South Carolina is not considered the state of residence for:

- A child under 18 whose parent or legal guardian lives in another state
- A person of any age placed in the facility by another state

**Medicaid Citizenship and Immigration Status** rules require a person to be either a U.S. citizen or a noncitizen with a qualified immigration status. The following must be verified:

- U.S. citizenship and identity when a person declares that he or she is a U.S. citizen
- Immigration status when the person states that he or she has a non-citizen status. Sponsored non-citizens must also provide information about their sponsors.

**Medicaid Third Party Liability** rules state that Medicaid is the payor of last resort. People must provide information about possible payment sources, such as other health insurance, Medicare or a liable third party. The other payment source pays their portion of medical expenses before Medicaid payments are made.

## **General Criteria for Medicaid Payment of LTC Services**

To be eligible for Medicaid payment of LTC services, a person must:

1. Meet the necessary Level of Care (LOC.) A Level of Care (LOC) is a determination of medical necessity for care. A qualified individual must meet either an Intermediate or Skilled level of care designation. Community Long Term Care (CLTC) or its designee must certify the individual's level of care before Medicaid can pay for long-term care services.
2. Reside in a Long Term Care Facility or receive services through one of the Home and Community Based Waivers.
3. Meet income and resource guidelines.
4. Have home equity of \$525,000 or less unless a spouse, child under the age of 21, or blind or disabled child is lawfully residing in the home. This figure is updated annually.

5. Disclose an interest in an annuity for self and spouse, if married. The state must be named as remainder beneficiary of annuities by the individual or spouse.
6. Not be in a penalty period for an uncompensated transfer of income or assets. A look-back is completed by SCDHHS for the five (5) year period prior to the date of application for services. If it is determined an uncompensated transfer occurred, a penalty period is calculated. During a penalty period, Medicaid will not pay for any Long Term Care services.

## **Income Eligibility Criteria for People Requesting MA Payment of Long-Term Care Services**

A person's Medicaid eligibility group determines income and budgeting considerations for that person, including:

- Income limits (which are adjusted annually)
- Income which is counted for Medicaid eligibility and that which is excluded
- Deductions allowed from total gross countable income
- Potential Medicaid eligibility if the person's income is over the allowable limit.

Basic budgeting information provided relates specifically to someone in a Nursing Home. People who receive HCBS through other waiver programs may be eligible for the Partnership, but will have different eligibility rules not addressed in this document. It is recommended that they contact their local eligibility office for information relating to their specific situations.

When looking at Medicaid eligibility, income of just the individual in the Nursing Home is counted. Income of a spouse or parent is not counted.

Deductions allowed for institutionalized individuals depend on his or her specific situation. Every deduction is not allowed for each person. General deductions include:

- Health insurance premiums
- An income allocation to a community spouse

- An income allocation to certain other family members (subject to specific limitations)
- Personal needs
- Home maintenance if the person is expected to return to the home within six (6) months
  - Health care expenses not paid by Medicaid or a third party.

After allowing applicable deductions, the result is the amount a person must contribute toward the cost of his or her monthly LTC services and is typically paid to the Nursing Home. Medicaid will pay for all other covered services received by the person.

## **Asset Eligibility Criteria for People Requesting Medicaid Payment of Long-Term Care Services**

A person's eligibility group and household size determine his or her asset limit for Medicaid. A resident of a Nursing Facility or someone receiving HCBS is considered a household size of one. He or she has an asset limit of \$2,000 in countable assets.

**Countable assets** are those which are available to the person and are not specifically excluded by the Medicaid program. Examples of countable assets include cash, bank accounts, stocks, bonds, and non-homestead real property.

**Excluded assets** are not counted toward a person's asset limit. Examples of excluded assets include homestead property in which the person or spouse or certain other family members live, some trusts, certain funds set aside for burial expenses, and one vehicle.

The local eligibility office will review all verified assets and determine which ones are:

- Counted toward Medicaid eligibility
- Excluded and not counted toward Medicaid eligibility
- Determined to be protected for the community spouse, if married
- Protected because benefits of an LTCP policy have been exhausted. (explained later)

The county will also determine if a person needs to reduce assets to the \$2,000 asset limit allowed for someone residing in a Nursing Home or receiving HCBS.

## Assets of Married Couples

A person residing in a Long Term Care Facility or receiving HCBS is considered a household of one and has an asset limit of \$2,000, whether the person is married or unmarried. However, evaluating assets of the married person is more complicated and several questions need to be addressed.

- Is the spouse also receiving or requesting Medicaid payment of Nursing Home services? If yes, then each one is treated as a single individual for purposes of the Medicaid eligibility and each has an asset limit of \$2,000 in countable assets.
- Is the spouse living independently in the community? If yes, then that spouse is considered a **community spouse** and the local eligibility office must consider special rules of spousal impoverishment.

**Spousal impoverishment** regulations require that the couple (the institutionalized spouse and the community spouse) complete an **asset assessment** of their total marital assets.

In an asset assessment, the married couple reports all assets owned by either spouse individually and by both spouses jointly. The eligibility worker then evaluates the reported assets to determine:

- The amount of countable assets that can be kept by the community spouse and not counted towards the institutionalized spouse's Medicaid eligibility and
- When the institutionalized spouse may possibly be eligible to receive Medicaid payment for LTC services.

A community spouse is allowed to keep up to \$66,480. At the initial determination the assets are considered together and the couple cannot exceed \$68,480 in total countable assets. Within 90 days of approval, the assets must be separated so that the institutionalized spouse has no more than \$2,000 and the community spouse has no more than \$66,480 in countable assets.

## **South Carolina Medicaid Estate Recovery**

In August of 1993, Congress passed a law that requires states to recover amounts that Medicaid has paid for certain recipients. In South Carolina the Estate Recovery Program went into effect on July 1, 1994. The state will recover amounts paid by Medicaid for services received July 1, 1994 or later.

Estate recovery applies to the following beneficiaries:

- A person who was 55 years of age or older when he or she received medical assistance consisting of nursing facility services, home and community based service care to include prescriptions and hospital stays associated with either of these services paid by Medicaid; or
- A person of any age who was an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or long term care facility at the time of death; and, who was required to pay most of his/her monthly income to the facility toward the cost of care.

Recovery may be made only after the death of the decedent's surviving spouse, if one exists, and only at a time when the decedent has no surviving child under age twenty- one or no child who is blind or permanently and totally disabled as defined in Title XVI of the Social Security Act.

Recovery must be waived by the department upon proof of undue hardship, asserted by an heir or devisee of the property claimed pursuant to 42 U.S.C. 1396p(b)(3) and in accordance with the guidance issued by the Secretary of the United States Department of Health and Human Services in the State Medicaid Manual as incorporated into the state plan. The department shall publish and maintain such guidance on the department's web site.

### Estate Recovery Process

When a beneficiary dies, the state files a claim with the probate court against the beneficiary's estate to recover amounts paid by Medicaid for the deceased

beneficiary's medical care. An estate is all real and personal property and other assets of the deceased person (recipient) as defined in South Carolina State Law. This claim will be similar to claims for funeral expenses, attorney's fees to administer the estate, and tax. This claim will need to be satisfied in order to close the estate; however, it may not require the selling of the decedent's home and land if there are other assets available to pay the Medicaid claim. In the event other assets are insufficient to repay the Medicaid claim and/or other expenses of the estate, the Personal Representative (Administrator, Executor, and Executrix) may choose other options to repay the Medicaid debt. The state is not interested in taking title to anyone's home.

For example, John Doe was in a nursing home for the month of July. He died August 3. Medicaid paid \$2,000 for his care in July and August. His estate is worth \$50,000. Medicaid will recover only \$2,000 from his estate, after claims with higher priority (i.e., mortgage, funeral expenses, and probate fees) are paid.

In another example, Joe Smith has been on Medicaid for years. Medicaid has spent \$25,000 on the medical services he received since he was age 55. His estate is worth \$20,000. The Medicaid program will recover from the remainder of the estate, after claims with higher priority are paid.

**Exceptions and special cases:**

- Estate recovery must be deferred if the beneficiary is survived by a spouse or a child under the age of 21, blind, or permanently disabled.
- Estate recovery may be waived if it would create an undue hardship.
- Estate recovery may exempt some or all assets of a Medicaid beneficiary who is covered under a Qualified Long Term Care Partnership (QLTCP) Insurance Policy. Estate recovery will not seek adjustment or recovery from the beneficiary's estate to the extent benefits were paid under the QLTCP policy.

## **Estate Recovery Hardship**

- (1) With respect to the decedent's home property, if the decedent could have transferred the home property on or after the date of his or her Medicaid application without incurring a penalty under 42 U.S.C. Section 1396p(c) if the property could have been transferred without penalty to a:
  - (a) Surviving sibling of the decedent who possessed an equity interest in the property and who lived in the home for a period of at least one year immediately prior to the date the decedent was institutionalized;  
or
  - (b) Surviving child of the deceased who lived in the home for a period of at least two years immediately before the decedent became institutionalized and who provided care which allowed the decedent to delay institutionalization. Does not apply to a child under the age of 21, or a child who is blind or disabled.

However, hardship under this item only applies if the individual to whom the property could have been transferred without penalty is actually residing in the home, at the time the hardship is claimed and this hardship status only protects a homestead of modest value. A homestead of modest value is defined as fifty percent (50%) or less of the average price of homes in the county where the homestead is located as of the date of the beneficiary's death. To the extent the value of the home property exceeds this modest value, that portion is subject to recovery by the department.

- (2) With respect to the decedent's home and one acre of land surrounding the house, if an immediate family member:
  - (a) Has resided in the home for at least two years immediately prior to the recipient's death;
  - (b) Is actually residing in the home at the time the hardship is claimed;
  - (c) Owns no other real property or agrees to sell all other interest in real property and give the proceeds to the department; and

- (d) Has annual gross family income that does not exceed one hundred eighty- five percent of the federal poverty guidelines.
- (3) With respect to a sole income producing asset:
- (a) An immediate family member’s annual gross family income would fall below the federal poverty guidelines or immediate family member agrees to pay all income in excess of one hundred eighty-five percent of the federal poverty guidelines to the department.

## **Interaction Between the Long-Term Care Partnership Program and Medicaid Eligibility**

1. A LTCP participant in South Carolina is someone who either:
  - Requests Medicaid payment of Long Term Care services after exhausting all benefits of a qualified LTCP policy, or
  - Exhausts all benefits of a LTCP policy while receiving Medicaid payment of  
LTC services, or
  - Receives Medicaid payment of LTC services and dies before the LTCP policy benefits are exhausted.
2. In determining Medicaid eligibility, SCDHHS will disregard an individual’s assets in an amount equal to the amount of payments made by the individual’s qualifying LTCP policy for services covered under the policy. Documentation of the amount in benefits paid will have to be provided.
3. A LTCP participant receives the following benefits during his or her lifetime:
  - Assets may be designated for protection in an amount equal to the total amount of LTC services paid by the qualified LTCP policy
  - Designated assets are not counted toward the Medicaid asset limit
  - The designated assets may be transferred to any other person without penalty.

4. After the LTCP participant is deceased:
  - Assets which were designated as protected during the person's lifetime are also protected from estate recovery
  - When the amount of assets protected during the person's lifetime was less than total benefits paid by the LTCP policy, additional assets may be protected in the estate recovery process - up to the total amount paid by the LTCP policy
  - If no assets were protected during the person's lifetime, the personal representative may designate assets to protect from estate recovery equal to the total amount paid by the LTCP policy - even if LTCP policy benefits were not completely exhausted.
  
5. Owning a LTCP policy does not guarantee eligibility for Medicaid, even if the policy holder exhausts all benefits. Individuals must still meet all other Medicaid eligibility requirements. The LTCP allows policy holders to have a portion of their assets disregarded (not counted) during the eligibility process and subsequently protected from estate recovery. REMINDER: Only SCDHHS can determine whether a person will qualify for Medicaid. Agents should be careful not to advise regarding eligibility requirements or whether a person will be eligible for Medicaid.

Two types of assets cannot be protected under the LTCP Program. Federal Medicaid rules require that when a person dies, the following assets must be available to reimburse SCDHHS for the amount of Medicaid benefits paid during his or her lifetime:

- Resources in a Special Needs Trust or a Pooled Trust  
and
- Annuity interests in which South Carolina must be named as a preferred remainder beneficiary.

## **How to Apply for South Carolina Medicaid Programs**

A person may apply for any of the South Carolina health care programs by completing an application. Applications can be obtained by contacting any local eligibility office or by visiting the agency website: [www.scdhhs.gov](http://www.scdhhs.gov).

- People may request an application form by:
  - Calling the Member Services Call Center at (888) 549-0820.
  - Visiting or calling their local eligibility office
  - Visiting the agency website at [www.scdhhs.gov](http://www.scdhhs.gov)
- A complete signed and dated application can be faxed or mailed to the local eligibility office
- People may ask the local eligibility office to help them complete the application and contact third parties for required information and/or verifications.
- Health Care coverage generally begins in the month that the county receives a completed, signed and dated application.
- People may ask that Medical Assistance coverage begin up to three months before the date they apply.

# South Dakota

## Medical Eligibility and the South Dakota Long-Term Care (LTC) Partnership Program

### Introduction

The South Dakota LTC Partnership Program is a joint effort between private long-term care insurers, the Department of Social Services, and the Division of Insurance to encourage people to plan for their potential long-term care needs and expenses.

In order to participate in the South Dakota LTC Partnership Program a person must have purchased and received the benefits of a qualified Partnership policy.

A qualified Partnership policy must meet all of the rules set out by the South Dakota Division of insurance including a specific amount of inflation protection based on the person's age at the time he or she purchases the policy.

The South Dakota LTC Partnership Program benefits a person by protecting assets in an amount equal to the benefits utilized under a qualified Partnership program if the person ever applies for and qualifies for SD LTC Medicaid. These assets are protected because the DSS will not count the value of the individual's assets when determining eligibility and if they are retained by the individual, DSS will not claim them during estate recovery.

This training will provide you with:

- A discussion of the general eligibility criteria for SD LTC Medicaid and the payment of LTC services.
- An explanation of the interaction between DSS and the South Dakota LTC Partnership Program.
- Information about how people can apply for SD LTC Medicaid.

**The material presented here is a general guide to understanding payment of long-term care and the interaction between SD LTC Medicaid and the South Dakota LTC Partnership Program. LTC Medicaid eligibility policy and is very complex and as many exceptions and special rules for various situations therefore this material should not be used to determine if an individual is eligible for South Dakota Medicaid. Inquiries about individual who is enrolled in SD Medicaid must be made by that individual or the individual's authorized representative to the Long Term Care Benefits Specialist who maintains the individual's case. Inquiries about how eligibility policy would be applied to a specific individual's circumstances cannot be provided in advance of the individual filing an application and providing the information necessary to determine his or her eligibility.**

**Please refer specific questions regarding eligibility to your local Department of Social Services. <http://dss.sd.gov/offices/>**

## **General Eligibility Criteria for LTC Medicaid**

### **1. South Dakota Residence**

Federal residence rules require that an applicant must be a South Dakota resident and must intend to remain in South Dakota. The state of residence for people who live in a LTC facility is the state in which they are physically present with intent to remain on the date of application for Medicaid.

### **2. Citizen and Immigration Status**

To be eligible for SD LTC Medicaid, a person must be either a U.S citizen or a non-citizen with a qualified immigration status.

### **3. Eligible Population**

Residents of medical institutions (includes nursing facilities) for over 30 consecutive days and individuals receiving Home and Community Based Services (HCBS) Waiver services.

#### **4. Third-Party Liability**

Medicaid is typically the payer of last resort.

- People with other health care coverage or who have another party liable for their medical expenses will have medical costs paid by those sources first before Medicaid pays claims.
- People are required to cooperate with providing information regarding other payment sources. This includes long term care insurance.

#### **5. Specific Requirements for LTC Medicaid**

A person must:

- Be aged, blind or disabled
- Have a Medical Review Team (MRT) or Utilization Review Team (URT) review that determines the person requires a level of care provided in a LTC facility
  - The MRT or URT determines a person's need for long-term care in one of the following medical facilities:
    - A nursing facility
    - An intermediate care facility for persons who have intellectual disabilities
    - Assisted Living
    - Swing-bed
  - The MRT or URT determines if the person qualifies to receive home and community based services through waiver programs. These services are provided to individuals who would otherwise be institutionalized in a Medicaid funded hospital, nursing facility, or an intermediate care facility for persons who have intellectual disabilities. The waiver programs are:
    - Developmentally Disabled - waiver for people with developmental disabilities providing service coordination, habilitation, supported employment services, nursing, and specialized medical equipment, supplies and drugs.
    - Family Support – services provided to eligible families of children or adults with a developmental disability such as

Down's syndrome, an intellectual disability, autism or cerebral palsy. The developmentally disabled individual lives in the family home on a full time basis.

- Adult Services and Aging Waiver—services provided to maintain eligible aged and physically disabled individuals at home, thus preventing or reducing unnecessary institutional care including homemaker services, private duty nursing, adult day care, emergency response systems, meals, specialized medical equipment and medication services in an assisted living arrangement.
  - Assistive Daily Living Services—a program specifically for persons who are diagnosed as having quadriplegia that may allow individuals to live independently in their own homes with the assistance of the following services: case management, consumer preparation, personal attendant, and ancillary services.
- Be a resident of a LTC facility or qualify to receive home and community based services under one of the Medicaid waiver programs
    - A LTC facility does not include placements in facilities that are not Medicaid-certified.
  - Have home equity of \$552,000 (2016) or less unless a spouse, child under the age of 21, or blind or disabled child is lawfully residing in the home.
  - Not be in a penalty period for a transfer of income or assets for less than fair market value.
    - Penalty periods are assessed when a person or the person's spouse, or someone acting on their behalf, transfer assets for less than fair market value during a specified period of time (called the look-back period) prior to a person requesting SD LTC Medicaid or anytime while the person is receiving SD LTC Medicaid.
  - Some Exceptions Exist – Transfer of the home to one of the following people will NOT prevent or delay LTC eligibility:
    - Spouse
    - Son or daughter under age 21
    - Son or daughter meeting Social Security Administration definition of disability or blindness

- Son/daughter who lived in the home at least 2 years prior to parent entering a medical facility and who provided care to prevent earlier nursing home care
  - Brother/sister who has an equity interest in the home and who resided in the home at least 1 year prior to the individual entering a medical facility
- The look back period for the transfer of assets is 60 months.
- The penalty period is calculated by dividing the value of the assets transferred by the Statewide Average Payment for Skilled Nursing Care in effect at the time a person requests LTC Medicaid. This calculation results in a number of days during which the person is ineligible for SD LTC Medicaid to cover the cost of nursing home or waiver services.
- The penalty period begins when the person applies for and is otherwise eligible to receive SD LTC Medicaid but for the penalty period, or the day after a prior penalty period has ended, whichever is later. For people receiving SD LTC Medicaid at the time of the transfer, the penalty period begins the month following the month in which the transfer occurred or the date after a prior period of ineligibility ends, whichever is later.
- Disclose any annuity interests, and if married, annuity interests of a spouse and name the State as a remainder beneficiary of any annuity owned by the person or person's spouse. This provision applies regardless of whether the annuity is irrevocable or treated as an asset, whether annuitized or not.

NOTE: Future payments from an annuity are countable assets.

## **6. Suitability of a Partnership Sale and Important Consumer Disclosures**

- Purchase of a LTC Partnership policy is not a guarantee of eligibility for SD LTC Medicaid nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility.
- The Partnership program protects assets not income so the state's rules for income limits or contributions to costs of care in excess of a certain allowed amount still apply.

# Financial Eligibility Criteria for People Requesting SD LTC Medicaid

## Income

Gross Income Limits Long Term Care income limit is \$2,199 (2016). If income is over this amount, an income trust established for the sole purpose of paying for care is required to meet the income eligibility requirements.

### **Examples of Income:**

Social Security or SSI

Workman's Compensation

VA Benefits

Pensions/Income

Railroad Retirement

Unemployment Benefits

Some Interest/Dividends

Life Insurance Proceeds

Trust Income

Earnings / Rent Income

Inheritance

### **Income Not Counted in the Gross Income Limits**

County assistance

Income tax or sales tax refunds

Veteran's aid/attendance; some other VA payments

Dividends paid on life insurance policies

Irregular (receipt is unexpected) and infrequent income (received once a quarter from same source)

    If earned income – amount is less than \$30 a quarter

    If unearned income – amount is less than \$60 a quarter

## Assets

Limit - \$2,000

### **Examples of Countable Assets:**

Bank Accounts / Bonds

Contract For Deeds

Stocks / Annuities (whether annuitized or not)

Real Property

Certificate of Deposits

Available Trust Funds

### **Common Assets Not Counted in Limits:**

- Most home property if the individual plans to return home or if it is occupied by the spouse
- Most household/personal items
- One vehicle used for transportation
- Certain pre-paid burial contracts

## **Asset Treatment for Married Couples**

If one spouse is entering a medical facility (hospital/nursing home) or has entered since September 30, 1989 and is expected to remain or has remained in a medical or nursing facility for 30 or more days, eligibility for LTC Medicaid allows for some assets to be "protected" for the community spouse. "Protecting" assets is also available for couples when the spouse needing assistance chooses:

- To remain with the other spouse at home and is eligible for Medicaid waiver services;
- To be in an Assisted Living Facility and qualifies for Waiver Services; for example, based on the need for medication management; or
- To otherwise live in the community and is eligible to receive home and community based Medicaid Waiver services.

### **The "protected share" for the community spouse is:**

- \$23,844 (2016) minimum, or
- 1/2 of the countable assets up to a maximum of \$119,220 (2016), or
- Amount specified by court order or through a fair hearing.

### **Examples:**

- Combined assets of the couple are \$28,000.

The "protected share" is \$23,844. No eligibility until assets are "spent down".

- Combined assets of the couple are \$100,000.

The "protected share" is \$50,000. No eligibility until assets are "spent down".

- Combined assets of the couple are \$350,000.

The "protected share" is \$119,220. No eligibility until assets are "spent down".

- Combined assets of the couple are \$18,000.

The "protected share" for the community spouse is \$23,844 - there IS asset eligibility for the spouse in the medical/nursing facility or Waiver Program.

In addition to the protected share for the community spouse, the spouse in the nursing home or receiving waiver services may also have up to \$2000 in assets.

### **Establishing "Protected Share"**

To determine the "protected share" of the couple's combined assets for the community spouse, a Resource Assessment is completed based on the following:

- Assets existing at 12:01 am on the day the spouse entered the medical facility (hospital; nursing home if not in hospital first; or began receiving Waiver Services).
- "Countable" assets of the couple, regardless of ownership.

(Prenuptial agreements are not recognized when looking at the total assets for couple.)

### **Common assets NOT counted in "Protected Share"**

- Home property occupied by the community spouse.
- Most household goods/personal effects.
- One vehicle used for transportation.
- Certain prepaid burial contracts

**Assessment of assets may be done when one spouse enters a hospital/nursing home even though there may be no immediate plans to apply for Medicaid assistance. (The advantage of NOT waiting is the ability to provide the necessary verification of the couple's assets the month the one spouse entered the hospital/nursing home.)**

**Examples:**

A. Spouse entered a medical facility January 26, 2016, but does not apply for assistance until May 5, 2016.

- The couple's combined countable assets on January 26, 2016 were \$35,000. The protected share for the community spouse is \$23,844.
- The couple's combined countable assets in May 2016 are \$25,000. There IS asset eligibility as \$23,844 is protected for the community spouse and \$2,000 is allowed for the spouse in the nursing home.

B. Spouse entered a medical facility on February 12, 2015 but does not apply for assistance until April 2, 2016.

- The couple's combined countable assets on February 12, 2015 were \$90,000. The protected share for the community spouse is \$45,000.
  - The couple's combined countable assets in April 2016 are \$40,000. There IS asset eligibility as \$45,000 is protected for the community spouse and \$2,000 is allowed for the spouse in the nursing home.
- (They could have requested LTC Medicaid assistance earlier!)

## **Interaction between the LTC Partnership Program and SD LTC Medicaid**

### **1. How Asset Protection Works Under the LTC Partnership**

- South Dakota's LTC Medicaid program accepts a LTC policyholder as a LTC Partnership participant when a person requests LTC Medicaid.
- A person who qualifies for participation in the Partnership program does not have to exhaust the benefits of his LTC policy, but will only receive a

dollar for dollar disregard of the benefits used up to the point of application for SD LTC Medicaid.

- Once identified the Partnership provides the participant with the following benefits:
  - DSS does not count the value of assets equal to the amount of benefits paid by the Partnership Policy toward the asset limit for Medicaid eligibility.
  - DSS allows the person to transfer the disregarded assets to another person without penalty.
  - DSS protects disregarded assets from estate recovery.

For example: A single individual has a Partnership Policy that has paid out \$100,000 in benefits. The individual will be eligible for LTC Medicaid when he/she has \$102,000 in assets instead of the \$2,000 limit.

After becoming eligible, the individual gives \$20,000 to his child. No penalty period is incurred due to this transfer. Upon the individual's death, the DSS Office of Recoveries and Fraud Investigation will only seek recovery if the estate is valued at over \$80,000.

## **2. Interaction of Partnership Protection with other Medicaid Rules**

- The LTC Partnership affects some Medicaid rules discussed above. Partnership participation affects the following:
  - Third party liability: Benefits under a Partnership policy that is available while a person is receiving Medicaid payment of LTC services are treated as third party liability.
  - Protected share under spousal impoverishment rules: The protected share for a married couple is completed before the evaluation of assets for protection under the LTC Partnership program. This allows the full protection under the LTC Partnership program to be applied to the assets considered available to the LTC spouse.
  - Transfers for less than fair market value: People who transfer assets protected under the Partnership program are not subject to penalty

## How to Apply for SD LTC Medicaid

A person may apply for any of the South Dakota health care programs by completing a South Dakota Application for Long Term Care or Related Medicaid (DSS EA 240)

A person may request an application form by:

- Visiting or calling their local office DSS Office. <http://dss.sd.gov/offices/>
- A person may download an application by visiting the following site: <http://dss.sd.gov/formspubs/>
- The application can be faxed or sent to their local office.
- A person may request help from the DSS in completing the application process, which includes help filling out the application form and contacting third parties to get needed information and/or verifications.
- DSS will verify the benefits paid by a LTC Partnership Plan at the time of application for LTC Medicaid.

# Tennessee

## Long-Term Care Partnership Agent Training

### Introduction to the Long-Term Care Partnership Program

The Long Term Care Partnership (LTCP) Program is a joint effort between the federal Medicaid Program and Long Term Care (LTC) insurers. The Long Term Care Partnership was developed to encourage people to plan for their future LTC needs, such as residing in a nursing facility or receiving LTC services in a home or community-based setting.

The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the Bureau of TennCare, the Department of Human Services (DHS) and the Department of Commerce and Insurance (TDCI). Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In Tennessee, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements determined by the TDCI.

TennCare is Tennessee's Medicaid Program. In order to participate in TennCare's LTCP program, a person must have purchased and received the benefits of a qualified Partnership policy.

A person who requests TennCare payment of LTC services after exhausting some or all benefits of a qualified LTCP policy may have certain assets "disregarded" equal to the benefits paid by the qualified LTCP policy at the time the person is determined eligible for TennCare. These assets are not counted when the person's TennCare eligibility is determined and will not be recovered during estate recovery when the person dies.

## **General Criteria for TennCare LTC Eligibility**

To be eligible for TennCare, a person must qualify in one of the eligibility groups that is covered under the TennCare Medicaid program and meet specific requirements relating to residency, citizenship, income and resources. To be eligible for TennCare payment of LTC services, a person must meet all of the following criteria:

- a) Have a Pre-Admission Evaluation (PAE) that determines a need for a level of care provided in one of these settings:
  - 1) Nursing facility
  - 2) Intermediate Care Facility for people with Mental Retardation (ICF-MR)

A person who meets the level of care and eligibility requirements for care in a nursing facility or ICF- MR may then be able to choose to receive LTC services in an alternative home and community based setting such as an HCBS Waiver program.

- b) Reside in a TennCare-certified Long Term Care facility or receive TennCare home and community- based LTC services under a federally approved waiver program.
- c) Meet income and resource guidelines.
- d) Disclose an interest in an annuity for self and spouse, if married. The state must be named as remainder beneficiary of annuities owned by the person or spouse.
- e) Not be in a penalty period for an uncompensated transfer of income or assets. During a penalty period, TennCare will not pay the cost of LTC services.
- f) Have home equity of \$500,000 or less unless a spouse, child under the age of 21, or blind or disabled child is lawfully residing in the home.

## **Interaction Between the LTCP Program and TennCare Eligibility**

- 1) A LTCP participant in Tennessee is someone who either:
  - Requests TennCare payment of LTC services after exhausting all benefits of a qualified LTCP policy, OR
  - Exhausts all benefits of a LTCP policy while receiving TennCare payment of LTC services, OR
  - Receives TennCare payment of LTC services and dies before the LTCP policy benefits are exhausted.
  
- 2) In determination of eligibility for TennCare, DHS shall disregard an individual's assets in an amount equal to the following:
  - The amount of payments made by the individual's qualifying LTC policy for services covered under the policy

TennCare applicants will be required to submit written proof of benefits paid from their LTCP policies.

- 3) A LTCP participant receives the following benefits during his or her lifetime:
  - Assets may be designated for disregard in an amount equal to the benefits paid out by the qualified LTCP policy as of the date of application for Medicaid eligibility.
  - Designated assets are not counted toward the TennCare asset limit for eligibility purposes.
  - The designated assets may be transferred to any other person without penalty.
  - Additional benefits paid by the qualified LTCP policy after application for Medicaid eligibility shall not be disregarded in future review and/or determination of Medicaid eligibility.
  
- 4) After the LTCP participant is deceased:
  - Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery.
  - When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the LTCP policy, additional assets may be

protected in the estate recovery process up to the amount of payments made by the individual's qualifying LTC policy for services covered under the policy.

- If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above - even if LTCP policy benefits were not completely exhausted.
- 5) TennCare is typically the payor of last resort. Individuals with other health care coverage or who have another party liable for their medical expenses will have medical costs paid by those sources first before TennCare pays claims. Individuals are required to cooperate with providing information regarding other payment sources. This includes long-term care insurance.
- LTC insurance benefits may not be used to offset the amount the person is required to contribute, pursuant to federal post-eligibility provisions, to the cost of TennCare- reimbursed LTC services (known as "patient liability"), but rather, must be used to help offset the cost of LTC services that would otherwise be reimbursable by TennCare. Thus, both the LTC insurance benefits and patient liability reduce the TennCare payment for LTC services.
- 6) It is the responsibility of the LTCP policy holder to inform the DHS eligibility worker that he has a Partnership policy.
- 7) When should an individual apply for TennCare?
- If the LTCP policy holder exhausts the benefits of his LTCP policy.
  - When the Partnership policyholder/spouse/family/friend feels that the policyholder can no longer afford to pay for the cost of care.
- 8) Does a LTCP policy guarantee access to TennCare?
- NO! Owning a LTCP policy does NOT guarantee access to TennCare—even if the policy holder exhausts his benefits. Individuals still must meet all other TennCare eligibility requirements in order to be eligible. The Partnership allows policy holders to have a portion of their assets disregarded (i.e., not counted) during the eligibility determination process and subsequently

protected from estate recovery (dollar for dollar the amount of benefits paid out by the qualified LTCP policy).

**REMEMBER:** Only DHS can determine whether a person will qualify for TennCare. Agents should be careful not to advise regarding eligibility requirements or whether a person will be eligible for TennCare.

## **How to Apply for TennCare**

In Tennessee, the Department of Human Services (DHS) accepts applications for TennCare through the county DHS offices. To locate local DHS offices, call DHS's Family Assistance Service Center at [1-866-311-4287](tel:1-866-311-4287) or visit the DHS website at [http://www.tennessee.gov/humanserv/st\\_map.htm](http://www.tennessee.gov/humanserv/st_map.htm).

Those interested in applying do not need an appointment at the county office to receive an application. One can be picked up at their county DHS office or they can have one mailed to them or they can apply on-line. To request an application, call the county office or the Family Assistance Service Center. Individuals can also apply online by visiting TennCare's website: <http://tennessee.gov/tenncare/mem-apply.html>.

If the person does not apply on-line, the application must be returned to the county DHS office for processing, by mail, fax or personal delivery. DHS recommends scheduling an intake appointment with a county DHS worker once the individual has completed the application. A face-to-face interview is not required but applicants should be sure to mention that they are in need of LTC services.

# Vermont

## Training Requirement for Vermont Producers

An agent of producer selling, soliciting or negotiating the sale of any long-term care insurance policy must complete one, eight (8) hour course specific to long-term care, not less than two hours of which shall contain Vermont-specific information including Vermont Medicaid information. The Vermont-specific information can be part of an eight-hour course or may be provided as a separate course.

## Vermont Medicaid

**Green Mountain Care** is the official state center for Vermont health insurance plans and coverage. Information about their programs can be found at [www.greenmountaincare.org](http://www.greenmountaincare.org).

Eligibility for Vermont Medicaid is based on income and resources. Vermonters enrolled in Medicare may also be eligible for Medicaid under certain circumstances. Coverage includes most services such as doctor visits, hospital care, prescription medicines, vision and dental care, long-term care, and physical therapy. Fees for Medicaid may include co-payments for outpatient services, prescription medicines and dentist visits. Co-payments are not required for those:

- under the age of 21
- pregnant women
- women in the 60 day post pregnancy period
- individuals in nursing facilities

To view a chart on the possible premium costs and current Vermont Medicaid information, visit this website: <http://www.greenmountaincare.org/vermont-health-insurance-plans/medicaid>

For further information on Vermont Medicaid, you can contact **Green Mountain Care** Member Services at (800)250-8427.

## **Vermont Long-Term Care Medicaid**

Vermont's Long-Term Care Medicaid Program is called *Choices for Care*. It assists Vermont residents pay for LTC in a location of their preference. *Choices for Care* is run by the Department for Children and Families' ([http://dcf.vermont.gov/esd/health\\_insurance/ltc\\_medicaid](http://dcf.vermont.gov/esd/health_insurance/ltc_medicaid)).

### **Choices for Care (Long-Term Care)**

*Choices for Care* is Vermont's Long-Term Care Medicaid Program. If you are eligible, it helps you pay for long-term care services in the setting of your choice.

Setting include:

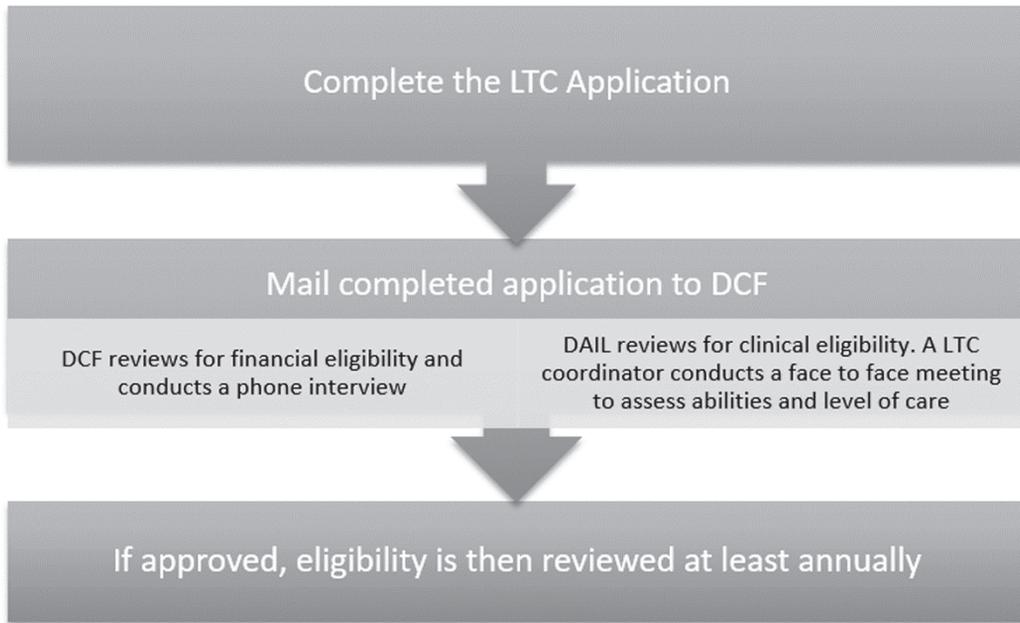
- Your home or the home of another person
- An approved residential care home or assisted-living facility
- An approved nursing home

### **Eligibility**

To be eligible, you must:

- Be a Vermont resident;
- Be at least 65 years old OR at least 18 years old with a physical disability;
- Meet the financial criteria; and
- Meet the clinical criteria for nursing home level of care.

## Application Process



## Services by Location

### Home-Based

- Case management
- Personal care services
- Adult day centers
- Respite for unpaid caregivers
- Companionship
- Emergency response
- Assistive devices
- Home modifications

### Residential Care Homes/Assisted-Living Facilities

- Case management
- Nursing overview & assessment
- Personal care services
- Medication management
- Recreational activities
- 24/7 onsite supervision
- Laundry services
- Housekeeping services

### Nursing Homes

- Room and board
- Skilled nursing & assessment
- Personal care
- Medication management
- Pharmacy services
- Social worker
- Recreational activities
- 24/7 onsite nursing care & supervision
- Laundry and housekeeping services
- Transportation services
- Physical, occupational, & speech therapy
- Nutrition and dietary services

## Information Resources

If you have questions about financial eligibility, call ESD's Benefits Service Center at 1-800-479-6151. Stay on the line. Wait to hear what number to push to speak to an agent. The agent will transfer you to a long-term-care worker who can help.

If you have questions about clinical eligibility, call the DAIL Long-Term Care coordinator in your area of the state.

If you want more detailed information about Choices for Care

- read the Participant Handbook (<http://ddas.vermont.gov/ddas-publications/publications-cfc/choices-for-care-participant-handbook>)
- go to the DAIL Choices for Care website at:  
<http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page>

## Vermont Long-Term Care Partnership (Rule H-2009-1; Appendix H)

### Partnership Program Notice

This Notice explains how the Vermont Long-Term Care Partnership Program works and provides important consumer information regarding the policies that are certified as Partnership Policies.

### The Vermont Long-Term Care Partnership Program

Some long-term care insurance policies sold in Vermont may qualify for the Vermont Long-Term Care Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term

care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Vermont's Medicaid program.

### Asset Protection

Long-term care insurance helps individuals prepare for future long-term care needs. Qualified Partnership Policies provide an additional level of protection. In particular, such policies may permit individuals to protect resources under Vermont's Medicaid Program if assistance is ever needed under that program and the individual would be otherwise eligible for the Vermont Medicaid program.

In addition, if these specific protected resources are still in existence when the individual dies and they are part of the decedent's probate estate, they will not be recoverable under state law. The resource, eligibility and estate recovery provisions of the Vermont Medicaid Program permit the disregard of an amount of assets which is equal to the amount of insurance benefits you have received from your qualified Partnership Policy. For example, if you receive \$200,000 of insurance benefits from your qualified Partnership Policy, you would be able to retain \$200,000 of resources and still be eligible for long-term care services provided under the Medicaid Program. This disregard is above and beyond the resources normally permitted to be retained by an individual and still qualify for Medicaid. (Note: special rules may apply to persons whose home equity exceeds \$500,000.) This protection of assets applies to individuals in need of long-term care services both in the community or residing in a long-term care facility.

It is important to understand that all other Medicaid eligibility criteria will apply at the time you apply for Medicaid. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*** In addition, please note that Medicaid eligibility requirements may change over time.

Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs.

## Asset Disregard

Long-term care insurance helps individuals prepare for future long-term care needs. Qualified Partnership Policies provide an additional level of protection. In particular, such policies may permit individuals to protect resources under Vermont's Medicaid Program if assistance is ever needed under that program and the individual would be otherwise eligible for the Vermont Medicaid program.

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

***Asset Disregard.*** Asset disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. In addition, if these specific protected resources are still in existence when the individual dies and they are part of the decedent's probate estate, they will not be recoverable under state law.

The resource, eligibility and estate recovery provisions of the Vermont Medicaid Program permit the disregard of an amount of assets which is equal to the amount of insurance benefits you have received from your qualified Partnership Policy. For example, if you receive \$200,000 of insurance benefits from your qualified Partnership Policy, you would be able to retain \$200,000 of resources and still be eligible for long-term care services provided under the Medicaid Program. This disregard is above and beyond the resources normally permitted to be retained by an individual and still qualify for Medicaid. (Note: special rules may apply to persons whose home equity exceeds \$500,000.) This protection of assets applies to

individuals in need of long-term care services both in the community or residing in a long-term care facility.

It is important to understand that all other Medicaid eligibility criteria will apply at the time you apply for Medicaid. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*** In addition, please note that Medicaid eligibility requirements may change over time.

### Partnership Policy Requirements

In order for a policy to be considered a Qualified State Long-Term Care Insurance Partnership Policy, it must meet the following requirements:

- The policy covers an insured who was a resident of Vermont (or a Partnership State) when coverage first became effective under the policy.
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986; as amended, and was issued no earlier than the effective date of Vermont's plan amendment required by section 6021 of the Deficit Reduction Act of 2005.
- The policy must meet all of the applicable requirements including the consumer protection standards of the National Association of Insurance Commissioners long-term care insurance model act and model regulation as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 USC Section 1396p(b)(5)(A)).
- meets the following inflation protection requirements:
  - For ages 60 or younger, the policy must provide Compound annual inflation protection
  - For ages 61 to 65, the policy must provide some level of inflation protection
  - For ages 76 and older, the policy does not have to provide inflation protection.

### Partnership Policy Disqualification

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

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

### Additional Consumer Protections

In addition to providing asset protection, a qualified Partnership Policy has other important features. Partnership Policies must be qualified long-term care insurance contracts under Federal tax law. As such the insurance benefits you receive from the policy generally will be subject to beneficial income tax treatment. (Please note that a policy can be a tax qualified long-term care insurance contract under Federal tax law, with the same beneficial income tax treatment, even if it is not a Partnership Policy.) In addition, if you were under age 76 when you purchased your qualified Partnership Policy, it must provide inflation protection to help protect against potential future

increases in the cost of long-term care. (Purchasers over the age of 76 must be offered the option of purchasing a policy with inflation protection).

**Additional Information.** If you have questions regarding the insurance policy please contact your carrier. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Vermont Health Access Member Services at 1-800-250-8427.

**Drafting Note:** This form is intended for use with individual long-term care insurance. The insurer may modify these forms for use with group long-term care insurance without filing with the Department so long as no substantive revisions are made. For example, the term "policy" may be replaced with "certificate" or "coverage," and the term "policyholder" may be replaced with "certificateholder."

# Virginia

## Virginia Partnership Policies

The state of Virginia LTC Partnership program became effective on September 1, 2007. These are the rules that have been developed as part of this implementation.

The following information was compiled based on information published in the following sources:

*Administrative Letter 2007-3 dated May 1, 2007, as released by the State Corporation Commission Bureau of Insurance of the Commonwealth of Virginia.*

*Virginia Administrative Code, Title 14, Agency No. 5, State Corporation Commission, Bureau of Insurance, Life and Health Chapter 200, Rules Governing Long-Term Care Insurance (14VAC 5-200-205)*

*Virginia Long-Term Care Insurance Partnership, [www.valtccpartnership.org](http://www.valtccpartnership.org)*

### Agent Training

The State Corporation Commission recently adopted revisions to the Rules Governing Long-Term Care Insurance, 14 VAC 5-200-10 et seq., (the Rules). The Rules were revised primarily to address requirements necessary to establish a Public-Private Long-Term Care Partnership Program (Partnership Program), between the Commonwealth of Virginia and private insurance companies. The revisions to the Rules will become effective September 1, 2007, concurrent with the implementation date of the Partnership Program in Virginia. The purpose of this letter is to provide general guidance to companies that are considering offering Long-Term Care Partnership policies (Partnership Policies), in Virginia. This letter focuses only on two processes related to the sale of Partnership Policies in Virginia – agent training and Partnership Product qualification. Insurers are expected and required to review the revised Rules in their entirety to ensure that they are compliant with all the

requirements in the Rules, including those that may not necessarily relate directly to the Partnership Program.

**Resident Agents:** licensed agents in Virginia may not sell a Partnership Policy unless and until they have received the requisite eight (8) hours of initial training addressed in the Rules at 14 VAC 5-200-205 E. Thereafter, agent must receive at least four (4) hours of ongoing training every twenty-four (24) months. All training must be approved by the Insurance Continuing Education (CE) Board and must, at a minimum, consist of the specific topics identified in the Rules. Insurers are responsible for ensuring that their agents are appropriately trained, maintaining documentation of such training, and to produce training records should the Bureau request it. Agents who meet said Partnership training requirements will be considered “qualified” to sell Partnership policies.

**Nonresident Agents:** those nonresident agents who comply with their home state requirement need only take a two-hour Virginia specific course to meet the requirement in Virginia.

**Lapsed Agents:** agents who fail to complete the ongoing four hours of training within 24 months must again complete the initial 8 hours of training.

### Initial Training

- All training shall be approved as continuing education by the Insurance Continuing Education Board in accordance with Section 38.2-1867 of the Code of Virginia.
- 14 VAC 5-200-205 E 3(a): an agent must complete a course that consists of at least two (2) hours, covering the topics identified in this section of the regulation which specifies training on state and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid
- 14 VAC 5-200-205 E 3(b through f): an agent must complete recent relevant training to satisfy all or part of the remaining six (6) hours of the initial

training requirement, on the topics identified in this section of the regulation which specifies training in: available long-term care services and providers, changes or improvements in long-term care services or providers, alternatives to the purchase of private long-term care insurance, the effect of inflation on benefits and the importance of inflation protection, and consumer suitability and standards. This training is subject to the following;

- Prior to January 1, 2008: may receive credit for up to six (6) hours of CE approved training covering the topics in (b) through (f), and completed between January 1, 2005 and September 1, 2007
- On or after January 1, 2008: may receive credit for up to six (6) hours of CE approved training covering topics in (b) through (f), and completed on or after January 1, 2007
- All previous training must be designated as CE for long-term care. Training that is received in another state will be recognized to complete the training requirements relating to the topics in (b) through (f) so long as the training is CE approved and designated as CE in the subject of long-term care.

### Ongoing Training

The four (4) hours of ongoing training must, at a minimum, consist of two (2) hours relating to the topics identified in section (a) as described above, and two (2) hours relating to the topics identified in section (b) through (f) as described above.

### Partnership Product Requirements

To be designated as a LTC Partnership-eligible policy in Virginia, a policy must meet the following requirements:

- 1) The policy covers an insured who was a resident of the Commonwealth of Virginia (a Partnership State) when coverage first became effective under the policy with a due date on or after September 1, 2007.

- 2) The policy is a qualified long-term care insurance policy (QP) as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than September 1, 2007.
- 3) The policy meets all applicable requirements of 14VAC 5-200-205 and those of the National Association of Insurance Commissioners Long-term Care Model Act and Model Regulations as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 USC Section 1396p(b)(5)(A)).
- 4) The policy must provide the following inflation protection provisions:
  1. If the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy shall provide compound annual inflation protection equivalent to minimum provisions of 14VAC 5-200-100;
  2. If the policy is sold to an individual who has attained age 61 but has not attained age 76 by the date of purchase, the policy shall provide inflation protection at least equivalent to minimum provisions of 14VAC 5-200-100;
  3. If the policy is sold to an individual who has attained age 76 by the date of purchase, the policy may provide inflation protection, but shall at least comply with the provisions of 14VAC 5-200-100.

### Disclosure and Notices

An insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Form 200-A), outlining the requirements and benefits of a partnership policy. A similar notice may be used if approved by the commission. This notice is to be provided along with the required Outline of Coverage.

Insurers shall include the following information in or with the Outline of Coverage:

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20 year period.

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums are based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. Any insurer may use a reasonable hypothetical, or a graphical demonstration, for the purposes of this disclosure.

Any partnership policy issued or issued for delivery in the Commonwealth of Virginia shall include a Partnership Disclosure Notice (Form 200-B) explaining the benefits associated with a partnership policy and indicating that at the time of issue, the policy is a qualified state long-term care insurance partnership policy. A similar notice may be used if approved by the commission. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid.

#### Insurer's Product Offerings for Partnership

A partnership policy issued or issued for delivery in Virginia must be approved by the Commission in accordance with §38.2-316 of the Code of Virginia, and all applicable statutes and rules. Policies submitted for approval as Partnership Policies must also be accompanied by a Partnership Certification Form (Form 200-C), or a similar form filed and approved by the commission.

Insurers requesting the use of a previously approved LTC policy can submit the Partnership Certification Form, a copy of the previously approved policy or certificate, the approval date, and a notation that this previously approved policy with the new LTC Partnership requirements.

Sales of any approved LTC Partnership policies cannot begin prior to September 1, 2007.

## Insurer Responsibilities

- Agent training shall be verified by the insurer offering a partnership policy to ensure an agent has received the training required by 14 VAC 5-200-205 E before they agent is permitted to sell, solicit or negotiate the insurer's partnership policy.
- Each insurer shall maintain records with respect to the training of its agents qualified to sell, solicit or negotiate partnership policies, to include training received and that the agent has demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this Commonwealth. These records shall be maintained for a period of not less than five years and shall be made available to the commission upon request.
- Each insurer issuing a LTC Partnership policy shall provide regular reports to the United States Secretary of Health and Human Services (HHS) in accordance with regulations that provide notification of the date benefits were paid, the amount paid, the date the policy terminates, and such other information as the Secretary determines may be appropriate to the administration of partnerships.

## The Virginia LTC Partnership Policy

This program is designed to reward Virginia residents who plan ahead for their future long-term care needs. The program protects personal assets should there be a need to apply for Medicaid. The program is an alliance between private insurance companies and the state government to protect Virginia residents from depleting their savings and assets to pay for long-term care. The Virginia LTC Partnership Policies and non-Partnership LTC insurance policies are similar. Partnership policies have the added benefit of allowing policyholders to protect a portion of their assets if they choose to apply for Medicaid using dollar-for-dollar asset protection.

### Dollar-for-Dollar Asset Protection

For every dollar that a LTC Partnership Policy pays out in benefits, a dollar of assets can be protected for purposes of determining Medicaid eligibility. For example, if the policyholder were to receive \$75,000 in benefits, the policyholder could then apply to Virginia's Medicaid program for assistance and still keep \$75,000 in assets (in addition to the \$2,000 everyone is allowed to keep and any other asset allowances under Medicaid). This feature is NOT available under non-qualified Partnership Policies.

The amount of the dollar-for-dollar asset protection is calculated based on:

- The amount of benefits paid by the LTC insurance company on the policyholder's behalf.
- It is not necessarily equal to the amount of the premiums paid or the maximum benefit.

### Inflation Protection

The following is a breakdown of the minimums referred to previously with regard to 14VAC 5-200-100.

An insurer 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 5%
2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status; so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made, or

3. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

When the policy is a group policy, the required offer shall be made to each proposed certificate holder; except if the policy is issued to a continuing care retirement community the offering shall be made to the group policyholder.

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

#### Importance of the Policy Issue Date

All Partnership policies must be issued after the program start date of September 1, 2007. No existing LTC policies will be "grandfathered" into the program.

#### Reciprocity

As of January 2009, Virginia participates in the national reciprocity agreement. Most, but not all states, are participating in this agreement. Under this agreement, policies will include dollar-for-dollar asset protection in other states. Applicants must still meet the Medicaid requirements in the state of application.

#### Carriers Approved to Solicit Long-Term Care Partnership Policies

To view the most up to date list of carriers who have been approved in Virginia to offer Partnership policies, visit this website:

<http://www.scc.virginia.gov/division/boi/webpages/inspagedocs/ltclist.pdf>

#### Dates of Note

State Plan Amendment Approval Date: December 19, 2006

State Plan Amendment Effective Date: January 1, 2007

Partnership Program Implementation Date: September 1, 2007

## **The Virginia Medicaid Program**

The Virginia Medicaid program is administered by the Department of Medical Assistance Services (DMAS). The program is authorized under Title XIX of the Social Security Act providing coverage of medical services for disabled and low income individuals. It is a program financed by the state and federal governments and then administered by the state for coverage of medical services for specific groups of low-income people within the guidelines established at the federal level. Federal financial assistance is provided to states. The federal match rate is based on the state's per capita income. The federal match rate for Virginia is currently 50%, meaning that for every dollar expended in the Medicaid program, 50 cents is from the federal government and 50 cents is from the state's general fund.

Medicaid is the largest healthcare program in Virginia. It provides for five distinct healthcare policy roles:

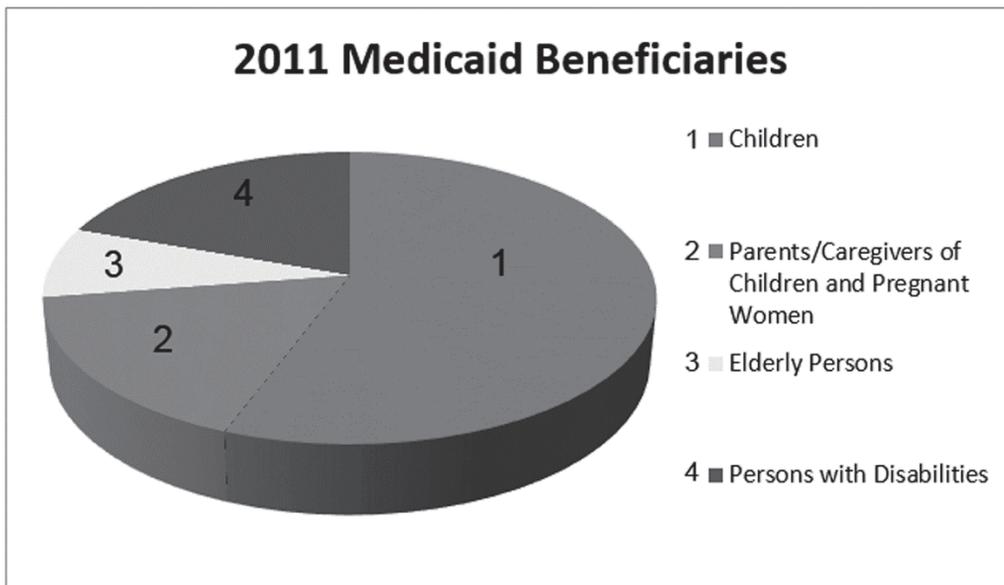
1. Ensuring access to healthcare for low-income pregnant women and children through prenatal care, delivery, and comprehensive coverage for children.
2. Provides access to care for low-income adults with children by establishing a set of mandatory and optional health care benefits.
3. Provides for chronic and long-term care needs of seniors and individuals with disabilities through institutional and community-based care services.
4. Finances the safety net for the uninsured who are not Medicaid eligible through community health centers and disproportionate share funding to hospitals.
5. Fills gaps in Medicare coverage for "dual eligible" through payment for Medicare premiums and deductibles, nursing home benefits, medical equipment, and some pharmacy costs.

### Individuals Covered by Medicaid

Medicaid eligibility is primarily for individuals such as low-income children, pregnant women, the elderly, persons with disabilities, and parents meeting specific income

thresholds. States establish their own income and asset eligibility criteria and in Virginia, income and resource requirements will vary by category.

The Virginia Medicaid population for fiscal year 2011 was comprised of:



The first two categories make up over 70% of the Medicaid beneficiaries; however, its seniors and individuals with disabilities that account for the majority of Medicaid spending due to costly acute and long-term care services.

*Source: The Virginia Medicaid Program at a Glance, February 2012.*

### Services Covered Under Medicaid

The Virginia Medicaid program covers all of the federally mandated services, including, but not limited to:

- Inpatient and outpatient hospital services
- Emergency hospital services

- Physician and nurse midwife services
- Federally qualified health centers and rural health clinic services
- Laboratories and x-ray services
- Transportation services
- Family planning services and supplies
- Nursing facility services
- Home health services (nurse, aide), and
- Early and Periodic Screening Diagnosis, and treatment program for children (EPSDT)

Optional Services also including, but not limited to:

- Certified pediatric nurse and family nurse practitioner services
- Routine dental care for persons under age 21
- Prescription drugs
- Rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services
- Home health services (PT, OT, SLP)
- Hospice
- Some mental health services
- Some substance abuse services, and
- Intermediate care facilities for persons with developmental and intellectual disabilities and related conditions

The Status of Virginia Medicaid

- Average number of enrollments has increased by 68% each month (2002–2012)

- Growing number of individuals enrolling due to a disability and the expansion of children's enrollment
- Virginia eligibility criteria remain among the strictest in the nation
- Expenditures continue to increase (consistent with other state increases)
- Virginia has higher than average per capita income (ranked 8th in 2010), yet Virginia ranks 24th in Medicaid spending per recipient (2008)
- Virginia ranks near the lowest levels nationally regarding Medicaid spending per capita (48th in 2009)

*Source: The Virginia Medicaid Program at a Glance, February 2012.*

### Medicaid Funded Long-Term Care Services

Medicaid is the main source of funding for long-term care services in Virginia. Medicaid covers services for low income seniors and individuals with disabilities in both institutional and community-based settings. Those who need long-term care services must meet both financial and functional eligibility criteria to qualify for Medicaid funded long-term care.

### Non-Financial Eligibility Requirements

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. Non-financial eligibility requirements apply to all Medicaid applicants and recipients, including those individuals in long-term care. These requirements include citizenship, Virginia residency, social security number, assignment of rights, application for other benefits, institutional status, and covered groups eligibility.

### Facility Care

Virginia Medicaid provides benefits for care in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. As some institutions have both medical and residential sections, note that an individual in the residential portion of the institution is a

resident of a residential facility and not a patient in a medical facility, whereas the individual in the medical section of the institution is a patient in a medical facility.

### Ineligible Individuals

- Inmates in a public institution
- Individuals under the age of 65 who are patients in an institution for mental diseases

### Types of Medical Institutions

- Chronic Disease Hospitals (aka "long-stay hospitals")
  - Hospital for Sick Children in Washington DC
  - Lake Taylor Hospital in Norfolk, VA
- Hospitals and/or Training Centers for the Mentally Retarded
- Institutions for Mental Diseases (IMDs)
- Intermediate Care Facility (ICF)
- Nursing Facility
- Rehabilitation Hospitals

## **Community-Based Care Waiver Services**

Virginia Medicaid provides coverage for long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living. Medicaid beneficiaries also receive coverage through these waiver programs. The program provides community-based long-term care services as an alternative to institutionalization. The following is a list of programs available to beneficiaries who meet the criteria:

- HIV/AIDS Waiver
- Alzheimer's Waiver

- Day Support for Persons with Intellectual Disabilities Waiver
- Elderly or Disabled with Consumer-Direction (EDCD) Waiver
- Intellectual Disability Waiver
- Technology Assisted Waiver
- Individual and Family Development Disabilities Support Waiver

## **Program for All-Inclusive Care for the Elderly (PACE)**

This program is an alternative delivery option for long-term care recipients. It is designed specifically to allow Medicaid eligible individuals, 55 and up, meeting the nursing facility criteria, to access comprehensive coordinated care in their homes and communities. As of February 2012, there are eight PACE programs available across Virginia.

The program was developed out of the Community Model put forth by the Department of Medical Assistance Services (DMAS). The program was based off a system that had been in place for over ten years, serving Hampton Roads (Sentara Senior Community Center). At this time Phase I of the program, to implement seven full PACE sites across the Commonwealth, is complete. The program is in the early stages of Phase II, to implement additional PACE sites in underserved areas of the state.

While PACE is not a CBC Waiver program, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are the same as those for individuals enrolled in the EDCD Waiver.

## **Financial Eligibility Requirements**

An individual in LTC must meet the financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services. Any individual whose Medicaid eligibility was determined prior to entering LTC must have their financial eligibility evaluated and determined including asset transfer evaluation,

home ownership and other resource evaluation. Financial eligibility requirements for an individual will differ depending on the individual's covered group, marital status, and type of long-term care.

## **Income**

Income includes earned income, such as wages and self-employment, as well as other income such as Social Security, retirement pensions, Veteran's benefits, child support, etc. All sources of income are added together and compared against the income limit to determine eligibility.

Income limits vary according to the covered group and the type of coverage. For some groups, the income limits vary depending on the county or city where you reside. Total "gross income" is evaluated; deductions are allowed according to the Medicaid policy, and the amount of income remaining is then compared to the appropriated Medicaid limit.

## **Resources (Assets)**

Resources include money on hand, in the bank and in a safe deposit box, stocks, bonds, certificates of deposit, trusts, or pre-paid burial plans. Resources also include cars, boats, life insurance policies, and real property. Not all resources are counted when determining eligibility for Medicaid. Example: all vehicles must be reported, but one vehicle is not a countable resource for Medicaid purposes. Resources that are sold or given away for less than what they are worth can cause ineligibility for Medicaid coverage of long-term care services for a defined period of time.

## **Long-Term Care (LTC) Asset Transfer**

Applicants for LTC services under Medicaid are required to disclose all transfers of assets (resources) that occurred within the five year prior. This includes but is not limited to; transferring the title of a vehicle, removing your name from a property deed, setting up a trust, or giving away money. Those individuals who sell, give away, or dispose of assets without receiving adequate compensation may be deemed

ineligible for Medicaid payment of long-term care services for a period of time. This can be overcome should the Medicaid program determine that the denial of Medicaid eligibility would cause an undue hardship. Be aware that transfers occurring after enrollment in Medicaid could also result in penalty for payment of LTC services.

## **Special Rules for Married Individuals Who Need Long Term Care**

Medicaid has special rules in place to determine the eligibility of an individual when the individual receives long-term care and the spouse does not. These rules are considered "spousal impoverishment protections". Under this rule a certain amount of resources and income are evaluated to determine how much can be reserved for the spouse who remains at home without having an impact on the Medicaid eligibility of the other spouse.

## **Applying for Medicaid**

A common question arises as to when a partnership policyholder should apply for Medicaid. Virginia lists three points to address this issue:

1. Anytime: Everyone in the state of Virginia has the right to apply for Medicaid at anytime
2. Exhaustion of Benefits: when the partnership policyholder has exhausted the benefits of their LTC partnership policy
3. Hardship and Need: when the partnership policyholder, their family/spouse, feels that the individual is experiencing difficulty and hardship paying for care.

*Note: Exhaustion of the LTC Partnership policy does NOT mean that an individual will automatically qualify for Medicaid. The individual must be eligible in order to qualify for coverage.*

## **Understanding Medicaid and Partnership**

The purchase of a LTC Partnership policy does NOT guarantee access to Medicaid. In the state of Virginia the following is true with regard to Medicaid:

- Medicaid eligibility is extremely complex and must be determined on an individual, case-by-case basis
- Medicaid eligibility determinations are completed by the applicant's local department of social services
- Medicaid has both financial and non-financial requirements
- Financial requirements involve the evaluation of both income and resources (assets)
- Non-financial requirements include Virginia residency, proof of citizenship and identity, provision of a Social Security number, and meeting the required level of care for LTC services.
- Medicaid eligibility has special rules for married people, especially important when only one spouse is receiving LTC services.
- Medicaid eligibility has special rules that apply to home property in which the applicant resides, vehicles, and burial arrangements.

### **For Additional Information:**

Virginia Department of Medical Assistance Services (DMAS)  
600 East Broad Street, Suite 1300  
Richmond, VA 23219-1857

Phone: 804-786-7933  
TDD: 800-343-0643

[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

# Washington State

## Rules and Regulations for LTC

### Chapter 48.84 RCW: Long Term Care Insurance Act

- 48.84.010** General provisions, intent.
- 48.84.020** Definitions.
- 48.84.030** Rules—Benefits-premiums ratio, coverage limitations.
- 48.84.040** Policies and contracts—Prohibited provisions.
- 48.84.050** Disclosure rules—Required provisions in policy or contract.
- 48.84.060** Prohibited practices.
- 48.84.070** Separation of data regarding certain policies.
- 48.84.900** Severability—1986 c 170.
- 48.84.910** Effective date, application—1986 c 170.

**NOTES:** *Long-term care insurance plans for eligible public employees: RCW 41.05.065.*

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#### **RCW 48.84.010 General provisions, intent.**

This chapter may be known and cited as the "long-term care insurance act" and is intended to govern the content and sale of long-term care insurance and long-term care benefit contracts issued before January 1, 2009, as defined in this chapter. This chapter shall be liberally construed to promote the public interest in protecting purchasers of long-term care insurance from unfair or deceptive sales, marketing, and advertising practices. The provisions of this chapter shall apply in addition to other requirements of Title 48 RCW.

[2008 c 145 § 19; 1986 c 170 § 1.]

**NOTES: Severability—Effective date—2008 c 145:** See RCW 48.83.900 and 48.83.901.

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## **RCW 48.84.020 Definitions.**

Unless the context requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Long-term care insurance" or "long-term care benefit contract" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Such terms do not include and this chapter shall not apply to policies or contracts governed by chapter 48.66 RCW and continuing care retirement communities.

(2) "Loss ratio" means the incurred claims plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

(3) "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

(4) "Medicare" means Title XVIII of the United States social security act, or its successor program.

(5) "Medicaid" means Title XIX of the United States social security act, or its successor program.

(6) "Nursing home" means a nursing home as defined in RCW **18.51.010**.

[1986 c 170 § 2.]

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## **RCW 48.84.030 Rules—Benefits-premiums ratio, coverage limitations.**

(1) The commissioner shall adopt rules requiring reasonable benefits in relation to the premium or price charged for long-term care policies and contracts which rules may include but are not limited to the establishment of minimum loss ratios.

(2) In addition, the commissioner may adopt rules establishing standards for long-term care coverage benefit limitations, exclusions, exceptions, and reductions and for policy or contract renewability.

[1986 c 170 § 3.]

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## **RCW 48.84.040 Policies and contracts—Prohibited provisions.**

No long-term care insurance policy or benefit contract may:

(1) Use riders, waivers, endorsements, or any similar method to limit or reduce coverage or benefits;

(2) Indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(3) Be canceled, nonrenewed, or segregated at the time of rating solely on the grounds of the age or the deterioration of the mental or physical health of the covered person;

(4) Exclude or limit coverage for preexisting conditions for a period of more than one year prior to the effective date of the policy or contract or more than six months after the effective date of the policy or contract;

(5) Differentiate benefit amounts on the basis of the type or level of nursing home care provided;

(6) Contain a provision establishing any new waiting period in the event an existing policy or contract is converted to a new or other form within the same company.

[1986 c 170 § 4.]

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## **RCW 48.84.050 Disclosure rules—Required provisions in policy or contract.**

(1) The commissioner shall adopt rules requiring disclosure to consumers of the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions contained in a long-term care insurance policy or contract. In adopting such rules the

commissioner shall require an understandable disclosure to consumers of any cost for services that the consumer will be responsible for in utilizing benefits covered under the policy or contract.

(2) Each long-term care insurance policy or contract shall include a provision, prominently displayed on the first page of the policy or contract, stating in substance that the person to whom the policy or contract is sold shall be permitted to return the policy or contract within thirty days of its delivery. In the case of policies or contracts solicited and sold by mail, the person may return the policy or contract within sixty days. Once the policy or contract has been returned, the person may have the premium refunded if, after examination of the policy or contract, the person is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy or contract to the insurer or insurance producer. If a person, pursuant to such notice, returns the policy or contract to the insurer at its branch or home office, or to the insurance producer from whom the policy or contract was purchased, the policy or contract shall be void from its inception, and the parties shall be in the same position as if no policy or contract had been issued.

(3) No later than January 1, 2010, or when the insurer has used all of its existing paper long-term care insurance policy forms which were in its possession on July 1, 2009, whichever is earlier, the notice required by subsection (2) of this section shall use the term insurance producer in place of agent.

[2008 c 217 § 67; 1986 c 170 § 5.]

**NOTES: Severability—Effective date—2008 c 217:** See notes following RCW 48.03.020.

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## **RCW 48.84.060 Prohibited practices.**

No insurance producer or other representative of an insurer, contractor, or other organization selling or offering long-term care insurance policies or benefit contracts may: (1) Complete the medical history portion of any form or application for the purchase of such policy or contract; (2) knowingly sell a long-term care policy or contract to any person who is receiving medicaid; or (3) use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies or contracts.

[2008 c 217 § 68; 1986 c 170 § 6.]

**NOTES: Severability—Effective date—2008 c 217:** See notes following RCW 48.03.020.

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## **RCW 48.84.070 Separation of data regarding certain policies.**

Commencing with reports for accounting periods beginning on or after January 1, 1988, all insurers, fraternal benefit societies, health care services contractors, and health maintenance organizations shall, for reporting and recordkeeping purposes, separate data concerning long-term care insurance policies and contracts from data concerning other insurance policies and contracts.

[1986 c 170 § 7.]

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## **RCW 48.84.900 Severability—1986 c 170.**

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

[1986 c 170 § 9.]

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## **RCW 48.84.910 Effective date, application—1986 c 170.**

RCW **48.84.060** shall take effect on November 1, 1986, and the commissioner shall adopt all rules necessary to implement RCW**48.84.060** by its effective date including rules prohibiting particular unfair or deceptive acts and practices in the advertising, sale, and marketing of long-term care policies and contracts. The commissioner shall adopt all rules necessary to implement the remaining sections of this chapter by July 1, 1987, and the remaining sections of this chapter shall apply to policies and contracts issued on or after January 1, 1988.

[1986 c 170 § 10.]

## Chapter 284-83 WAC: Long Term Care Insurance Rules

### WAC 284-83-005 Applicability and Scope.

(1) Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies delivered or issued for delivery in this state on or after January 1, 2009, including qualified long-term care policies and life insurance policies that accelerate benefits for long-term care. This chapter applies to insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations and all similar entities (collectively called "issuers" in this chapter).

(2) Some sections of this chapter apply only to qualified long-term care insurance policies, as provided for by the Health Insurance Portability and Accountability Act of 1996 and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(3) This chapter applies to policies delivered or issued for delivery in this state having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(b) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(c) Benefits under the policy commence after the policyholder has reached Social Security's normal retirement age, unless the benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

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### WAC 284-83-010 Definitions and standards.

For the purpose of this chapter, the following definitions and standards apply, unless the context clearly requires otherwise.

(1) "Certificate" has the meaning set forth in RCW **48.83.020**(2).

(2) "Exceptional increase" means only those increases filed by the issuer 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 issuers of similar products. Except as provided in WAC **284-83-090**, 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, must also determine any potential offsets to higher claims costs.

(3) "Incidental," as used in WAC **284-83-090**, means a value of the long-term care benefits provided that is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

(4) "Group long-term care insurance" has the meaning set forth in RCW **48.83.020**(6).

(5) "Guaranteed renewable" means that renewal of a long-term care insurance policy cannot be declined by the issuer for any reason except nonpayment of premiums, but the issuer can revise rates on a class basis.

(6) "Insured" means any beneficiary or owner of a long-term care policy regardless of the type of issuer.

(7) "Issuer" has the meaning set forth in RCW **48.83.020**(4).

(8) "Noncancellable" means that renewal of a long-term care insurance policy cannot be declined and rates cannot be revised by the issuer.

(9) "Policy" has the meaning set forth in RCW **48.83.020**(7), unless the context clearly indicates otherwise, and includes certificates issued under a group policy.

(10) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(11) "Qualified long-term care insurance" has the meaning set forth in RCW **48.83.020**(8).

(12) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by the issuer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in RCW **48.83.020** (6)(a) are not considered similar to certificates or policies otherwise

issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: Institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

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## **WAC 284-83-015 Standards for policy definitions and terms.**

A long-term care insurance policy or certificate delivered or issued for delivery in this state must not use the following terms unless the terms are defined in the policy or certificate and the definitions satisfy the following standards. This section specifies minimum standards for several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(2) "Acute condition" means that the individual is medically unstable. An individual with an acute condition requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" or "adult day health care" means a program of social or 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.

(4) "Bathing" 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.

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

(6) "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 caring for catheter or colostomy bag).

(7) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(8) "Eating" 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.

(9) "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(10) "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(11) "Managed-care plan" or "plan of care" means 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.

(12) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services must be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(15) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(16) "Transferring" means moving into or out of a bed, chair or wheelchair.

(17) "Skilled nursing facility," "nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," "home care agency" and terms used to identify other providers of services must be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it must also state what requirements a provider must meet in lieu of licensure, certification or registration if the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

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## **WAC 284-83-020 Standards for policy provisions.**

The following standards for policy provisions apply to all long-term care insurance policies delivered or issued for delivery in this state.

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" must not be used in any individual long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements of WAC **284-83-035**.

(a) A policy or certificate issued to an individual must not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

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

(c) The term "noncancellable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to unilaterally make any change in any provision of the insurance and has no right to unilaterally make any change in the premium rate.

(d) The term "level premium" may be used only if the issuer does not have the right to change the premium.

(e) In addition to the other requirements of this subsection, a qualified long-term care insurance policy or certificate must be guaranteed renewable, within the meaning of Section 7702B (b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and exclusions. A long-term care policy or certificate shall not be delivered or issued for delivery in this state as long-term care insurance if it limits or excludes coverage by type of illness, treatment, medical condition or accident, except for the following permitted exclusions:

(a) Preexisting conditions or diseases;

(b) Alcoholism and drug addiction;

(c) Illness, treatment or medical condition arising out of war or act of:

(i) War (whether declared or undeclared);

- (ii) Participation in a felony, riot or insurrection;
- (iii) Service in the armed forces or units auxiliary thereto;
- (iv) Suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury; or
- (v) Aviation (this exclusion applies only to nonfare-paying passengers);
- (d) 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;
- (e) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;
- (f) In the case of a qualified long-term care insurance policy only, 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;
- (g) Issuers may not prohibit, exclude or limit services based on type of provider or limit a coverage if services are provided in a state other than the state where the policy was originally issued, except:
  - (i) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, unless the provider satisfies the policy requirements outlined for providers in lieu of licensure certificate or registration; or
  - (ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
  - (iii) Issuers may exclude or limit payment for services provided outside the United States or permit or limit benefit levels to reflect legitimate variations or differences in provider rates, but issuers must cover services that would be covered in the state of issue irrespective of any licensing, registration or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved for payment.
- (3) Extension of benefits. Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began

while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(4) Continuation or conversion. Group long-term care insurance issued in this state on or after January 1, 2009, must provide covered individuals with a basis for continuation or conversion of coverage.

(a) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(i) Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy.

(ii) The commissioner will make a determination as to the substantial equivalency of benefits, and in doing so, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) For the purposes of this section, "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, is entitled to the issuance of a converted policy by the issuer under whose group policy he or she is covered, without evidence of insurability.

(c) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers 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 nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(d) Written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the issuer not later than thirty-one days after termination of coverage under the group policy. The converted policy must be issued effective on the day following the termination of coverage under the group policy, and must be renewable annually.

(e) Except where the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(f) Continuation of coverage or issuance of a converted policy is mandatory, except where:

(i) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(ii) The terminating coverage is replaced not later than thirty-one days after termination by group coverage effective on the day following the termination of coverage and the replacement coverage provides 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 is calculated in a manner consistent with the requirements of (e) of this subsection.

(g) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that 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 one hundred percent of incurred expenses. The provision may 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.

(h) 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, do not exceed those that would have been payable had the individual's coverage under the group policy remained in full force and effect.

(i) Notwithstanding any other provision of this section, the insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to

another person must be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(5) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding issuer must offer coverage to all insured persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the issuer and premiums charged to persons under the new group policy:

(a) Must not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

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

(6)(a) The premium charged to the insured must not increase due to either the increasing age of the insured at ages beyond sixty-five or the duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase; but for purposes of the calculation required under WAC **284-83-090**, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change; but for purposes of the calculation required under WAC **284-83-090**, the initial annual premium must be based on the reduced benefits.

(7) Electronic enrollment for group policies.

(a) In the case of a group, as defined in RCW **48.83.020** (6)(a), any requirement that a signature of the insured be obtained by an insurance producer or issuer will be deemed satisfied only if:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer and verification of enrollment information is provided to the insured;

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

(b) Upon request of the commissioner, the issuer must make available records that demonstrate the issuer's ability to confirm enrollment and coverage amounts.

(8) Each long-term care policy delivered or issued for delivery to any person in this state must clearly indicate on its first page that it is a "long-term care insurance" policy.

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## **WAC 284-83-025 Unintentional lapse.**

As a protection against unintentional lapse, each issuer offering long-term care insurance must comply with all of the following:

(1)(a) Notice before lapse or termination. No individual long-term care policy or certificate may be issued until the issuer 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.

(i) The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured.

(ii) Designation does not constitute acceptance of any liability on the third party for services provided to the insured.

(iii) The form used for the written designation must provide space clearly designated for listing at least one person.

(iv) The designation must include each person's full name and home address.

(v) If the applicant 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 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

(vi) No less frequently than once every two years the issuer must notify the insured of the right to change this written designation.

(b) 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 contained in (a) of this subsection need not be met until sixty days after the

policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for such policies or certificates must clearly show the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the issuer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to (a) of this subsection, 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 days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirements in subsection (1) of this section, 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 issuer 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.

(a) Reinstatement must be available to the insured if requested within five months after lapse and may allow for the collection of past due premium, where appropriate.

(b) The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

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## **WAC 284-83-030 Required disclosure provisions.**

(1) Renewability. Long-term care insurance policies must contain a renewability provision.

(a) The renewability provision must be appropriately captioned, must appear on the first page of the policy, and must clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder, such as long-term care policies which are part of or combined with life insurance policies because life insurance policies generally do not contain renewability provisions.

(b) A long-term care insurance policy or certificate, other than one where the issuer does not have the right to change the premium, must include a statement that premium rates may change.

(2) Riders and endorsements.

(a) Except for riders or endorsements by which the issuer 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 the date of issue, or at reinstatement or renewal, that reduce or eliminate benefits or coverage in the policy must require signed acceptance by the individual insured.

(b) After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in a writing signed by the insured, except when the increase in benefits or coverage is required by law.

(c) If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy, rider or endorsement.

(3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import, must include a definition and explanation of the terms in its accompanying outline of coverage, as set forth in WAC **284-83-145**.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy or certificate and must be labeled as "preexisting condition limitations."

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited under chapter **48.83** RCW, must set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and must label that paragraph "limitations or conditions on eligibility for benefits."

(6) Disclosure of tax consequences. At the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, a life insurance policy or certificate that provides an accelerated benefit for long-term care must disclose that receipt of the accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently

displayed on the first page of the policy, certificate or rider and any other related documents. This subsection does not apply to qualified long-term care insurance policies.

(7) Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure the insured's need for long-term care and must be described in the policy or certificate in a separate paragraph labeled "eligibility for the payment of benefits." Any additional benefit triggers must be explained in the same section.

(a) If benefit triggers differ for different benefits, a clear explanation of the benefit trigger must accompany each benefit description.

(b) If an attending physician or other specified person is required to certify a certain level of functional dependency in order for the insured to be eligible for benefits, this must be specified.

(8) A qualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC **284-83-145**, that the policy is intended to be a qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC **284-83-145**, that the policy is not intended to be a qualified long-term care insurance policy.

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## **WAC 284-83-035 Required disclosure of rating practices to consumers.**

(1)(a) Except as provided in (b) of this subsection, this section applies to any long-term care policy or certificate issued for delivery in this state on or after January 1, 2009.

(b) Certificates issued on or after January 1, 2009, under a group long-term care insurance policy as defined in RCW **48.83.020** (6)(a), that were in force prior to January 1, 2009, the provisions of this section apply on the policy anniversary first following January 1, 2009.

(2) Except for policies for which no applicable premium rate or rate schedule increases can be made, the issuer must provide all of the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the issuer must 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. For example, a method of delivery that does not allow for all

listed information to be provided at time of application or enrollment is an application by mail.

- (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 including:
  - (i) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date or next billing date); and
  - (ii) The right to a revised premium rate or rate schedule as provided for in (c) of this subsection if the premium rate or rate schedule is changed;
- (e)(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:
  - (A) The policy forms for which premium rates have been increased;
  - (B) The calendar years when the form was available for purchase; and
  - (C) 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.
- (ii) The issuer, in a fair manner, may provide additional explanatory information related to the rate increases.
- (iii) The issuer may exclude from the disclosure, premium rate increases that only apply to blocks of business acquired from other nonaffiliated issuers or the long-term care policies acquired from other nonaffiliated issuers when those increases occurred prior to the acquisition.
- (iv) If the acquiring issuer files for a rate increase on a long-term care policy form acquired from a nonaffiliated issuer or a block of policy forms acquired from a nonaffiliated issuer on or before the later of January 1, 2009, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring issuer may exclude that rate increase from the disclosure; however, the nonaffiliated selling issuer

must include the disclosure of that rate increase in accordance with (e)(i) of this subsection.

(v) If the acquiring issuer in (e)(iv) of this subsection files for a subsequent rate increase at any time (including during the twenty-four-month period following the acquisition of the block or policies) on the same policy form acquired from a nonaffiliated issuer or block of policy forms acquired from a nonaffiliated issuer referenced in (e)(iv) of this subsection, the acquiring issuer must make all disclosures required by (e) of this subsection, including disclosure of the earlier rate increase.

(vi) If the policy is for employer-group coverage, the disclosures in this subsection need to be made only to the employer if the employer is paying the entire premium and no contributions or coverage elections are made by individual employees.

(3) The 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 issuer made the disclosure required under subsection (2)(a) and (e) of this section. 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.

(4) The forms provided in WAC **284-83-170** and **284-83-190** must be used by the issuer to comply with the requirements of subsections (2) and (3) of this section.

(5) The issuer must provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least forty-five days prior to the implementation of any premium rate schedule increase by the issuer. The notice must include the information required by subsection (2) of this section when the rate increase is implemented.

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## **WAC 284-83-040 Initial rate filing requirements.**

The issuer must provide the following information to the commissioner no fewer than thirty days prior to making a long-term care insurance form available for sale in this state:

(1) A copy of each disclosure document required in WAC **284-83-035**; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is

reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for policy reserves that are anticipated to be held under the form, including:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating, where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or, if such a statement cannot be made, a complete description of the situations where this does not occur;

(A) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(B) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration based on a standard age distribution; and

(e)(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the issuer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the issuer with an explanation of the differences.

(3)(a) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include:

(i) Premium and claim experience on similar policy forms, adjusted for any premium or benefit differences;

(ii) Relevant and credible data from other studies; or

(iii) Both (a)(i) and (ii) of this subsection.

(b) In the event the commissioner asks for additional information, the period in subsection (2) of this section does not include the period during which the issuer is preparing the requested information.

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## **WAC 284-83-045 Prohibition against post-claims underwriting.**

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

(2)(a) If an application for long-term care insurance includes a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the prescribed medications.

(b) If the medications listed in the application were known by the issuer, or should have been known by the issuer 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 cannot be rescinded based on that condition.

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

(a) The following language must be set out conspicuously and in close conjunction with the applicant's signature block on the 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."**

(b) The following language, or language substantially similar to the following, must be set out conspicuously on every 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]"**

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the issuer must obtain one of the following:

- (i) A report of a physical examination;
- (ii) An assessment of functional capacity;
- (iii) An attending physician's statement; or
- (iv) Copies of the applicant's medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) must 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.

(5) Every issuer or other entity selling or issuing long-term care insurance benefits must maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily requested, and must annually furnish this information to the commissioner. The format is prescribed by the National Association Of Insurance Commissioners, and is set forth in WAC **284-83-165**.

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## **WAC 284-83-050 Minimum standards for home health and community care benefits in long-term care insurance policies.**

(1) If a long-term care insurance policy or certificate provides benefits for home health care or community care services, it must not limit or exclude benefits:

- (a) By requiring that the insured or claimant would need care in a nursing facility if home health care services were not provided;
- (b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;
- (c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered under 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;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) 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;

(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) By limiting benefits to services provided by medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) If a long-term care insurance policy or certificate provides for home health or community care services, it 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, at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(a) This permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy.

(b) Home health care benefits must not be restricted to a period of time which would make the benefit illusory. For example, fewer than three hundred sixty-five benefit days and less than a twenty-five dollar daily maximum benefit are considered illusory home health care benefits.

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## **WAC 284-83-055 Requirement to offer inflation protection.**

(1) No issuer may offer a long-term care insurance policy in this state unless the issuer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably

anticipated increases in the costs of long-term care services covered by the policy. Issuers 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:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than five percent.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit must be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) of this section must be made to the group policyholder; however, if the policy is issued to a group defined in RCW **48.83.020** (6)(d), other than to a continuing care retirement community, the offering must be made to each proposed certificate holder.

(3) The offer in subsection (1) of this section is not required of life insurance policies or riders containing accelerated long-term care benefits.

(4)(a) Issuers must include the following information in or with the outline of coverage:

(i) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a twenty-year period; and

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) The issuer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure. For example, meaningful benefit minimums or durations could be demonstrated by showing increases to attained age, for a period such as at least twenty years, for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a policy that includes these benefits must continue without regard to the insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases must include an offer of a premium which the issuer expects to remain constant. Unless the premium is guaranteed to remain constant, the offer must disclose in a conspicuous manner that the premium may change in the future.

(7)(a) Inflation protection as provided in subsection (1)(a) of this section must be included in any long-term care insurance policy unless the issuer obtains a rejection of inflation protection signed by the policyholder. The rejection may be either part of the application or on a separate form.

(b) The rejection is considered a part of the application.

(c) The following language, or language substantially similar to the following, must be set out conspicuously on the rejection:

**"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."**

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## **WAC 284-83-060 Requirements for application forms and replacement coverage.**

(1) Application forms must include questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other health or long-term care policy or certificate presently in force.

(a) A supplementary application or other form, signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by RCW **48.83.020** (6)(a), the required questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

(b) The following questions, or words substantially similar to the following, must be used:

(i) "Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?"

(ii) Did you have another long-term care insurance policy or certificate in force during the last twelve months? If so, with which company? If that policy lapsed, when did it lapse?

(iii) Are you covered by medicaid?

(iv) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?"

(2) Insurance producers must list any other health insurance policies they have sold to the applicant that are still in force and any similar policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, the issuer, other than an issuer using direct response solicitation methods, or its insurance producer, must furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of health care or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy must be signed by the applicant and must be retained by the issuer. The notice set forth in WAC **284-83-063** must be used.

(4) Direct response solicitations. Issuers using direct response solicitation methods must deliver a notice regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy. The required notice set forth in WAC **284-83-067** must be used.

(5) If replacement is intended, the replacing issuer must notify the existing issuer of the proposed replacement in writing. The existing policy must be identified by the issuer, including the name of the insured and policy number or address plus zip code. Notice must be made within five working days after the date the application is received by the issuer or the date the policy is issued, whichever is sooner.

(6) 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.

(a) If the policy being replaced is a life insurance policy, the issuer must comply with the replacement requirements of WAC **284-23-400** through **284-23-485**.

(b) If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing issuer must comply with both the long-term care and the life insurance replacement requirements.

## **WAC 284-83-063 Notice to applicant regarding replacement of individual accident and sickness or long-term care insurance marketed by an insurance producer.**

The following notice is required in WAC **284-83-060**(3):

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

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing [accident and sickness] [health] 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 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] [health] or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [INSURANCE PRODUCER 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 that 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. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new

policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

- (3) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its appointed [insurance producer] regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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(Signature of [Insurance Producer] or Other Representative)

[Typed Name and Address of [Insurance Producer]]

The above "Notice to Applicant" was delivered to me on:

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(Applicant's Signature)

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(Date)

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## **WAC 284-83-067 Notice to applicant regarding replacement of direct marketed individual accident and sickness or long-term care insurance.**

The following notice is required by WAC **284-83-060**(4):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF [ACCIDENT AND SICKNESS]  
[HEALTH] OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing [accident and sickness] [health] 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 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] [health] 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. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- (3) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its [agent] [insurance producer] regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (4) [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

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## **WAC 284-83-070 Reporting requirements.**

(1) Every issuer must maintain records for each insurance producer of that producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(2) Every issuer must report annually by June 30 the ten percent of its insurance producers with the highest percentages of lapses and replacements as measured by subsection (1) of this section on the form set forth in WAC **284-83-195**.

(3) 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 insurance producer activities regarding the sale of long-term care insurance.

(4) Every issuer must report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year on the form set forth in WAC **284-83-195**.

(5) Every issuer must report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year on the form set forth in WAC **284-83-195**.

(6) Every issuer must report annually by June 30, for qualified long-term care insurance policies, the number of claims denied for each class of business, expressed as a percentage of claims denied on the form set forth in WAC **284-83-185**.

(7) As used in this section:

(a) "Policy" refers only to long-term care insurance policies;

(b) "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means that the issuer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this section must be filed with the commissioner.

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## **WAC 284-83-075 Discretionary powers of commissioner.**

Upon written request and after an administrative hearing, the commissioner may enter an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- (1) The modification or suspension would be in the best interest of the insureds;
- (2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- (3)(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or  
(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or  
(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

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## **WAC 284-83-080 Reserve standards.**

(1) If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits must be determined in accordance with RCW **48.74.030** (1)(g). Claim reserves must also be established in the case when the policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits; however, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard must be given to

the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (a) Definition of insured events;
- (b) Covered long-term care facilities;
- (c) Existence of home convalescence care coverage;
- (d) Definition of facilities;
- (e) Existence or absence of barriers to eligibility;
- (f) Premium waiver provision;
- (g) Renewability;
- (h) Ability to raise premiums;
- (i) Marketing method;
- (j) Underwriting procedures;
- (k) Claims adjustment procedures;
- (l) Waiting period;
- (m) Maximum benefit;
- (n) Availability of eligible facilities;
- (o) Margins in claim costs;
- (p) Optional nature of benefit;
- (q) Delay in eligibility for benefit;
- (r) Inflation protection provisions; and
- (s) Guaranteed insurability option.

(2) If long-term care benefits are provided other than as provided in subsection (1) of this section, reserves must be determined in accordance with the accounting practices and procedures manuals adopted by the National Association Of Insurance Commissioners, unless otherwise provided by law, as required by RCW **48.05.073**.

(3) Any applicable valuation morbidity table must be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

## **WAC 284-83-090 Premium rate schedule increases.**

(1)(a) Except as provided in (b) of this subsection, this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2009.

(b) For certificates issued on or after January 1, 2009, under a group long-term care insurance policy as defined in RCW **48.83.020** (6)(a), which policy was in force before January 1, 2009, the provisions of this section apply on the first policy anniversary following January 1, 2009.

(2) The issuer must provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to giving the notice to the policyholders and must include:

(a) Information required by WAC **284-83-035**;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated;

(ii) The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the five years preceding and the three years following the valuation date must be provided separately.

(B) The projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase.

(C) The projections must demonstrate compliance with subsection (3) of this section.

(D) For exceptional increases:

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines that offsets may exist, the issuer must use appropriate net projected experience;

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the issuer have been relied on by the actuary;

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) Composite rates reflecting projections of new certificates, if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(e) Sufficient information for review of the premium rate schedule increase by the commissioner.

(3) All premium rate schedule increases must be determined in accordance with the following requirements:

(a) Exceptional increases must provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight percent;

(ii) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight percent; and

(iv) Eighty-five percent of the present value of future projected premiums not in (b)(iii) of this subsection on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in (b)(ii) and (iv) of this subsection will also include seventy percent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases must use the maximum valuation interest rate for policy reserves as specified in the accounting practices and procedures manuals adopted by the National Association Of Insurance Commissioners, except as otherwise provided by RCW **48.05.073**. The actuary must disclose as part of the actuarial memorandum the use of any appropriate averages.

(4) For each rate increase that is implemented, the issuer must file for review by the commissioner updated projections, as defined in subsection (2)(c)(i) of this section, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions set forth in subsection (11) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (2)(c)(i) of this section, must be filed for review by the commissioner every five years following the end of the required period in subsection (4) of this section. For group insurance policies that meet the conditions in subsection (11) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(6)(a) If the commissioner determines that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (3) of this section, the commissioner may require the issuer to implement either premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (2)(c)(v) of this section, as applicable.

(c) For purposes of this section:

(i) The term "adequately match the projected experience" requires more than a comparison between actual and projected incurred claims. Other assumptions should be

taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product.

(ii) It is to be expected that the actual experience will not exactly match the issuer's projections. During the period that projections are monitored, the commissioner will determine whether there is an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the issuer must file:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form, requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection (8) of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (8) of this section, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in subsection (3)(b)(i) and (iii) of this section.

(8)(a) For a rate increase filing that meets the following criteria for all policies included in the filing, the commissioner must review the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

(iii) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the issuer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the issuer to offer all in-force insureds subject to the rate increase the option to

replace existing coverage with one or more reasonably comparable products being offered by the issuer or its affiliates without underwriting.

(i) The offer shall:

(A) Be subject to the approval of the commissioner;

(B) Be based on actuarially sound principles, but not be based on attained age; and

(C) Provide that maximum benefits under any new policy accepted by the insured must be reduced by comparable benefits already paid under the existing policy.

(ii) The issuer must maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase will be limited to the lesser of:

(A) The maximum rate increase determined based on the combined experience; and

(B) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

(9) If the commissioner determines that the issuer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, in addition to the provisions of subsection (8) of this section, the commissioner may prohibit the issuer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Subsections (1) through (9) of this section do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in WAC **284-83-010**, if the policy complies with all of the following provisions:

(a) 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;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements (as applicable) in any of the following:

(i) Chapter **48.76** RCW;

(ii) RCW **48.23.420** through **48.23.450**; and

(iii) RCW **48.18A.050**;

(c) The policy meets the disclosure requirements of RCW **48.83.070**(2) and **48.83.080**;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable requirements in the following:

(i) Policy illustrations as required by chapter **48.23A** RCW;

(ii) Disclosure requirements in WAC **284-23-300** through **284-23-370**; and

(iii) Disclosure requirements in RCW **48.18A.030**;

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must 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 must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Subsections (6) and (8) of this section do not apply to group insurance policies as defined in RCW **48.83.020** (6)(a), if:

(a) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(b) The policyholder, and not the certificate holder, pays a material portion of the premium, which must not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

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### **WAC 284-83-095 Filing requirements.**

Prior to offering group long-term care insurance to a resident of this state pursuant to RCW [48.83.030](#), the issuer or similar organization must file with the commissioner evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those of this state.

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### **WAC 284-83-100 Filing requirements for advertising.**

(1) Every issuer or other entity issuing 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 for review by the commissioner. In addition, a copy of all advertisements must be retained by the issuer for at least three years after the date the advertisement was first used.

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

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### **WAC 284-83-105 Standards for marketing.**

(1) Every issuer or entity marketing long-term care insurance coverage in this state, directly or through its insurance producers, must:

(a) Establish marketing procedures and insurance producer training requirements to ensure that:

(i) Any marketing activities, including any comparison of policies, by its insurance producers, other representatives, or employees are fair and accurate; and

(ii) Excessive insurance is not sold or issued.

(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:

**"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."**

(c) Provide copies of the disclosure forms required in WAC **284-83-035(3)**, **284-83-170** and **284-83-190** to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance. For qualified long-term care insurance policies, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has health care coverage is not required.

(e) Every issuer or other entity marketing long-term care insurance must establish auditable procedures for verifying compliance with this subsection.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by its commissioner, at time of solicitation for long-term care insurance the issuer must provide written notice to the prospective policyholder and certificate holder that the counseling program is available and provide its name, address and telephone number.

(g) For long-term care insurance policies, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to WAC **284-83-020** (1)(c).

(h) Provide an explanation of contingent benefit upon lapse provided for in WAC **284-83-130** (4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in WAC **284-83-130** (4)(d).

(2) In addition to the practices prohibited in chapters **48.30** RCW and **284-30** WAC, the following acts and practices are prohibited:

(a) Twisting, as defined in RCW **48.30.180**.

(b) 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.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method

of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3)(a) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in RCW **48.83.020** (6)(b), when endorsing or selling long-term care insurance must be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations must provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The issuer must file with the commissioner the following material:

(i) The policy and certificate;

(ii) A corresponding outline of coverage; and

(iii) All advertisements requested by the commissioner.

(c) The association must disclose in any long-term care insurance solicitation:

(i) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(ii) A brief description of the process under which the policies and the issuer issuing the policies were selected.

(d) If the association and the issuer have interlocking directorates or trustee arrangements, the association must disclose that fact to its members.

(e) The board of directors of associations selling or endorsing long-term care insurance policies or certificates must review and approve the insurance policies as well as the compensation arrangements made with the issuer.

(f) The association must also:

(i) At the time of the association's decision to endorse the selling of long-term care insurance policies or certificates, engage the services of a person with expertise in long-term care insurance not affiliated with the issuer to conduct an examination of the

policies (including its benefits, features, and rates) and update the examination thereafter in the event of material change;

(ii) Actively monitor the marketing efforts of the issuer and its producers; and

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

Subsections (3)(f)(i) through (f)(iii) of this section do not apply to qualified long-term care insurance policies.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the issuer files with the commissioner the information required in this subsection.

(h) The issuer must not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the issuer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice.

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## **WAC 284-83-110 Suitability.**

(1) This section does not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every issuer or other entity marketing long-term care insurance must:

(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) Train its insurance producers in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

(3)(a) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and the issuer must develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) 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

(iii) 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.

(b) The issuer, and if an insurance producer is involved, the insurance producer must make reasonable efforts to obtain the information set out in subsection (2)(a) of this section. 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 set forth in WAC **284-83-170**, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the form of the issuer's personal worksheet must be filed with the commissioner.

(c) Except for sales of employer-group long-term care insurance to employees and their spouses, a completed personal worksheet must be returned to the issuer prior to the issuer's consideration of the applicant for coverage.

(d) The sale, distribution, use or dissemination in any way by the issuer or insurance producer of information obtained through the personal worksheet is prohibited.

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

(5) Insurance producers must use the suitability standards developed by the issuer in all marketing or solicitation of long-term care insurance.

(6) 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" must be provided. The form must be in the format set forth in WAC **284-83-175**, in not less than twelve point type.

(7) 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 may send the applicant a letter similar to the form set forth in WAC **284-83-180**. If the applicant declines to provide financial information, the issuer may use another method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification must be made part of the applicant's file.

(8) The issuer 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 applicants who chose to confirm after receiving a suitability letter.

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### **WAC 284-83-115 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates.**

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

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### **WAC 284-83-120 Availability of new services or providers.**

(1) The issuer must notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the issuer to the general public. The notice must be provided within twelve months after the date the new policy series is made available for sale in this state. Changes to policy structure or benefits or provisions that are minor in nature are not "new long-term care services or providers material in nature." Examples of when notification need not be provided include changes in elimination periods, benefit periods or benefit amounts.

(2) Notwithstanding subsection (1) of this section, notification is not required for any long-term care insurance policy issued prior to January 1, 2009, or to any policyholder or certificate holder who is currently eligible for benefits, within an elimination period or on a claim, previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy series. The issuer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium in order to add the new services or providers.

(3) The issuer must make the new coverage available in one of the following ways:

(a) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(b) By exchanging the existing policy or certificate for one with an issue age based on the attained age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits must be based on premiums paid or reserves held for the prior policy or certificate;

(c) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(d) By an alternative program developed by the issuer that meets the intent of this section if the program is filed with and approved by the commissioner.

(4) The issuer is not required to notify its policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means distribution through a discrete entity, such as a financial institution or brokerage, through which specialized products are made available that are not available for sale to the general public. Policyholders that purchase a new proprietary policy must be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(5) Policies issued pursuant to this section will be considered exchanges and not replacements. These exchanges are not subject to WAC **284-83-060** and **284-83-110**, and the reporting requirements of WAC **284-83-065** (1) through (5).

(6)(a) If the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in subsection (1) of this section must be made to the offering entity.

(b) If the policy is issued to a group defined in RCW **48.83.020** (6)(d), the notification must be made to each certificate holder.

(7) Nothing in this section prohibits the issuer from offering any policy, rider, certificate or coverage change to any policyholder or certificate holder. Upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The issuer may require the policyholder to meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

(8) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

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## **WAC 284-83-125 Right to reduce coverage and lower premiums.**

(1)(a) Every long-term care insurance policy and certificate must include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

- (i) Reducing the maximum benefit; or
- (ii) Reducing the daily, weekly or monthly benefit amount.

(b) The issuer may also offer other reduction options that are consistent with the policy or certificate design or the issuer's administrative processes.

(2) The provision must include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(3) The age to determine the premium for the reduced coverage must be based on the age used to determine the premiums for the coverage currently in force.

(4) The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(5) If a policy or certificate is about to lapse, the issuer must provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by WAC **284-83-025** (1)(c).

(6) Compliance with this section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

(7) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

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## **WAC 284-83-130 Nonforfeiture benefit requirement.**

(1) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(2) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of RCW **48.83.120**:

(a) A policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage issued by the issuer without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subsection (5) of this section; and

(b) The offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made under RCW **48.83.120** is rejected, the issuer must provide the contingent benefit upon lapse described in this section. The contingent benefit on lapse in subsection (4)(d) of this section applies even if this offer is accepted for a policy with a fixed or limited premium paying period.

(4)(a) After rejection of the offer required under RCW **48.83.120**, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the issuer must provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) A contingent benefit on lapse must be triggered every time the issuer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, and the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
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%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
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%

(d) A contingent benefit on lapse must also be triggered for policies with a fixed or limited premium paying period every time the issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, the policy or certificate lapses within one hundred

twenty days after the due date of the premium so increased, and the ratio in (f)(ii) of this subsection is forty percent or more. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due. This requirement is in addition to the contingent benefit provided by subsection (3) of this section and if both are triggered, the benefit provided must be at the option of the insured.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

(e) On or before the effective date of a substantial premium increase as defined in (c) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (5) of this section. This option may be elected at any time during the one hundred twenty-day period provided for in (c) of this subsection; and

(iii) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period provided for in (c) of this subsection will be deemed to be the election of the offer to convert in (e)(ii) of this subsection unless the automatic option in (f)(iii) of this subsection applies.

(f) On or before the effective date of a substantial premium increase as defined in (d) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the

number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period provided for in (d) of this subsection; and

(iii) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period provided for in (d) of this subsection will be deemed to be the election of the offer to convert in (f)(ii) of this subsection if the ratio is forty percent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (4)(c) but not (d) of this subsection, are described in this subsection:

(a) For purposes of this subsection, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

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

(c) The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The issuer 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 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (6) of this section.

(d)(i) 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 years as well as thereafter.

(ii) Notwithstanding (d)(i) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) 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.

(6) All benefits paid by the issuer while the policy or certificate is in premium-paying status or in paid-up status must not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

(7) No difference in the minimum nonforfeiture benefits as required under this section for group and individual policies is permitted.

(8) The requirements set forth in this section must become effective twelve months after adoption of this provision and must apply as follows:

(a) Except as provided in (b) and (c) of this subsection, this section applies to any long-term care policy issued in this state on or after January 1, 2009.

(b) This section does not apply to certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in RCW **48.83.020** (6)(a), if policy was in force on January 1, 2009.

(c) The last sentence in subsection (3) of this section and subsection (4)(d) and (f) of this section apply to any long-term care insurance policy or certificate issued in this state six months after their adoption, except as to new certificates on a group policy as defined in RCW **48.83.020** (6)(a), those sentences apply to any long-term care insurance policy or certificate issued in this state one year after adoption.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse is subject to the loss ratio requirements of WAC **284-83-085** or **284-83-090**, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (4)(c) or (d) of this section, a replacing issuer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another issuer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original issuer.

(11) A nonforfeiture benefit for qualified long-term care insurance policies that are level premium policies must be offered and must meet the following requirements:

(a) The nonforfeiture provision must be appropriately captioned;

(b) 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 policies approved by the commissioner for the same policy form; and

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

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the commissioner.

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## **WAC 284-83-135 Standards for benefit triggers.**

(1) A long-term care insurance policy must condition the payment of benefits on a determination of the insured's ability to perform activities of daily living or on cognitive impairment of the insured. Eligibility for the payment of benefits must 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.

(2)(a) Activities of daily living must include at least the following, as defined in WAC **284-83-015**, and must be defined in the policy:

(i) Bathing;

(ii) Continence;

(iii) Dressing;

(iv) Eating;

(v) Toileting; and

(vi) Transferring;

(b) Issuers may use activities of daily living to trigger covered benefits in addition to those contained in subsection (1)(a) of this section only if they are defined in the policy.

(3) The issuer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions must not restrict, and must not be in lieu of, the requirements contained in subsections (1) and (2) of this section.

(4) For purposes of this section the determination of a deficiency must not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

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

(5) Assessments of activities of daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) Long-term care insurance policies must include a clear description of the process for appealing and resolving benefit determinations.

(7)(a) Except as provided in (b) of this subsection, the provisions of this section apply to a long-term care policy issued in this state on or after January 1, 2009.

(b) The provisions of this section do not apply to certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in RCW **48.83.020** (6)(a) that were in force on January 1, 2009.

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## **WAC 284-83-140 Qualified long-term care insurance policies—Additional standards for benefit triggers.**

(1) For purposes of this section the following definitions apply:

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

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

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

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner certified that the individual meets these requirements.

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

(d) "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).

(2) A qualified long-term care insurance policy must pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance policy must condition the payment of benefits on a determination that the insured is a chronically ill individual as defined in subsection (1)(b)(i) of this section.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (3) of this section must be performed by a licensed or certified physician, registered professional nurse, licensed social worker, or other individual who meet requirements prescribed by the federal Secretary of the Treasury.

(5) Certifications required pursuant to subsection (3) of this section may be performed by a licensed health care professional at the direction of the issuer as is reasonably necessary with respect to a specific claim; except that when a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

## **WAC 284-83-145 Standard format outline of coverage.**

The following standards apply to the format and outline of coverage to be used in this state.

(1) The outline of coverage must be a free-standing document, using no smaller than ten-point type.

(2) The outline of coverage must contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) The following format for outline of coverage must be used in this state:

**[COMPANY NAME]**

**[ADDRESS - CITY & STATE]**

**[TELEPHONE NUMBER]**

**LONG-TERM CARE INSURANCE**

**OUTLINE OF COVERAGE**

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

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].

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of

coverage to outlines of coverage for other policies available to you. This is not an insurance policy, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY [OR CERTIFICATE] CAREFULLY!

### 3. FEDERAL TAX CONSEQUENCES.

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

### 4. 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 must 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 must 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.]

5. 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.]

6. 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.]

7. 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 insurance producers] neither [insert company name] nor its [agents] [insurance producers] 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.

8. 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.]

9. BENEFITS PROVIDED BY THIS POLICY.

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

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

(c) [Noninstitutional 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 must 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.]

#### 10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

(c) Noneligible 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.

11. 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.]

#### 12. ALZHEIMER'S DISEASE AND OTHER 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.]

#### 13. 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.]

#### 14. 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.

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### **WAC 284-83-150 Requirement to deliver shopper's guide.**

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

(a) In the case of solicitations by an insurance producer, the insurance producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

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

(2) Issuers or insurance producers of life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but must furnish the policy summary required by RCW **48.83.070**(2).

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### **WAC 284-83-155 Prohibited practices.**

The following practices are prohibited:

(1) No insurance producer or other representative of the issuer may complete the medical history portion of any form or application, including an electronic application, for the purchase of a long-term care policy.

(2) No issuer or insurance producer or other representative of the issuer may knowingly sell a long-term care policy to any person who is receiving medicaid.

(3) No issuer or insurance producer or other representative of the issuer may use or engage in any unfair or deceptive act or practice in the advertising, sale or marketing of long-term care policies.

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### **WAC 284-83-165 Form for reporting rescission of long-term care policies.**

The following form must be used by issuers to annually report rescission of long-term care policies.

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE  
OF \_\_\_ FOR THE REPORTING YEAR 20[ ]

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

Detailed reason for rescission: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Name and Title (please type)

\_\_\_\_\_

Date

\_\_\_\_\_

## **WAC 284-83-170 Form of personal worksheet.**

The following form of personal worksheet must be used by issuers in the sale of long-term care insurance policies.

### **Long-Term Care Insurance**

#### **Personal Worksheet**

People buy long-term care insurance for many 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** (noncancellable or 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 form in the future, provided it raises rates for all policies in the same class in this state.] [Issuers must use appropriate bracketed statement. Rate guarantees must 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 ten years.] [The company has raised its premium rates on this policy form or similar policy forms in the last ten 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%?

*Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.*

What is your annual income? (check one)  Under \$10,000  \$[10-20,000]  \$[20-30,000]  \$[30-50,000]  Over \$50,000

*Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.*

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 how 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

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

*Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.*

**What elimination period are you considering?** Number of days \_\_\_\_ Approximate cost \$\_\_\_\_ for that period of care.

**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

### **Questions Related to Your Savings and Investments**

Not counting your home, about how much are all of your assets (your 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**

The answers to the questions above describe my financial situation.

**OR**

I choose not to complete this information.

(Check one.)

I acknowledge that the issuer and/or its [agent] [insurance producer] (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: \_\_\_\_\_

(Applicant) (Date)

I explained to the applicant the importance of completing this information.

Signed: \_\_\_\_\_

[(Agent)] [(Insurance Producer)] (Date)

[Agent's] [Insurance Producer's] Printed Name: \_\_\_\_\_]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My [agent] [insurance producer] has advised me that this policy does not seem 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] [insurance producer] sale.

The company may contact you to verify your answers.

*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.*

## WAC 284-83-175 Disclosure form.

The following form of disclosure must be used in this state.

### 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.]

*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** Make sure the insurance company or agent gives you a copy of a book

- Guide** 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 insurance, 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.
- Facilities** Some long-term care insurance policies provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.
- 

## **WAC 284-83-180 Response letter.**

The following form of response letter must be used in this state.

### **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.]

*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.

*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].*

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## **284-83-185 Sample claims denial reporting form.**

The following form for reporting claims denials must be used in this state.

### **Claims Denial Reporting Form**

#### **Long-Term Care Insurance**

**For the State of** \_\_\_\_\_

**For the Reporting Year of** \_\_\_\_\_

Company Name: \_\_\_\_\_

Due: June 30, annually

Company Address: \_\_\_\_\_

\_\_\_\_\_

Company NAIC Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Line of Business:    Individual            Group

### Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		<b>State Data</b>	<b>Nationwide Data1</b>
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		

		<b>State Data</b>	<b>Nationwide Data1</b>
7	Number of Long-Term Care Claim Denied Due to:		
8	<ul style="list-style-type: none"> <li>• Long-Term Care Services Not Covered Under the Policy<sup>2</sup></li> </ul>		
9	<ul style="list-style-type: none"> <li>• Provider/Facility Not Qualified Under the Policy<sup>3</sup></li> </ul>		
10	<ul style="list-style-type: none"> <li>• Benefit Eligibility Criteria Not Met<sup>4</sup></li> </ul>		
11	<ul style="list-style-type: none"> <li>• Other</li> </ul>		

Footnotes:

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—Home health care claim filed under a nursing home only policy.
3. Example—A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

## **WAC 284-83-190 Potential rate increase disclosure form.**

The following form must be used in this state to disclose a potential rate increase.

### **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.

### **Issuers must provide all of the following information to the applicant:**

#### **Long-Term Care Insurance**

#### **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] for an increase [is][are] [on the application][ $\$$ \_\_\_\_\_]

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 CANNOT 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.)

<b>Contingent Nonforfeiture</b>
<b>Cumulative Premium Increase Over Initial Premium</b>
<b>That qualifies for Contingent Nonforfeiture</b>
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
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%

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
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%

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which WAC **284-83-130** (4)(d) and (f) are applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect;

AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

**Example:**

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

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## **WAC 284-83-195 Form for reporting replacement and lapse of long-term care insurance policies.**

The following form must be used in this state to report replacements and lapses of long-term care insurance.

### **Long-Term Care Insurance Replacement and Lapse Reporting Form**

For the State of \_\_\_\_\_ For the Reporting Year of \_\_\_\_\_

Company Name: \_\_\_\_\_

Due: June 30, Annually

Company Address: \_\_\_\_\_

Company NAIC Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Instructions**

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every issuer must maintain records for each [agent] [insurance producer] on that [agent's] [insurance producer's] amount of long-term care insurance replacement sales as a percent of the [agent's] [insurance producer's] total annual sales and the amount of lapses of long-term care insurance policies sold by the [agent] [insurance producer] as a percent of the [agent's] [insurance producer's] total annual sales. The tables below should be used to report the ten percent of the issuer's [agents] [insurance producers] with the greatest percentages of replacements and lapses.

**Listing of the 10% of [Agents] [Insurance Producers] with the Greatest Percentage of Replacements**

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Replaced by This [Agent] [Insurance Producer]	Number of Replacements as % of Number Sold by This [Agent] [Insurance Producer]

**Listing of the 10% of [Agents] [Insurance Producers] with the Greatest Percentage of Lapses**

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Lapsed by This [Agent] [Insurance Producer]	Number of Lapses as % of Number Sold by This [Agent] [Insurance Producer]

## Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales \_\_\_%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year)\_\_\_%

Percentage of Lapsed Policies to Total Annual Sales\_\_\_%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) \_\_\_%

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## WAC 284-83-210 Definitions.

For purposes of WAC 284-83-210 through **284-83-250**:

(1) "Actual loss ratio" means a retrospective calculation and calculated as the benefits incurred divided by the "premiums earned," both measured from the beginning of the calculating period to the date of the loss ratio calculations.

(2) "Benefits incurred" means the claims incurred plus any increase (or less any decrease) in the reserves.

(3) "Calculating period" means the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with the actuary's best estimate of future experience and during which the actuary does not expect to request a rate increase.

(4) "Claims incurred" means:

(a) Claims paid during the accounting period; plus

(b) The change in the liability for claims which have been reported but not paid; plus

(c) The change in the liability for claims which have not been reported but which may reasonably be expected.

Claims incurred does not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

(5) "Expected loss ratio" means a prospective calculation calculated as the projected benefits incurred divided by the projected premiums earned and based on the actuary's best projections of the future experience within the calculating period.

(6) "Overall loss ratio" means the benefits incurred divided by the premiums earned over the entire calculating period; it may involve both retrospective and prospective data.

(7) "Premium" means all sums charged, received or deposited as consideration for a long-term care insurance policy and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges paid.

(8) "Premiums earned" means the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

(9) "Reserves" includes:

(a) Active life disability reserves;

(b) Additional reserves whether for a specific liability purpose or not;

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

(e) Increased reserves which may be required by the commissioner.

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## **WAC 284-83-220 Grouping of policy forms for purposes of rate making and requests for rate increase.**

(1) The actuary responsible for setting premium rates must group similar policy forms, including forms no longer being marketed, in the pricing calculations.

(a) The grouping must be satisfactory to the commissioner, who may rely on the judgment of the pricing actuary.

(b) Factors that must be considered include similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between policyholders.

(c) A grouping must enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW **48.18.480**.

(d) A grouping is not required to include forms issued by health care service contractors or health maintenance organizations before January 1, 1988.

(2) Persons insured under similar policy forms must be grouped at the time of ratemaking in accord with RCW **48.18.480** because they are expected to have substantially like insuring, risk and exposure factors and expense elements.

(a) The morbidity and mortality experience of these insureds, as a group, will deteriorate over time.

(b) A form may not be withdrawn from its assigned grouping by reason only of the deteriorating health of the people insured thereunder, as provided for in RCW **48.83.170**.

(3) One or more of the policy forms grouped for ratemaking purposes, by random chance, may experience significantly higher or more frequent claims than the other forms. A form may not deviate from the assigned grouping of policy forms for pricing purposes at the time of requesting a rate increase unless the actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive generic policy forms and policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.

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## **WAC 284-83-225 Separation of data regarding certain policies.**

For reporting and record-keeping purposes, commencing with reports for accounting periods beginning on or after January 1, 2009, all issuers must separate data concerning long-term care insurance policies from data concerning other insurance policies.

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## **WAC 284-83-230 Loss ratio requirements for long-term care insurance forms.**

The following standards and requirements apply to long-term care insurance forms:

(1) Benefits for individual long-term care insurance forms will be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(2) Benefits for group long-term care insurance forms will be deemed reasonable in relation to the premiums if the overall loss ratio is at least seventy percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(3) The calculating period may vary with the benefit and renewal provisions. The issuer may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period must accompany the filing.

(4) Policy forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, must use a relatively short calculating period reflecting the uncertainties of estimating the risks involved.

(a) Policy forms based on more dependable statistics may employ a longer calculating period.

(b) The calculating period may be the lifetime of the policy for guaranteed renewable and noncancellable policy forms if these forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverages, inside benefit limits, or the inherent nature of the benefits.

(c) The calculating period may be as short as one year for coverages that are based on statistics of minimal reliability or which are highly exposed to inflation.

(5) A request for a rate increase to be effective at the end of the calculating period must include a comparison of the actual to the expected loss ratios, must employ any accumulation of reserves in the determination of rates for the new calculating period, and must account for the maintenance of such reserves for future needs. The request for the rate increase must be further documented by the expected loss ratio for the new calculating period.

(6) A request for a rate increase submitted during the calculating period must include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and must account for the maintenance of such reserves for future needs. If the experience justifies a premium increase, it will be deemed that the calculating period has prematurely been brought to an end. The rate increase must further be documented by the expected loss ratio for the next calculating period.

(7) Issuers must review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

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### **WAC 284-83-240 Experience records.**

Issuers must maintain records of earned premiums and incurred benefits for each policy year for each contract, rider, endorsement and similar form which is combined for purposes of premium calculations, including the reserves. Records must be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of policy year experience based on calendar year data.

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### **WAC 284-83-245 Evaluating experience data.**

In determining the credibility and appropriateness of experience data, due consideration will be given by the commissioner to all relevant factors including:

(1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;

(2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, economic cycles affecting disability income experience, inflation in expense charges and others;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later policy durations;

(4) The mix of business by risk classification;

(5) The expected lapses and antiselection at the time of rate increases.

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## **WAC 284-83-250 Life insurance policies that accelerate benefits for long-term care.**

(1) WAC **284-83-210** through **284-83-245** do not apply to life insurance policies that accelerate benefits for long-term care.

(2) 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:

(a) 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;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of chapter **48.76** RCW;

(c) The policy meets the disclosure requirements of RCW **48.83.070**(2) and **48.83.080**;

(d) Any policy illustration that meets the applicable requirements of the chapter **48.23A** RCW; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must 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 must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) 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.

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## **WAC 284-83-300 Standards for protecting patient privacy rights.**

Issuers must adopt and use administrative, business, and operational practices and procedures designed to protect an insured's right to privacy granted under chapter **70.02** RCW and federal laws and regulations. For example, issuers must not disclose the insured's health information without the written authorization of the insured, except where the recipient needs to know the information, such as:

- (1) To any person, health care provider or health care facility that the issuer reasonably believes is providing health care to the insured;
  - (2) To any other person who requires health care information to provide planning, quality assurance, peer review, or administrative, legal, financial, billing or actuarial services;
  - (3) To assist a health care provider or health care facility in the delivery of health care and the issuer reasonably believes that the recipient will not use or disclose the health care information for any purpose other than the delivery of health care and will take appropriate steps to protect the information;
  - (4) To a health care provider or health care facility reasonably believed to have previously provided health care to the insured to the extent necessary to provide health care services, unless the insured has instructed the health care provider or health care facility in writing not to make the disclosure.
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## **WAC 284-83-310 Right of insureds to receive confidential health services.**

Issuers must adopt and use administrative, business, and operational practices and procedures to protect the insured's right to confidential health care services.

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## **WAC 284-83-320 Standards for the issuer's timely review of a claim denial.**

The following administrative, business, and operational standards must be used by issuers to ensure timely review of a claim denial.

- (1) Issuers must have a fully operational, comprehensive claims denial review process.
- (2) Issuers must implement procedures for registering and responding to oral and written requests for review of a claim denial in a timely and thorough manner.
- (3) Issuers must provide written notice to the insured, to the insured's designated representative, and to the insured's provider of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility or any other long-term care services or benefits.
- (4) Issuers must process as an appeal an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. The issuer must not require that the insured file a complaint prior to seeking appeal of any such decision.
  - (5) The issuer must:
    - (a) Provide written notice to the insured when the appeal is received;
    - (b) Assist the insured with the appeal process;
    - (c) Make its decision regarding the appeal within thirty days after the date the appeal is received, except when a determination is made that the issuer's action must be expedited;
    - (d) Cooperate with a representative authorized in writing by the insured;
    - (e) Consider all information submitted by the insured;
    - (f) Investigate and resolve the appeal; and
    - (g) Provide written notice of its resolution of the appeal to the insured and, with the permission of the insured, to the insured's providers, that:
      - (i) Explains the issuer's decision and the supporting coverage or clinical reasons for the decision; and

(ii) If applicable, explains any further appeal process, including, if applicable, information about how to exercise the insured's rights to a second opinion and how to continue receiving or reinstate services.

(6) An appeal must be expedited if the insured's provider or the insured's medical director reasonably determines that following the appeal process, response timelines could seriously jeopardize the insured's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours after the time the appeal is received by the issuer.

(7) If the insured requests that the issuer reconsider its decision to modify, reduce, or terminate an otherwise covered health care service, and if the issuer's decision is based on the issuer's determination that the health service or level of health service is no longer covered, the issuer must continue to provide the health service until the appeal is resolved.

(8) Issuers must provide a clear explanation of their grievance processes and procedures at the time of application and upon request of the insured.

(9) Issuers must ensure that their grievance processes and procedures are accessible to insureds who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Issuers must track each appeal until final resolution and, upon request, make available to the commissioner a log of all appeals and grievances.

(11) Issuers must establish a process to identify and track problems encountered by enrollees when filing claims denials and, where appropriate, to make reasonable modifications to their appeals and grievance processes and procedures.

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## **WAC 284-83-325 Prompt payment of clean claims.**

(1) The purpose of this section is to effectuate RCW 48.83.090 and 48.83.170 by establishing prompt payment requirements for long-term care insurance.

(2) For purposes of this section, the following definitions apply:

(a) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

(3) Within thirty business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer must pay such a claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(a) The insurer is declining to pay all or part of the claim and the specific reason(s) for the denial; or

(b) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

(4) Within thirty business days after receipt of all the requested additional information, an insurer must pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

(5) If an insurer fails to comply with subsection (3) or (4) of this section, such insurer must pay interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid for forty-five business days after the receipt of the claim with respect to subsection (3) of this section or all requested additional information with respect to subsection (4) of this section. The interest payable pursuant to this subsection must be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(6) The provisions of this section do not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

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## **WAC 284-83-350 Standard applied if there is a conflict between a master policy and certificate of insurance.**

If there is a discrepancy between a description of the terms and conditions of insurance between the master policy and any certificate issued under that master policy, the description most favorable to the insured must be used by the issuer and governs the matter.

## **LONG-TERM CARE PARTNERSHIP PROGRAM**

### **WAC 284-83-400 Purpose and authority.**

WAC 284-83-400 through 284-83-420 is adopted pursuant to RCW 48.85.030 and 48.85.040. The purpose of these sections is to effectuate chapter 48.85 RCW, the Washington Long-Term Care Partnership Act. Pursuant to RCW 48.85.030, these sections establish minimum standards and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care partnership insurance policies to include: Contracts, certificates, riders, and endorsements.

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### **WAC 284-83-405 Applicability and scope.**

(1) WAC 284-83-400 through 284-83-420 applies to any qualified long-term care insurance partnership policy, as defined by federal law and this chapter.

(2) These sections do not apply to medicare supplement policies regulated under chapters 48.66 RCW and 284-55 or 284-66 WAC; policies or contracts between a continuing care retirement community and its residents; or to long-term care insurance policies that are not intended to provide asset protection under chapter 48.85 RCW.

(3) Policies that do not meet the requirements of the Washington Long-Term Care Partnership Act and the requirements of this chapter may not be advertised, issued or delivered in this state as partnership policies.

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### **WAC 284-83-410 Minimum standards for long-term care partnership policies.**

Every long-term care partnership policy must meet the standards for long-term care policies or contracts in chapters 48.83 and 48.85RCW and this chapter, unless specifically provided otherwise.

(1) As used in WAC 284-83-400 through 284-83-420, "qualified long-term care partnership policy" or "partnership policy" means a long-term care policy that meets all of the following additional requirements:

(a) The policy was issued on or after January 1, 2012, or exchanged as provided in WAC 284-83-415 on or after January 1, 2012, and covers an insured who was a resident of this state or of another state that has entered into a reciprocal agreement with this state when coverage first became effective under the policy.

(b) The policy is a tax qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)).

(c) The policy provides at least the following levels of inflation protection:

(i) If the policy is sold to an individual who has not attained age sixty-one as of the date of purchase, the policy must provide automatic annual compounded inflation increases at a rate not less than three percent or automatic annual compounded inflation increases at a rate based on changes in the consumer price index.

(ii) If the policy is sold to an individual who has attained age sixty-one but has not attained age seventy-six as of the date of purchase, the policy must provide automatic simple inflation increases at a rate not less than three percent or automatic inflation increases at a rate based on changes in the consumer price index.

(iii) If the policy is sold to an individual who has attained age seventy-six as of the date of purchase, the policy may, but is not required to, provide automatic inflation increases at a rate based on changes in the consumer price index.

(iv) If the change in the consumer price index is a negative number for the time period in question, the carrier may not apply the change in the index to reduce the benefit payable under the partnership policy. However, the carrier may offset this negative number against the next annual increase in the consumer price index to reduce the automatic inflation increase which would otherwise occur during that year. If the negative consumer price index exceeds the next annual increase in the consumer price index, it may be offset against multiple annual increases, the net effect of which may never be less than zero.

(v) For purposes of this section, "consumer price index" means the consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

(2) Issuers must file a long-term care insurance policy for approval for use as a partnership policy. The long-term care Partnership Policy Certification Form must be completed and accompany the request for approval. The form is available on the commissioner's web site: [www.insurance.wa.gov](http://www.insurance.wa.gov).

(3) Issuers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy must:

(a) Submit to the commissioner a Partnership Policy Certification Form signed by an officer of the company; and

(b) File for approval an amendatory rider or endorsement indicating the policy is partnership qualified.

(4) An issuer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, must provide to each prospective applicant a Partnership Program Notice found on the commissioner's web site: [www.insurance.wa.gov](http://www.insurance.wa.gov), outlining the requirements and benefits of a partnership policy. The Partnership Program Notice must be provided with the required outline of coverage.

(5) A partnership policy issued for delivery in Washington must be accompanied by a Partnership Status Disclosure Notice found on the commissioner's web site: [www.insurance.wa.gov](http://www.insurance.wa.gov), explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified Washington state long-term care insurance partnership policy. The Partnership Disclosure Notice must also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for medicaid.

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## **WAC 284-83-415 Long-term care partnership policy exchange or replacement.**

(1) Within one year of the date that an issuer begins to advertise, market, offer, or sell policies that qualify under the Washington state long-term care partnership program, the issuer must offer to all of its current policyholders and certificate holders the opportunity to exchange their existing long-term policy for a policy that is intended to qualify under the state's long-term care partnership program provided that:

(a) The existing long-term care policy was issued on or after February 8, 2006; and

(b) The existing long-term care policy is the type certified by the issuer for purposes of the state long-term care partnership program.

(2) In making an offer to exchange, an issuer must comply with the following requirements:

(a) The offer must be made on a nondiscriminatory basis without regard to the age or health status of the insured; and

(b) The offer must remain open for a minimum of ninety days from the date of mailing by the issuer.

(3) An exchange occurs when an issuer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a long-term care partnership policy, and the insured accepts the offer to terminate the existing policy and accepts the new policy.

(4) Notwithstanding subsections (1), (2), and (3) of this section:

(a) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(b) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the issuer's long-term care underwriting guidelines.

(5) If the partnership policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then the following requirements apply:

(a) The partnership policy must not be underwritten; and

(b) The rate charged for the partnership policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(6) If the partnership policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then the following requirements apply:

(a) The issuer must apply its long-term care underwriting guidelines to the increased benefits only; and

(b) The rate charged for the partnership policy must be determined using the method set forth in subsection (5)(b) of this section for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(7) The partnership policy offered in an exchange must be on a form that is currently offered for sale by the issuer in the general market.

(8) In the event of an exchange, the insured must not lose any rights, benefits, or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy including, but not limited to, rights established because of the lapse of time related to preexisting condition exclusions, elimination periods, or incontestability clauses.

(9) Issuers may complete an exchange by either issuing a new policy or by amending an existing policy with an endorsement or rider. An issuer must file such endorsement or rider for approval prior to issue.

(10) For those insureds with long-term care policies issued before February 8, 2006, an issuer may offer an insured the option to exchange an existing policy for a policy that qualifies as a Washington state long-term partnership policy. The requirements set forth in subsections (2) through (9) of this section apply to any such exchange.

(11) Policies issued pursuant to this section shall be considered exchanges and not replacements and are not subject to WAC 284-83-060 through 284-83-070.

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### **WAC 284-83-420 Reporting.**

All issuers of qualified long-term care partnership policies must provide regular reports to the United States Secretary of Health and Human Services in accordance with regulations of the secretary. These reports include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the secretary determines may be appropriate to the administration of partnership policies.

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### **WAC 284-83-425 Producer education.**

Prior to selling, soliciting, or negotiating, or continuing to sell, solicit, or negotiate long-term care partnership policies in this state, all licensed producers must meet the education requirements in RCW 48.83.130(2).

## **Chapter 48.85 RCW: WASHINGTON LONG-TERM CARE PARTNERSHIP**

- 48.85.010** Washington long-term care partnership program—Generally.
- 48.85.020** Protection of assets—Federal approval—Rules.
- 48.85.030** Insurance policy criteria—Rules.
- 48.85.040** Consumer education program.
- 48.85.900** Short title—Severability—Savings—Captions not law—Reservation of legislative power—Effective dates—1993 c 492.

### **RCW 48.85.010 Washington long-term care partnership program—Generally.**

The department of social and health services shall, in conjunction with the office of the insurance commissioner, coordinate a long-term care insurance program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care. For individuals purchasing a long-term care insurance policy or contract governed by chapter [48.84](#) or [48.83](#) RCW and meeting the criteria prescribed in this chapter, and any other terms as specified by the office of the insurance commissioner and the department of social and health services, this program shall allow for the exclusion of some or all of the individual's assets in determination of medicaid eligibility as approved by the centers for medicare and medicaid services.

[2012 c 211 § 9; 2008 c 145 § 21; 1995 1st sp.s. c 18 § 76; 1993 c 492 § 458.]

NOTES: Severability—Effective date—2008 c 145: See RCW [48.83.900](#) and [48.83.901](#).

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW [74.39A.030](#).

Findings—Intent—1993 c 492: See notes following RCW [43.20.050](#).

## **RCW 48.85.020 Protection of assets—Federal approval—Rules.**

The department of social and health services shall seek approval from the centers for medicare and medicaid services to allow the protection of an individual's assets as provided in this chapter. The department shall adopt all rules necessary to implement the Washington long-term care partnership program, which rules shall permit the exclusion of all or some of an individual's assets in a manner specified by the department in a determination of medicaid eligibility to the extent that private long-term care insurance provides payment or benefits for services.

[2012 c 211 § 10; 1995 1st sp.s. c 18 § 77; 1993 c 492 § 459.]

NOTES: Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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## **RCW 48.85.030 Insurance policy criteria—Rules.**

(1) The insurance commissioner shall adopt rules defining the criteria that qualified long-term care partnership insurance policies must meet to satisfy the requirements of this chapter. The rules shall incorporate any requirements set forth by chapter **48.83** RCW and the deficit reduction act of 2005 for qualified long-term care partnership insurance policies purchased for the purposes of this chapter.

(2) Insurers offering long-term care policies for the purposes of this chapter shall demonstrate to the satisfaction of the insurance commissioner that they:

(a) Have procedures to provide notice to each purchaser of the long-term care consumer education program;

(b) Have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits identifying those payments or services available under the policy that meet the purposes of this chapter;

(c) Agree to provide the insurance commissioner any required annual report containing information derived from the long-term care partnership long-term care insurance uniform data set as specified by the office of the insurance commissioner.

[2011 c 47 § 12; 1995 1st sp.s. c 18 § 78; 1993 c 492 § 460.]

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## **48.85.040 Consumer education program.**

The insurance commissioner shall, with the cooperation of the department of social and health services and members of the long-term care insurance industry, develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided under this chapter.

[1995 1st sp.s. c 18 § 79; 1993 c 492 § 461.]

NOTES: Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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## **48.85.900 Short title—Severability—Savings—Captions not law—Reservation of legislative power—Effective dates—1993 c 492.**

See RCW 43.72.910 through 43.72.915.

## **LTCP LTC Eligibility**

### **What is long-term care?**

For the purposes of Medicaid eligibility, long-term care is for individuals residing in a Medical institution (primarily nursing homes) for 30 days or more or on a Home and Community Based Waiver.

**"Institutionalized client"** means a client who has attained institutional status as described in WAC [388-513-1320](#) **"Institutional services"**. Means services paid for by Medicaid or

state funds and provided in a medical institution, through a Home and Community Based (HCB) Waiver ,or Program of All-Inclusive Care for the Elderly (PACE).

**“Home and Community Based Services”** (HCBS) means services provided in the home or a residential setting to individuals assessed by the department.

**“Home and Community Based (HCB) Waiver Programs”** means Section 1915 (c) of the Social Security Act enables states to request a waiver of applicable federal Medicaid requirements to provide enhanced community support services to those Medicaid beneficiaries who would otherwise require institutional care.

#### Additional Definitions Used in Long-Term Care Eligibility

#### **Eligibility Requirements:**

- Eligibility requirements for long-term care are found in WAC388-513-1315 Some of the key requirements are:
- Identity and citizenship requirements
- Furnish a valid social security number
- Be a Washington resident
- Meet aged, blind or disabled criteria
- Income and resource guidelines
- Institutional Medicaid is subject to penalties for resource transfers described in WAC 388-513-1363
- Home equity cannot exceed \$506,000 as described in WAC388-513-1350
- Declaration of interest in an annuity and naming the State of Washington as a remainder beneficiary as described in WAC388-561-0201

#### **Resource standards for long-term care**

- WAC388-513-1350 describes resource eligibility for long-term care.
- \$2,000 applicant

- \$3,000 couple both applying in the same month
- \$48,639 State spousal resource standard
- \$109,560 Federal spousal resource standard maximum

## **Income**

- Countable income is compared to 300% of the Federal Benefit Rate (FBR). The 2010 rate is \$2,022 and may also be called the SIL (Special Income Level).
- Individuals with income at or below are eligible for categorically needy (CN) medical coverage.
- Individuals with countable income over 300% of the FBR may be eligible for medically needy (MN) coverage based on the projected monthly cost of care in the facility or at home.
- Clients must contribute income after allowable deductions towards the costs of their care.
- [Income and Resource Standard Charts Used in Long-Term Care Eligibility](#)

## **LTC Partnership – Background**

- Section 6021 of the 2005 Deficit Reduction Act expands LTC Partnership opportunities for States by effectively lifting the moratorium on expansion imposed by the Omnibus Budget Reconciliation Act (OBRA) 1993.
- DRA provides for a unique Medicaid/private insurance model designed to attract consumers who might not otherwise purchase LTC insurance by allowing them to protect a specified level of assets.
- Considered by many States as a critical link in helping citizens plan for their own future.
- Help States offset rising Medicaid costs for LTC by shifting costs to private insurance
- Discourage impermissible transfers of assets to qualify for Medicaid.
- Consumers can protect assets for estate planning and inheritance purposes.

## **LTC Partnership in Washington**

- Washington State uses the dollar for dollar resource protection model. An individual can protect \$1 in resource for every \$1 paid out by the LTC partnership policy.
- Individuals would need to meet all other Medicaid eligibility rules, but will be able to bank additional resources based on the amount the LTC policy has paid.
- Resources banked due to a Partnership policy are protected from [EstateRecovery](#).

- Individuals with a LTC Partnership Policy must submit a DSHS XXXX LTCP Asset Designation form to Washington State Medicaid at the time of application and at each annual review in order to designate assets as protected based on the dollar amount paid for services by the LTC Partnership Policy. This will track protected assets for both LTC Medicaid eligibility and Estate Recovery purposes.

### **LTC Partnership - Reciprocity**

- HHS published the reciprocity standards in the Federal Register and are effective 1/1/09. Provisions require:
- Benefits paid under a LTCP policy will be treated the same by all States.
  - all States will be subject to the standards unless the State notifies the Secretary in writing of the desire to opt out.
  - all States will implement a \$ for \$ disregard.
  - policies will be treated uniformly regardless of where purchased.
  - exempt assets from Estate Recovery.
- Washington accepts approved LTC partnership policies purchased in other states.

### **Resources and LTC Partnership an example**

- Individual with a LTC partnership has \$50,000 in liquid resources and an excluded home.
- The LTC partnership insurance has paid \$48,000 in benefits. Total policy pays \$150,000 in benefits.
- Individual meets general Medicaid requirements and is allowed to keep \$2,000 in resources for Medicaid plus \$48,000 based on the amount the LTC partnership has paid.
- As the partnership pays, the individual is allowed to save additional resources dollar for dollar.

### **Resources and LTC Partnership**

- Resources banked due to a LTC partnership is not subject to Estate Recovery as indicated in chapter 388-527 WAC.
- This would include part of all value of a home that is excluded for Medicaid eligibility but not excluded from Estate Recovery at death.
- Based on the previous example If the individual's excluded home is worth \$100,000 and the partnership pays out a total of the \$150,000 benefit during the lifetime, the value of the home may be banked and would not be subject to Estate Recovery.

**More information on Long-term Care eligibility in Washington State:**

- <http://www.dshs.wa.gov/manuals/eaz/sections/LTCIndex.shtml> Long-term care eligibility manual includes the Washington
- Administrative Code
- <http://www.lawhelp.org/documents/1541615102EN.pdf?stateabbrev=/WA/> Questions and Answers on the COPES Program by Columbia Legal Services (COPES is the main home and community based waiver used in Washington State).
- <http://www.lawhelp.org/documents/1538915170EN.pdf?stateabbrev=/WA/> Questions and Answers on Medicaid for nursing home residents by Columbia Legal Services
- <http://www.ada.dshs.wa.gov/> Aging & Disability Services Administration Internet Site
- <http://www.dshs.wa.gov/pdf/Publications/22-619.pdf> Medicaid and Long-Term Care Services for Adults in Washington State
- <http://apps.leg.wa.gov/wac/default.aspx?cite=388-513> Washington Administrative Code (WAC) Institutional Medical <http://apps.leg.wa.gov/wac/default.aspx?cite=388-515> WAC Home and Community Based Waivers

# Wisconsin

## Long-Term Care Insurance Partnership Program WI Medicaid Training—Part I

### Introduction to the WI Long-Term Care Insurance Partnership Program and the Wisconsin Medicaid Program: An Overview

The information contained in this training material is current as of June 2, 2008.

#### Why is this training important to me?

This Training is Important to You because...

- The WI Long-Term Care Insurance Partnership (LTCIP) program creates a new role for you to play relative to your clients and the WI Medicaid program.
- This training is intended to help you learn that role by gaining an understanding of WI Medicaid and
- How WI Medicaid relates to the WI Long-Term Care Insurance Partnership (LTCIP) program.
- Becoming familiar with this relationship is the key to knowing how low income WI residents can benefit most from participating in the WI LTCIP program.

### Introduction to the WI Long Term Care Insurance Partnership Program

The WI Long Term Care Insurance Partnership (LTCIP) Program is a joint effort between the federal Medicaid Program, long-term care insurers, and the State of Wisconsin.

The purpose of the WI LTCIP program is to encourage people to plan for future long-term care needs, such as:

1. Residing in a nursing facility

OR

2. Receiving long-term care services in one's home or another community-based setting.

In Wisconsin, the LTCIP Program Includes:

- Private Long-Term Care Insurers
- Long-Term Care Insurance Producers (agents and brokers)
- The Department of Health and Family Services (DHFS)
- The Office of the Commissioner of Insurance (OCI)

At the federal level, the LTCIP program is overseen by the federal Centers for Medicare and Medicaid Services (CMS).

Under the WI LTCIP program, an amount equal to the amount of benefits that an individual receives under a qualifying LTCIP insurance policy is excluded when determining:

- The individual's resources for purposes of determining WI Medicaid eligibility and
- The amount to be recovered from the individual's estate if the individual receives WI Medicaid benefits

## **Intro RECAP**

- Participation in the WI LTCIP program can affect the low income person's WI Medicaid eligibility and estate planning.
- Some low income people who wish to participate in the WI LTCIP program may already be eligible for WI Medicaid.
- Some will become eligible for WI Medicaid at some point after they

begin participating in the WI LTCIP program.

It is important to understand the precise relationship between the WI LTCIP program and WI Medicaid so that:

- ❑ You can provide sound advice to low income people who inquire about the WI LTCIP program and
- ❑ You can also accurately explain to low income people the potential benefit of participating in the WI LTCIP program relative to qualifying for WI Medicaid and protecting their estate.

## **The Wisconsin Medicaid Program: An Overview**

- What is WI Medicaid?
- What is WI Family Care?
- What is WI Family Care Partnership?
- What is Institutional Medicaid?
- How Can Consumers Learn About Long-Term Care Options in WI?

### What is WI Medicaid?

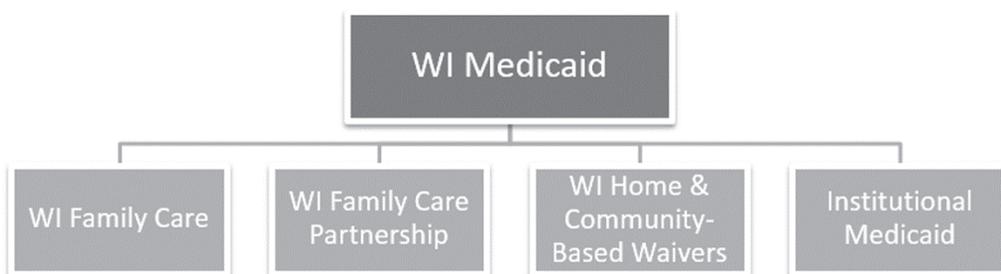
And more importantly....Why do I need to know about WI Medicaid?

It is Important to Know About WI Medicaid because...

- ❑ You will consider selling qualified WI LTCIP policies to people who may become, or who perhaps already are, eligible for WI Medicaid.
- ❑ The amount of benefits paid by a qualified WI LTCIP policy could have an effect on a person's eligibility for WI Medicaid, as well as his/her estate planning. Part II of this training explains this in detail.
- ❑ You will need to understand this potential effect before you sell the policy so that you can explain it to the person who is considering purchasing the policy.

AND Because...

- ❑ When one of your clients does apply for WI Medicaid, you will be asked to verify the qualified policy's payout amount as part of the WI Medicaid application process. Part II of this training explains this in detail.
- ❑ You may also be asked to verify the qualified policy's premium amount. Part II of this training explains this in detail.
- ❑ To fulfill this new role, you will need to understand some WI Medicaid basics.



- WI Medicaid covers certain acute, primary and long-term care services.
- Institutional Medicaid, the WI Medicaid Home- and Community-Based Waivers, WI Family Care and WI Family Care Partnership comprise the four main ways that WI Medicaid delivers long-term care.
- Of these, WI Family Care and WI Family Care Partnership are designed specifically to allow functionally impaired elderly and disabled persons to remain in their homes and communities. (Note: the WI Home- and Community-Based Waivers are in the process of being replaced by WI Family Care and WI Family Care Partnership. For that reason, the waivers are not addressed in this training. Waiver eligibility policy is the same as that used for WI Family Care Partnership. Waiver benefits are similar to those under WI Family Care; however, WI Family Care is a managed care program, whereas, waiver services are provided on a fee-for-service basis).

WI Medicaid is paid for in part by the federal government and in part by state government.

The benefits that WI Medicaid will pay for are established by the federal government and certain additional benefits that WI has chosen to cover WI Medicaid has very specific financial limits for persons applying for coverage.

## **Medicaid Applications**

Applications for WI Medicaid are accepted at county government human service agencies. WI Medicaid eligibility is reviewed annually

## **Medicaid Reimbursement**

WI Medicaid will reimburse covered services provided by WI Medicaid certified providers. Not all service providers will accept WI Medicaid as payment. WI Medicaid reimbursement is often lower than market rates.

## **Medicaid and Payment for Services**

- Payment goes directly to certified service provider
- Other insurance carrier must be billed first before WI Medicaid will consider for payment.
- As payer of last resort, WI Medicaid pays what is not covered by other insurance (e.g., Medicare or private health insurance).

If a person moves to a nursing home or receives home health services on a private pay/insured basis, can no longer pay and becomes eligible for WI Medicaid, WI Medicaid is not obligated to pay for services from that provider unless:

- a. the provider is WI Medicaid certified and
- b. the person has a need for that level of care, as determined by the State of Wisconsin

**Individuals in WI Medicaid are entitled to covered acute, primary and long-term care services including:**

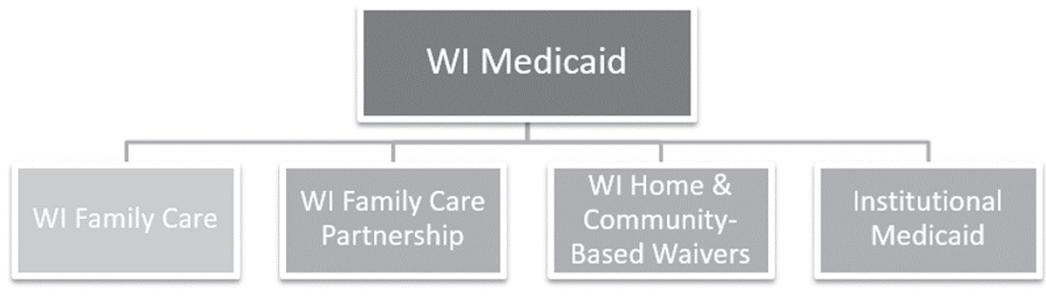
- Physician
- Hospital
- Durable medical equipment (wheelchairs; hospital beds)
- Home health (nursing)
- Medical supplies
- Nursing facility (skilled and intermediate care nursing homes)
- Occupational therapy
- Personal care (assistance with bathing, dressing, toileting, eating, etc.)
- Pharmacy and prescription drugs
- Physical therapy
- Speech and language therapy
- Transportation for medical visit

**What is WI Medicaid? RECAP**

- ❑ WI Medicaid is a publicly-subsidized, means tested program that pays for certain acute, primary and long-term care services for low income elderly and disabled persons.
- ❑ In addition to covering institutional settings, WI Medicaid offers several unique subprograms specifically designed to allow functionally impaired elderly and disabled persons to remain in their homes and communities.
- ❑ WI Medicaid reimburses only service providers who are certified by the WI Medicaid program.
- ❑ WI Medicaid-covered long-term care services may also be covered by a qualified WI LTCIP program policy.
- ❑ WI Medicaid is the “payer of last resort,” meaning that WI Medicaid will reimburse a claim for covered services only after all other payment sources have been billed.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect the elderly or disabled person’s WI Medicaid eligibility and estate planning.
- ❑ Long-term care insurers need to understand these and other WI

Medicaid policy fundamentals, which are based on federal and state law, in order to better serve their customers.

## What is WI Family Care?



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You Are Here. WI Family Care is a subprogram of WI Medicaid.

WI Family Care is a public program unique to Wisconsin.

This program offers a full range of managed long-term care services to people who need a nursing home level of care, but who wish to live in their own home or another community-based setting.

To join WI family care, a person...

- must be financially eligible for WI Medicaid
- must be functionally eligible for WI family care (i.e., must meet a certain level of functional impairment)
- must pay "cost share" (determined based on a sliding fee schedule) if income is above a certain level

## Functional Screening Process

- Extensive interview which gathers medical information
- Establishes a level of care necessary for health and safety
- Establishes whether the person's functional impairments qualify him/her

to receive the WI Family Care benefit

## **Network of Providers**

- ❑ Participants cannot necessarily choose an out-of-network provider, unless it is necessary for quality of care or quality of life
- ❑ Network providers focus on enabling people to live at home or an apartment-like setting of their choice
- ❑ Quality of care is assured by the state of Wisconsin
- ❑ The WI Family Care benefit for community-based long-term care is more extensive than would be available to persons qualifying only for WI Medicaid.
- ❑ WI Family Care members can access any long-term care benefit that they need, based on joint decisions with the care team.
- ❑ WI Family Care does not cover acute and primary care services, but such services are covered by the WI Medicaid program and, for those eligible, by Medicare.

## **WI Family Care Benefits Include:**

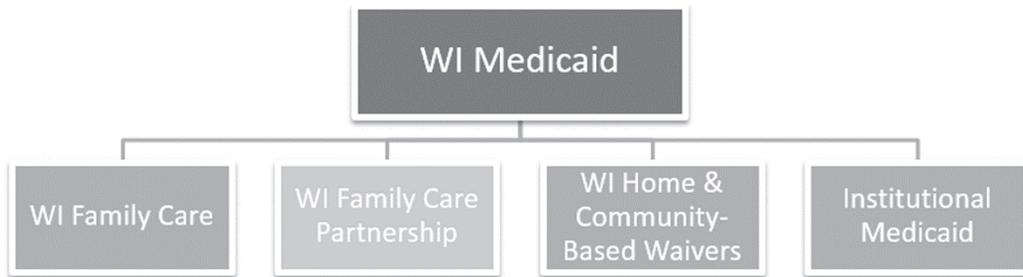
- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services
- Care/Case Management (including Assessment and Case Planning)
- Communication Aids/Interpreter Services
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Day Services/Treatment
- Durable Medical Equipment, except for hearing aids and prosthetics
- Home Health
- Home Modifications
- Housing Counseling
- Meals: home delivered
- Medical Supplies
- Mental Health Day Treatment

- Nursing Facility
- Nursing Services (including respiratory care)
- Occupational Therapy
- Personal Care (assistance with bathing, eating, toileting, dressing)
- Personal Emergency Response System Services
- Physical Therapy
- Relocation Services (from nursing home to community)
- Residential Services: Certified Residential Care Apartment Complex (RCAC)
- Community-Based Residential Facility (CBRF)
- Adult Family Home
- Respite Care (for care givers and members)
- Specialized Medical Supplies
- Speech and Language Pathology Services
- Supportive Home Care
- Transportation (limited to certain needs)

## **What is WI Family Care? RECAP**

- ❑ WI Family Care is a managed long-term care option for WI Medicaid eligible individuals who have a certain level of functional impairment and who prefer to live in a community-based setting rather than a nursing home.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect a person's WI Medicaid eligibility and, therefore, his/her eligibility to enroll in WI Family Care.
- ❑ You may be asked to document the amount of benefits paid by the qualified WI LTCIP program policy when a person applies for WI Family Care.
- ❑ The premiums associated with a qualified WI LTCIP program policy may affect the amount that a person must pay monthly to remain enrolled in WI Family Care.
- ❑ You may be asked to document the amount of the premium paid by the individual for coverage under the qualified WI LTCIP program policy.

## What is WI Family Care Partnership?



You Are Here. WI Family Care Partnership is a subprogram of WI Medicaid.

- ❑ This program is not to be confused with the WI Long-Term Care Insurance Partnership Program.
- ❑ The WI Family Care Partnership program is a managed care program like the rest of WI Family Care, offering the long-term care services listed previously. Additionally, Partnership offers acute and primary care and provides a more medically-oriented care team that works in close consultation with the physician.
- ❑ To join WI Family Care Partnership, people must be financially eligible for Medicaid.
- ❑ People with incomes above the eligible income level may be required to pay a cost-share.
- ❑ WI Family Care Partnership members must require the equivalent of a nursing home level of care, as determined by the functional screen.

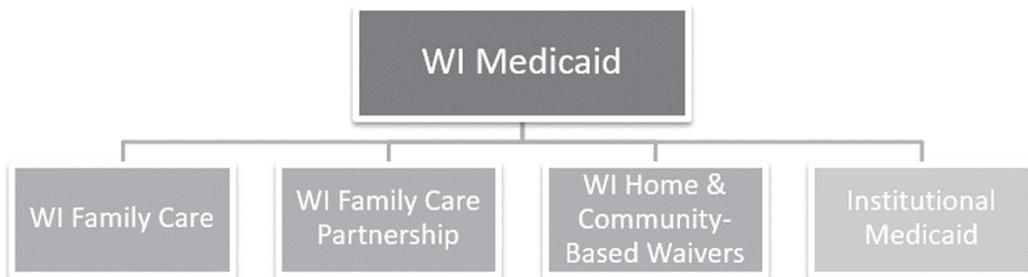
## What is WI Family Care Partnership? RECAP

- ❑ WI Family Care Partnership is another managed long-term care option for WI Medicaid eligible individuals who require a nursing home level of care, but who prefer to live in a community-based setting rather than a nursing home.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may

affect a person's WI Medicaid eligibility and, therefore, his/her eligibility to enroll in WI Family Care Partnership.

- ❑ You may be asked to document the amount of benefits paid by the qualified LTCIP program policy when a person applies for WI Family Care Partnership.
- ❑ The premiums associated with a qualified WI LTCIP program policy may affect the amount that a person must pay monthly to remain enrolled in WI Family Care Partnership.
- ❑ You may be asked to document the amount of the premium paid by the individual for coverage under the qualified WI LTCIP program policy.

## What is Institutional Medicaid?



You Are Here. Institutional Medicaid is a subprogram of WI Medicaid.

Institutional Medicaid provides a full range of medical services for those who reside in a medical care facility including skilled nursing facilities (SNF), intermediate care facilities (ICF), and hospitals.

- ❑ To be eligible for Institutional Medicaid, the person must have resided in a medical facility for at least 30 days and meet certain WI Medicaid financial requirements.
- ❑ To remain eligible for Institutional Medicaid, the person must contribute toward the cost of their care ("patient liability"), an amount determined based on income.

## **What is Institutional Medicaid? RECAP**

- ❑ Institutional Medicaid is a long-term care option for WI Medicaid eligible individuals who have resided in a medical facility for at least 30 days.
- ❑ The amount of benefits paid by a qualified WI LTCIP program policy may affect a person's eligibility for Institutional Medicaid.
- ❑ You may be asked to document the amount of benefits paid by the qualified WI LTCIP program policy when a person applies for Institutional Medicaid.
- ❑ The premiums associated with a qualified WI LTCIP program policy may affect the amount that a person must pay monthly to remain eligible for Institutional Medicaid.
- ❑ You may be asked to document the amount of the premium paid by the individual for coverage under the qualified WI LTCIP program policy.

## **How Can Consumers Learn About the Long-Term Care Options in Wisconsin?**

### Aging and Disability Resource Centers or ADRCs

- ❑ These agencies are "one-stop" sources of information and advice about long-term care, aging and disability in Wisconsin, and specifically in that county.
- ❑ Where none exist, there are county offices on aging.
- ❑ Refer your clients to their local ADRC (or aging office) when they have questions about long-term care, aging, or disability.

### Information and Assistance Specialists

These specialists maintain up-to-date data bases about all programs and resources, and can assist people to problem-solve when a relative has a need for care, service or financial support.

### Benefit Specialist

- ❑ Each ADRC has a Benefit Specialist to help cut the "red tape" of Social

- Security Medicare, Part D prescription plans, etc.
- Benefit specialists also assist consumers with problems related to private insurance, financial abuse and Medicare fraud.
- The ADRC is under contract with the state of Wisconsin.
- A strong culture of customer service is expected.
- There is no charge for the services of the ADRC.
- Families can make contact by telephone from anywhere in the country or on-line using an internet search engine to locate information on "Wisconsin ADRCs."

For a listing of ADRCs, go to the DHFS website: [www.dhfs.wisconsin.gov](http://www.dhfs.wisconsin.gov)

- All counties are slated to have Aging and Disability Resource Centers by 2011.
- Refer your clients to their local ADRC (or aging office) when they have questions about long-term care, aging, or disability.

#### How Can Consumers Learn About the Long-Term Care Options in WI? RECAP

- The information provided about WI's long-term care options in this training document is at a relatively high level.
- Much more detailed information is available to consumers and their families through WI's Aging and Disability Resource Centers (ADRCs).
- Long-term care insurers should understand the role of ADRCs and be able to refer their clients to ADRCs as appropriate.

# Long-Term Care Insurance Partnership Program WI Medicaid Training—Part II

## WI Medicaid Eligibility

- General Eligibility Requirements for WI Medicaid
- Detailed Eligibility Requirements for WI Medicaid Payment of Long-Term Care
- WI Estate Recovery
- How Asset Protection Works under the WI LTCIP Program
- How to Apply for WI Medicaid

## Why is it important for you to know about WI Medicaid?

### It is Important for You to Know About WI Medicaid because...

1. Wisconsin statute intends that you gain a thorough understanding of the relationship between the qualified WI LTCIP policies that you market and the WI Medicaid program. [s. 49.45 (31) (c)]
2. This relationship is grounded in WI Medicaid eligibility and estate recovery policy.
3. You need this understanding to fulfill your obligation to explain to consumers the protections offered by qualified WI LTCIP policies.

## General Eligibility Requirements for WI Medicaid

To be eligible for WI Medicaid:

- A person must meet both non-financial and financial requirements.
- A person must fit into a general eligibility group and meet specific requirements relating to residency, citizenship, immigration status, third party liability, income and assets.

General WI Medicaid eligibility groups include the following:

- People age 65 or older
- People who are blind
- People with a certified disability

A person must be a Wisconsin resident to be eligible for WI Medicaid. S/he must:

- Be physically present in Wisconsin (there is no required length of time the person has to have been physically present), and
- Express intent to reside in Wisconsin.

**Federal Citizenship and Immigration Status rules require a person to be either a U.S. citizen or a non-citizen with a qualified immigration status.**

WI Medicaid Third Party Liability rules state:

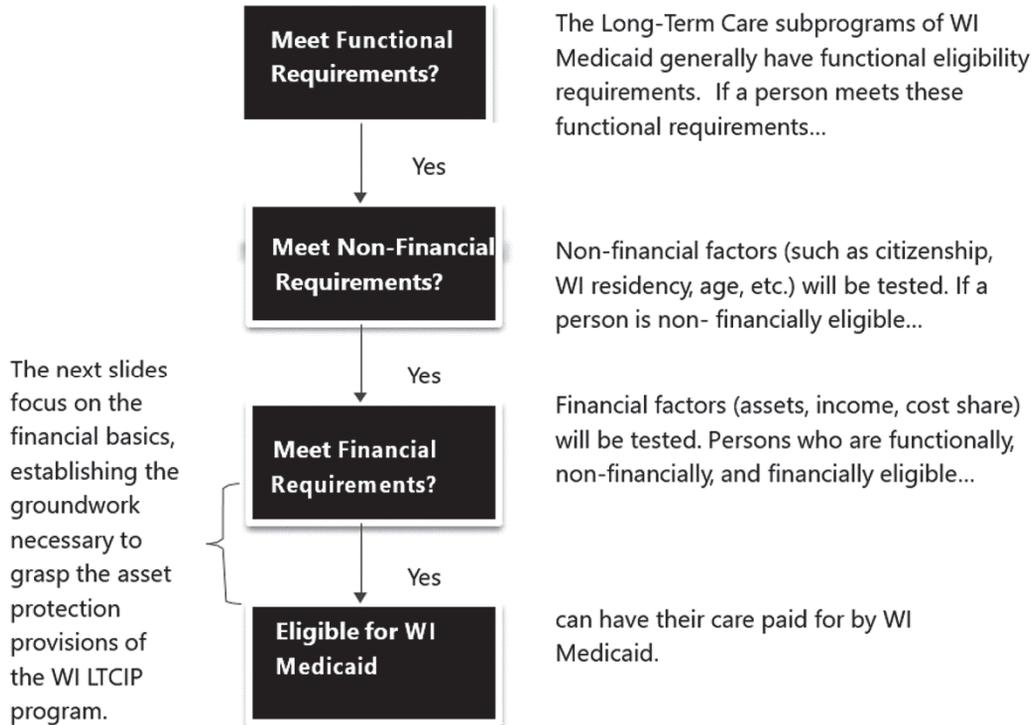
- People must provide information about possible payment sources, such as other health insurance, Medicare or another liable third party (such as a qualified WI LTCIP policy).
- Other payment source pays their portion of medical expenses before WI Medicaid payments are made.

## **General Eligibility Requirements for WI Medicaid RECAP**

- WI Medicaid eligibility policy is complicated, but it can be viewed as having two distinct components: financial and non-financial requirements.
- Together, WI Medicaid's financial and non-financial requirements dictate whether a person will qualify to receive the WI Medicaid benefit.
- WI Medicaid's financial requirements relate to the maximum amount of income and assets a person may have and still be found eligible for the program.
- Non-financial requirements relate to things such as the person's age, disability status, living arrangement, residency, citizenship, etc.
- Understanding this general framework will allow long-term care insurers to better grasp key details associated with WI Medicaid eligibility policy and its relationship to the WI LTCIP program.

# Eligibility Requirements for WI Medicaid Payment of Long-Term Care

## The Basics:



## Key Points:

- ❑ The relationship between the WI LTCIP program and WI Medicaid is grounded in WI Medicaid financial eligibility requirements and, ultimately in WI Estate Recovery policy
- ❑ Therefore, some background information on both WI Medicaid financial eligibility and estate recovery is necessary

To receive comprehensive long-term care benefits through WI Medicaid, the person must:

- meet the program's functional requirements
- meet the program's non-financial requirements
- meet the program's financial requirements
- contribute toward cost of care

**The WI LTCIP program directly affects WI Medicaid financial requirements (i.e., the income test, the asset test and the cost share calculation).**

### **Financial Requirements: Income Test**

- When looking at WI Medicaid eligibility for payment of long-term care services, only the income of the elderly or disabled applicant is counted in determining his or her budget.
- The income of that person's spouse or parent is not counted.

An applicant's gross monthly income, minus certain "credits" is compared to the income limit associated with the program for which the person is applying.

Under certain circumstances, the premium associated with the qualified WI LTCIP policy could be one of the "credits" deducted from gross income to help the person qualify for WI Medicaid payment of long-term care.

If the person qualifies on the basis of his/her income, a separate calculation is performed to determine the amount the individual must contribute toward the cost of his or her long-term care services each month.

### **Financial Requirements: Cost Share**

The cost share calculation starts with the applicant's gross monthly income and subtracts various deductions or credits. Each possible deduction is not allowed for each person.

General deductions include:

- Medicare premiums and health insurance premiums not paid by Medicaid (this includes WI LTCIP policy premiums)
- An income allocation to a spouse who is living in the community, if it is determined that the spouse has a financial need
- An income allocation to certain other family members (subject to specific limitations)
- Personal needs (an amount which changes annually)
- Health care expenses not paid by WI Medicaid or a third party

After allowing applicable income deductions, the result is the amount a person must contribute toward the cost of his or her services monthly. It is typically paid to the WI Family Care (or WI Family Care Partnership) managed care organization, or the medical care facility (for Institutional Medicaid).

## **Financial Requirements: Asset Test**

### **Asset Limit:**

The asset limit for a person applying for WI Medicaid payment of LTC services is \$2,000. If the person applying has a spouse living in the community, the spouse will be able to keep assets substantially above the \$2,000 limit without affecting the applicant's eligibility. This policy is often referred to as "Spousal Impoverishment Protection."

### **Countable Assets:**

- Countable assets are those which are available to the person and are not specifically excluded by the WI Medicaid program.
- Not all assets are countable.

### **Countable Assets include:**

- cash
- checking accounts
- savings accounts

- certificates of deposit
- life insurance policies
- stocks
- bonds
- non-homestead real property
- property agreements like contracts-for-deed
- other liquid assets

**Excluded Assets include:**

- homestead property in which the person or spouse or certain other family members live
- some trusts
- certain funds set aside for burial expenses
- one vehicle
- some federal payments
- household goods
- personal items (such as clothing and jewelry)

The county agency will review all verified assets and determine the amount:

- Counted toward WI Medicaid eligibility
- Excluded and not counted toward WI Medicaid eligibility (including the amount of verified benefits paid out by a qualified WI LTCIP policy)
- Determined to be protected for the community spouse, if married

**Spousal Impoverishment Asset Protections:**

WI Medicaid provides special financial protection to allow the spouse and dependent children of the applicant for LTC Services to retain both assets and income that are above regular WI Medicaid financial limits.

- For long-term care cases where one spouse is still living in the community, special asset protection provisions apply at application.
- An Asset Assessment is conducted by the county agency to establish the

asset limit/test that the person will have to pass when applying for WI Medicaid.

### **Asset Assessment:**

- Person is required to provide documentation of assets that s/he owned with his/her spouse on the date of first continuous period of institutionalization for 30 days or more

OR

- the date of initial request for WI Family Care (including WI Family Care Partnership), whichever occurs earlier

### **CSAS:**

Based on the documentation provided, the county agency will determine the total assets of the couple and the community spouse asset share (CSAS).

- The CSAS is the amount of countable assets above \$2000 that the community spouse, the applicant, or both can have at the time of application and still be found eligible for WI Medicaid. CSAS is based on policy (explained later).
- The long-term care applicant must transfer his/her assets to the community spouse by the next regularly scheduled review (12 months).

If a person's assets are above \$2,000 on the date of the next scheduled WI Medicaid review, s/he will be determined ineligible and will remain ineligible until his/her assets no longer exceed the \$2000 WI Medicaid asset limit.

Once the applicant is enrolled in a long-term care WI Medicaid program, the assets of the community spouse are considered unavailable to the enrollee for the purpose of his/her WI Medicaid eligibility.

### CSAS and Excess Assets:

The amount of assets above the asset limit can be reduced to allowable limits if they are used to pay for:

- nursing home or home care costs
- other costs such as home repairs or improvements, vehicle repair or replacement, clothing or other household expenses

The asset limit for the long-term care WI Medicaid applicant is \$2,000 plus the CSAS:

- If the total countable assets of the couple are \$208,800 or more, then the CSAS is \$104,400. The WI Medicaid asset limit is \$106,400, that is, CSAS plus \$2,000.
- If the total countable assets of the couple are less than \$208,800 but greater than \$100,000, then the CSAS is  $\frac{1}{2}$  of the total countable assets and the WI Medicaid asset limit is  $\frac{1}{2}$  of the countable assets plus \$2000.
- If the total countable assets of the couple are \$100,000 or less, then the CSAS is \$50,000 and the WI Medicaid asset limit is \$52,000.

\*\*The above amounts are based on federal guidelines which change each year.

### **Example**

Robert was first institutionalized September 2003. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2003. The couple had total combined assets of \$42,000, \$32,000 of which was owned solely by Robert.

Robert had until the next scheduled review (September 2004) to get his total assets under the \$2000 WI Medicaid asset limit. By September 2004 Robert had only transferred \$23,000 to Lucinda.

Robert still had \$9,000 in assets. Robert became ineligible October 2004, and will remain ineligible as long as his assets remain over \$2000.

## **Divestment**

- ❑ Divestment is giving away resources, such as income, non-exempt assets and property for less than fair market value to become eligible for WI Medicaid.
- ❑ Fair market value is an estimate of the price for which an asset could have been sold on the open market at the time it was given away

Divestment is also an action taken by a person to avoid receiving income or assets to which the person is entitled.

- ❑ Divesting financial resources within 60 months of the application for WI Medicaid, or institutionalization, may result in a divestment penalty period.
- ❑ WI Medicaid will not pay for long-term care benefits through WI Family Care, WI Family Care Partnership, or Institutional Medicaid during a divestment penalty period.
- ❑ The divestment penalty period begins with the month in which the divestment occurred.
- ❑ The amount divested is divided by the average monthly private pay nursing home cost to arrive at the number of months of the divestment penalty period.

## **Eligibility Requirements for WI Medicaid Payment of Long-Term Care RECAP**

- ❑ Institutional Medicaid, the WI Medicaid Home- and Community- Based Waiver programs (which are being replaced by...), WI Family Care, and WI Family Care Partnership comprise four ways that WI Medicaid delivers long-term care to eligible persons.
- ❑ WI LTCIP program participants are most likely to access WI Medicaid

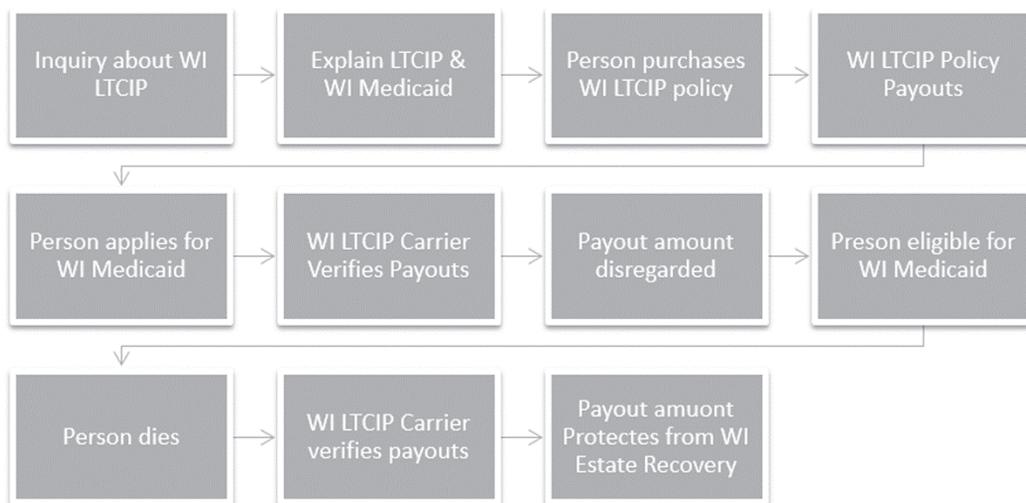
long-term care services through one of these programs.

Each of these programs:

- ❑ Serves individuals requiring a nursing home level of care
- ❑ Applies an income limit that is significantly higher than the limits associated with other kinds of WI Medicaid
- ❑ Requires the eligible person to contribute toward the cost of his/her long-term care, based on his/her income
- ❑ Offers significant asset protections for the community spouse
- ❑ Includes penalties for those who dispose of assets for less than fair market value

## How Asset Protection Works Under the WI LTCIP Program

### Overview



A WI LTCIP program participant receives the following benefits during his or her lifetime:

Assets may be disregarded up to the total amount of long-term care services paid by

the qualified WI LTCIP policy. The disregarded amount is not counted toward the WI Medicaid asset limit.

- ❑ The amount paid out under a qualified WI LTCIP policy must be verified before it can be disregarded for Medicaid eligibility (or estate recovery) purposes.
- ❑ Adequate verification consists of documentation from the qualified WI LTCIP policy carrier specifying the amount paid in benefits as of the date of the documentation (on carrier letterhead, signed by a carrier representative).
- ❑ The carrier must provide adequate verification to the client, the client's representative, or the county agency, or DHFS upon request.

After the WI LTCIP program participant is deceased:

The maximum amount that can be protected from estate recovery under the WI LTCIP program is the verified amount of benefits paid out by the qualified WI LTCIP policy

When the amount of assets disregarded during the person's lifetime due to verified payouts under a qualified WI LTCIP policy is less than total benefits paid by the qualified WI LTCIP policy, additional assets may be protected in the estate recovery process - up to the verified total amount paid by the qualified WI LTCIP policy.

Following are some examples that depict the interaction between the following programs:

- ❑ WI LTCIP program
- ❑ WI Medicaid
- ❑ WI Estate Recovery

## **WI LTCIP Asset Protection for WI Medicaid Eligibility**

### **Example 1: "WI LTCIP Policy Benefits Not Exhausted"**

Ruth is a resident of a medical care facility. She has no spouse. Her qualified \$90,000

LTCIP policy has been paying for her care. When Ruth applies for WI Medicaid payment of long-term care services, she verifies that her qualified WI LTCIP policy has paid out \$80,000 in policy benefits.

Ruth owns the following countable assets:

- \$5,000 savings account
- \$6,000 checking account
- \$70,000 equity value in recreational lakeshore property

The worker determines that Ruth's total countable assets equal \$81,000 (\$5,000 + \$6,000 + \$70,000). Her WI Medicaid asset limit is \$2,000; however, because \$80,000 has been paid out by Ruth's qualified WI LTCIP policy, an additional \$80,000 in countable assets may be disregarded.

In essence then, Ruth's WI Medicaid asset limit is \$82,000. Ruth passes the asset test for WI Medicaid because, at \$81,000, the value of her countable assets totals less than her asset limit. (Of course, Ruth's income would still need to be tested.)

If Ruth were to pass away the next day, \$80,000 of her assets would be protected from estate recovery. The \$2,000 basic asset allowance/limit does NOT apply after death and the \$2,000 is subject to recovery.

### **Example 2: "WI LTCIP Policy Benefits Exhausted"**

A year later, Ruth's eligibility for WI Medicaid is reviewed. At that time, she verifies that she has exhausted her qualified LTCIP policy benefit, which has paid out the full \$90,000.

Ruth owns the following countable assets:

- \$4,000 savings account
- \$7,000 checking account
- \$80,000 equity value in recreational lakeshore property

The worker determines that Ruth's total countable assets equal \$91,000 (\$4,000 +

\$7,000 + \$80,000). Her WI Medicaid asset limit is \$2,000; however, because \$90,000 has been paid out by Ruth's qualified LTCIP policy, an additional \$90,000 in countable assets may be disregarded.

In essence then, Ruth's WI Medicaid asset limit is \$92,000. Ruth continues to qualify for WI Medicaid because, at \$91,000, the value of her countable assets totals less than her asset limit.

If Ruth were to pass away the next day, \$90,000 of her assets would be protected from estate recovery. The \$2,000 basic asset allowance/limit does not apply after death and is subject to recovery.

### **Example 3: "WI LTCIP and Spousal Impoverishment Protections"**

Ruth is applying for WI Family Care benefits. She and her spouse reside in their home and have \$100,000 in countable assets. Her qualified \$80,000 LTCIP policy has been paying for long-term care she has received in her home and is now exhausted. When Ruth applies for WI Family Care payment of long-term care services, she verifies that her LTCIP policy has paid out \$80,000 in benefits.

Because Ruth is living with her husband, Spousal Impoverishment Protections apply. Under Spousal Impoverishment policy, Ruth's WI Medicaid asset limit is \$52,000 (i.e., CSAS plus \$2000...see earlier slides). However, \$80,000 is added to this to reflect the amount of benefits paid by her qualified LTCIP policy. Therefore, when Ruth applies for WI Family Care, her asset limit is \$132,000.

Within one year of applying, Ruth must transfer her assets to her spouse sufficient to allow her to qualify at an asset limit of \$82,000 (i.e., the LTCIP policy pay out amount plus the regular WI Medicaid asset limit of \$2000).

## **WI LTCIP Asset Protection for Estate Recovery**

### **Example 4:**

Ruth is a WI Medicaid eligible resident of a medical care facility. Her qualified \$90,000 LTCIP policy has been paying for her care. As of her last WI Medicaid review, the policy had paid out \$70,000, an amount disregarded in determining her continued WI Medicaid eligibility.

Ten months after her last WI Medicaid review, Ruth dies. Ruth's representatives verify that, during those ten months, her qualified LTCIP policy paid out an additional \$10,000 toward her long-term care.

Ruth's estate can protect a total of \$80,000 (i.e., the total amount paid out by the qualified policy) from estate recovery.

## **How Asset Protection Works under the WI LTCIP Program RECAP**

- When determining WI Medicaid eligibility, assets may be disregarded in an amount equal to the verified total amount of long-term care services paid by the qualified WI LTCIP policy.
- These disregarded assets are not counted toward the WI Medicaid asset limit.
- Assets may be protected from estate recovery in an amount equal to the verified total amount of long-term care services paid by the qualified WI LTCIP policy.

At the request of the WI Medicaid recipient or their representative, the WI LTCIP policy carrier must provide documentation which details date(s) and amount(s) paid in benefits by the policy. The WI Medicaid recipient or his/her representative must provide this documentation to the income maintenance agency worker or estate recovery staff to determine and verify the asset disregard/protection.

## **How to Apply for WI Medicaid Programs**

A person can apply for WI Medicaid in person, by mail, by telephone, or using a web-based internet application. Application forms and instructions are available on-line through the following link:

<http://dhfs.wisconsin.gov/medicaid1/applications.htm>

People who are age 65 or older, blind, or disabled should use form HCF 10101 to apply for WI Medicaid. Completed forms should be returned to the applicant's local county/tribal human or social services agency.

ACCESS is an online tool that allows people to apply for benefits, check the status of benefits, or report changes in circumstances to their worker. ACCESS is available online at:

[www.access.wisconsin.gov](http://www.access.wisconsin.gov)

An online ACCESS application is the same as a paper application.

## **How to Apply for Wisconsin Medicaid Programs RECAP**

Application forms and instructions are available on-line through the following link:

<http://dhfs.wisconsin.gov/medicaid1/applications.htm>

# Long-Term Care Insurance Partnership Program WI Medicaid Training—Part III

## WI Estate Recovery

For current information regarding the Wisconsin Estate Recovery, access the internet at: <http://dhfs.wisconsin.gov/medicaid1/recpubs/erp/p hc13032.htm>

- What is WI Estate Recovery?
- What Services Does Wisconsin Recover?
- When Does The State Not Recover Medicaid Benefits?

## What is WI Estate Recovery?

- Wisconsin Medicaid Estate Recovery seeks repayment for the cost of certain long-term care services paid for by Medicaid on behalf of recipients.
- Recovery is made from the estate of recipients and from liens placed on their homes.
- The money recovered is returned to the WI Medicaid Program and used to pay for care for other WI Medicaid recipients.
- Note that Wisconsin, unlike some other states, does not recover for ALL services that are paid by WI Medicaid.
- The amount Wisconsin can recover is limited to the amount paid by WI Medicaid for certain long-term care services.
- The amount of assets disregarded for WI Medicaid eligibility purposes due to verified payouts under a qualified WI LTCIP policy are protected from estate recovery except for the basic \$2,000 asset allowance/limit that all persons receive while they are alive.
- This \$2,000 asset disregard may be subject to recovery when the person is no longer alive.

The long-term care services for which the program seeks repayment mainly include nursing home services, community-based waiver services and certain other long-

term care services received in the community by a person at least age 55 or older

With the new WI LTCIP qualifying policies, the amount of assets that are protected due to verified payouts are not subject to estate recovery.

## **What is WI Estate Recovery? RECAP**

- ❑ The Wisconsin Medicaid Estate Recovery Program seeks repayment for the cost of certain long term care services paid for by Medicaid on behalf of recipients.
- ❑ Recovery is made from the estates of recipients and from liens placed on their homes.
- ❑ The money recovered is returned to the WI Medicaid Program and used to pay for care for other WI Medicaid recipients.

The amount of assets that are protected due to verified payouts from a qualified WI LTCIP policy are also protected from estate recovery

## **What Services Does Wisconsin Recover?**

As noted previously Wisconsin does not recover for all services provided to a WI Medicaid recipient.

Wisconsin recovers all the costs for a recipient (of any age) for the period of time in a nursing home or inpatient (more than 30 days) in a hospital, as long as the recipient was considered permanently institutionalized. Wisconsin also recovers all costs from any nursing home for a recipient over the age of 55, even if it was a short-term stay in a nursing home.

Wisconsin seeks to recover services that are generally thought of as “long-term care services” for anyone age 55 and older, living in the community

Services that a recipient age 55 and older may receive in the community, subject to recovery, include the following:

- Skilled nursing services
- Home health aide services
- Home health therapy and speech pathology services
- Private duty nursing services
- Personal care services

Wisconsin also seeks to recover benefits paid for any recipient age 55 and older in a WI Medicaid Waiver program, including but not limited to WI Family Care, WI Family Care Partnership, Community Options Waiver, Community Integration Programs IA, IB, and II, Brain Injury Waiver and Community Supported Living Arrangements.

**The benefits recovered for a Medicaid Waiver recipient age 55 and older are:**

- ❑ All services received through the home and community-based Waiver program (i.e., WI Family Care and WI Family Care Partnership).
- ❑ All inpatient hospital services and all prescription drugs received while the recipient was eligible for a Waiver program.

An individual who receives all or a combination of the services listed previously may have the amount paid by WI Medicaid for those services recovered from his or her estate, or through a lien while the recipient is alive - except for an amount equal to the verified payouts under a qualified WI LTCIP policy.

**Example 1:**

Ruth was in the WI Family Care Program. She received services through Family Care that were not eligible for payment by her qualified WI LTCIP policy (worth \$100,000).

She passed away and WI Family Care had paid out \$50,000 in services over the course of three years. WI Estate recovery would file a claim against her estate which includes her home valued at over \$100,000.

When the home in her estate sells, the state would collect on its \$50,000 claim, assuming sufficient funds were available to first pay other priority claims. She was not

able to protect any assets as the qualified WI LTCIP policy did not pay out any benefits to protect her assets.

### **Example 2:**

Millie was also in the WI Family Care Program. At the time she applied for WI Family Care, \$25,000 had been paid out in benefits by her qualifying WI LTCIP program policy; hence \$25,000 of her countable assets were disregarded. She owned her own home worth \$150,000. Because she lived in her home, the home remained an exempt asset for purposes of eligibility.

At the time of Millie's death, \$60,000 had been paid out by the WI LTCIP program policy, however, WI Family Care had paid out \$90,000 in WI Medicaid benefits. WI Estate recovery would file a claim in her estate for \$90,000, however, \$60,000 would be protected from recovery. Annie had a qualified WI LTCIP policy worth \$200,000.

### **Example 3:**

Annie had a qualified WI LTCIP policy worth \$200,000. She had cash assets of \$50,000 and a home valued at \$150,000 that she lived in. She received \$50,000 in benefits from her qualified WI LTCIP policy and then applied for WI Medicaid in a Home-and-Community Based Waiver program. Her qualified WI LTCIP policy had verified pay-outs of \$50,000 at the time of her initial eligibility determination for the Waiver program.

The policy continued to pay benefits while she lived in the community and then she moved into the nursing home. While she was in the nursing home, the qualified policy had verified pay-outs to the maximum benefits - \$200,000; hence the verified \$200,000 would be exempted at the time of recovery from her estate.

## **What Services Does Wisconsin Recover? RECAP**

WI Medicaid recipients who are any of the following may be subject to WI estate recovery provisions:

- ❑ nursing home residents
- ❑ institutionalized persons who received inpatient hospital benefits
- ❑ persons age 55 and older who reside in the community

## **When Does the State Not Recover Benefits?**

- ❑ The state may not seek recovery of any WI Medicaid benefits from a recipient's liquid estate assets while the recipient's spouse or a minor or disabled, or blind child survives the recipient, regardless of any qualified WI LTCIP policy. However, if the recipient's estate includes a home, the state will receive a lien for the amount that exceeds the verified payouts under a qualified WI LTCIP policy.
- ❑ Repayment from the lien will be delayed until after the death of the surviving spouse and any minor, disabled, or blind children.

If the state is granted a lien as noted above, through the estate on the home of a surviving spouse, minor, disabled or blind child of a WI Medicaid recipient and if that property is sold for fair market value while the spouse, minor, disabled or blind child lives, the state will release its lien and no recovery will be made, regardless of the existence of a qualified WI LTCIP policy.

The state may not file a claim on the estate of the surviving spouse to recover WI Medicaid benefits paid on behalf of the pre-deceased recipient.

If a qualified policy has paid out verified benefits in an amount that is equal to or more than the remaining assets of a deceased WI Medicaid recipient, then the state can make no recovery as the assets are protected because of the WI LTCIP policy.

### **Example 4:**

Maynard lived in a nursing home. His wife, Millie, continues to live in their jointly owned home. At the time he applied for WI Medicaid, he had only \$2,000 in cash which was exempted for eligibility purposes. Within one year of becoming eligible for MA, their home was transferred solely to Millie. Maynard had a WI LTCIP qualifying

policy worth \$100,000 that paid most of the cost of the nursing home until it was exhausted.

Then, WI Medicaid paid for his nursing home care for the next two years until he passed away (WI Medicaid paid (\$150,000). The state would file a claim against his estate assets (which are minimal) for \$150,000, however, because there is no home in his estate and only liquid assets, the state would make no recovery because **Millie is a surviving spouse.**

### **When Does the State Not Recover Benefits? RECAP**

- The state may not seek recovery of any WI Medicaid benefits from a recipient's estate while the recipient's spouse or a minor, disabled, or blind child survives the recipient.
- The state may not file a claim on the estate of the surviving spouse to recover WI Medicaid benefits paid on behalf of the recipient.

The verified amount of benefits paid by the qualified WI LTCIP policy are protected from estate recovery. The WI LTCIP policy carrier must provide documentation which specifies the amount paid in benefits as of the date of the documentation.



# **Appendix 5:**

## **Medicaid Annuity Impaired-Risk Life Expectancy Tables**

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**Table 1: Life Expectancy of Men**

	Life expectancy		Life expectancy		Life expectancy		Life expectancy
0	71.80	30	44.06	60	18.42	90	3.86
1	71.53	31	43.15	61	17.70	91	3.64
2	70.58	32	42.24	62	16.99	92	3.43
3	69.62	33	41.33	63	16.30	93	3.24
4	68.65	34	40.23	64	15.62	94	3.06
5	67.67	35	39.52	65	14.96	95	2.90
6	66.69	36	38.62	66	14.32	96	2.74
7	65.71	37	37.73	67	13.70	97	2.60
8	64.73	38	36.83	68	13.09	98	2.47
9	63.74	39	35.94	69	12.50	99	2.34
10	62.75	40	35.05	70	11.92	100	2.22
11	61.76	41	34.15	71	11.35	101	2.11
12	60.78	42	33.26	72	10.80	102	1.99
13	59.79	43	32.37	73	10.27	103	1.89
14	58.82	44	31.49	74	9.77	104	1.78
15	57.85	45	30.61	75	9.24	105	1.68
16	56.91	46	29.74	76	8.76	106	1.59
17	55.97	47	28.88	77	8.29	107	1.50
18	55.05	48	28.02	78	7.83	108	1.41
19	54.13	49	27.17	79	7.40	109	1.33
20	53.21	50	26.32	80	6.98	110	1.25
21	52.29	51	25.48	81	6.59	111	1.17
22	51.38	52	24.65	82	6.21	112	1.10
23	50.46	53	23.82	83	5.85	113	1.02
24	49.55	54	23.01	84	5.51	114	0.96
25	48.63	55	22.21	85	5.19	115	0.89
26	47.72	56	21.43	86	4.89	116	0.83
27	46.80	57	20.66	87	4.61	117	0.77
28	45.88	58	19.90	88	4.34	118	0.71
29	44.97	59	19.15	89	4.09	119	0.66

**Table 2: Life Expectancy of Women**

	Life expectancy		Life expectancy		Life expectancy		Life expectancy
0	78.79	30	50.15	60	22.86	90	4.71
1	78.42	31	49.19	61	22.06	91	4.40
2	77.48	32	48.23	62	21.27	92	4.11
3	76.51	33	47.27	63	20.49	93	3.84
4	75.54	34	46.31	64	19.72	94	3.59
5	74.56	35	45.35	65	18.96	95	3.36
6	73.57	36	44.40	66	18.21	96	3.16
7	72.59	37	43.45	67	17.48	97	2.97
8	71.60	38	42.50	68	16.76	98	2.80
9	70.61	39	41.55	69	16.04	99	2.64
10	69.62	40	40.61	70	15.35	100	2.48
11	68.63	41	39.66	71	14.66	101	2.34
12	67.64	42	38.72	72	13.99	102	2.20
13	66.65	43	37.78	73	13.33	103	2.06
14	65.67	44	36.85	74	12.68	104	1.93
15	64.68	45	35.92	75	12.05	105	1.81
16	63.71	46	35.00	76	11.43	106	1.69
17	62.74	47	34.08	77	10.83	107	1.58
18	61.77	48	33.17	78	10.24	108	1.48
19	60.80	49	32.27	79	9.67	109	1.38
20	59.83	50	31.37	80	9.11	110	1.28
21	58.86	51	30.48	81	8.58	111	1.19
22	57.89	52	29.60	82	8.06	112	1.10
23	56.92	53	28.72	83	7.56	113	1.02
24	55.95	54	27.86	84	7.08	114	0.96
25	54.98	55	27.00	85	6.63	115	0.89
26	54.02	56	26.15	86	6.20	116	0.83
27	53.05	57	25.31	87	5.79	117	0.77
28	52.08	58	24.48	88	5.41	118	0.71
29	51.12	59	23.67	89	5.05	119	0.66

Source: Centers for Medicare and Medicaid Services (CMS)



# Appendix 6:

## Sample CLTC Exam

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### Sample Questions for the CLTC Exam, Version 10

1. The *six activities of daily living* in a tax-qualified LTCI policy include...
  - A. bathing, dressing, eating, walking, toileting, transferring
  - B. eating, dressing, toileting, bathing, continence, transferring
  - C. ambulating, dressing, toileting, continence, walking, bathing
  - D. dressing, cooking, transferring, continence, bathing, walking
  
2. *Acute impairments* are generally treated...
  - A. in nursing homes
  - B. at home
  - C. in hospitals
  - D. in CCRCs

3. In the Three-Step Process, Step 1 establishes...
  - A. the plan of care
  - B. the severe consequences to the client's family and finances
  - C. the funding sources of the plan
  - D. that the client could live a long life and become frail
  
4. A *chronic* condition is a condition that is...
  - A. manageable, but not curable
  - B. curable with appropriate medical intervention
  - C. always going to require custodial care services
  - D. recoverable in the short-term
  
5. Social Workers do all of the following, except...
  - A. determine the type of impairment
  - B. determine the necessary level of care
  - C. decide whether informal or formal caregivers will provide the care
  - D. provide respite care

6. The entrance fee in a CCRC generally guarantees a resident...
  - A. can stay in his apartment as long as he lives
  - B. a full return of the fee at death
  - C. placement in the assisted-living or skilled nursing facility
  - D. home health care
  
7. *Homemaker aides* are available to help with all of the following, except...
  - A. medication administration
  - B. light housekeeping
  - C. meal preparation
  - D. transportation to doctor's appointments
  
8. The goal of rehabilitation in a skilled nursing facility is to...
  - A. return the resident to his home
  - B. send the resident to an assisted-living facility
  - C. qualify the resident for Medicare
  - D. qualify the resident for Medicaid benefits

9. Which is not true of a CCRC?
- A. It offers independent living arrangements with meals in common dining areas
  - B. Its entrance fee is exempt from Medicaid spend-down
  - C. It includes a skilled nursing facility
  - D. It has an assisted-living component
10. If a person retires before age 65, he can receive Medicare...
- A. after his last day of employment
  - B. at age 69
  - C. at age 65
  - D. at age 70½
11. Where is custodial care covered under Medicare?
- A. under Part A
  - B. under either Parts A & B
  - C. it is not covered
  - D. under Part D

12. The VA program that covers medical care for active and retired military personnel is called...
- A. Medicare
  - B. TriCare
  - C. Federal Long-Term Care Insurance Program
  - D. Aid and Attendance
13. Ed, a South Carolina resident, has \$350,000 in life savings. He is very ill and has been advised to transfer all of his assets to his children. He does so on Jan. 1, 2012. He enters a skilled nursing facility, on Dec. 31, 2013, and applies for Medicaid benefits on January 1, 2014. The Look-Back Period begins on...
- A. January 1, 2012
  - B. December 31, 2013
  - C. January 1, 2015
  - D. January 1, 2014
14. Which is considered a countable asset for Medicaid spend-down purposes?
- A. A primary residence
  - B. Stocks and bonds
  - C. Term life insurance policy
  - D. Prepaid funeral

15. Most states permit funds that otherwise would be spent on nursing-home care to be transferred to a Community Spouse in the form of an annuity, if it is...
- A. actuarially sound on the basis of life expectancy
  - B. a life-only SPIA
  - C. assignable
  - D. jointly owned with the institutionalized spouse
16. In a revocable trust, a Trustee...
- A. makes the initial rules of the trust and funds it with assets
  - B. is responsible for making decisions about the trust
  - C. will receive the benefit of the trust's assets
  - D. cannot make any decisions regarding the trust
17. What organization meets regularly to review current and ongoing issues related to the insurance industry?
- A. COBRA
  - B. CMS
  - C. HIPAA
  - D. NAIC

18. Guaranteed renewable means the insurer...
- A. can refuse to renew a policy on the basis of claims experience
  - B. cannot raise premiums once a policy is issued
  - C. can raise premiums on a policy based on the number of claims filed
  - D. cannot refuse to renew a policy regardless of claims experience
19. In a tax-qualified LTCI policy, dividends can only be used to...
- A. reduce future premiums
  - B. refund a cash payment
  - C. reduce taxable income
  - D. pay for long-term care
20. The form requiring income and asset information for LTCI applicants is called the...
- A. Producer's Report
  - B. Financial Verification
  - C. Personal Worksheet
  - D. HIPAA Form

21. As part of the underwriting process, the underwriter may request the applicant's...
- A. bank statements
  - B. attending physician's statement
  - C. trust documents
  - D. health care proxy
22. Prior to accepting a signed application, a producer must provide the applicant with...
- A. an outline of coverage
  - B. a copy of the producer's state insurance license
  - C. a product brochure
  - D. a specimen contract
23. The financial instrument that provides a monthly payout based on the life expectancy and extent of the applicant's illness is...
- A. an equity-indexed annuity
  - B. a medically underwritten HECM
  - C. a viatical settlement
  - D. a medically underwritten SPIA

24. The unethical practice of a producer using misleading or incorrect information in the sale of LTCI is considered...

A. misrepresentation

B. twisting

C. false advertising

D. defamation

25. If a producer tries to damage the reputation of a competitor or his products, it is considered...

A. bait and switch

B. misrepresentation

C. twisting

D. defamation

## **Answers**

1. **B**

2. **C**

3. **D**

4. **A**

5. **D**

6. **B**

7. **A**

8. **A**

9. **B**

10. **C**

11. **C**

12. **B**

13. **D**

14. **B**

15. **A**

16. **B**

17. **D**

18. **D**

19. **A**

20. **C**

21. **B**

22. **A**

23. **D**

24. **A**

25. **D**

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