LONG TERM CARE (PARTNERSHIP)

for

ILLINOIS INSURANCE PRODUCERS

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Chapter 1:
The Practical and Ethical Importance of Product Suitability

It seems rare these days when industries look away from the standard demographic of 18 to 49-year-olds with disposable income and turn their attention toward products that may be helpful to America's older population. In some businesses—particularly where marketers desire a hip, cutting-edge image for their brand—dismissing the likes, dislikes, and needs of older people might be part of an effective marketing strategy. Yet the repetitive talk about the need to reach a wide demographic with enough money to buy goods and services often tends to avoid some striking facts about U.S. consumers.

From a population perspective, roughly 35 million Americans are 65 or older, and, according to the 2000 census, the fastest growing age group in the United States is comprised of people who are 85 or older. From a financial standpoint, businesses might want to think about a 2005 report by the Los Angeles Times, which said the consumers who marketers generally ignore (those people aged 50 and above, and generally referred to throughout this text as "seniors") were estimated to possess 70 percent of the wealth in the United States.

Today's seniors have more dollars to spend than their parents did upon retirement; so much so that many of them have been able to retire comfortably before reaching the standard retirement age of 65. Unlike their children's and grandchildren's generations, modern seniors generally have transferred their focus from the wise ways to accumulate money toward the wise ways to protect money.

This fiscally conservative philosophy ought to make older consumers and insurance professionals a fine match, with one group tired of taking risks with personal finances and the other group specializing in absorbing those risks. What's more, insurance producers who embrace service to seniors will have plenty of opportunities to find perfect business matches for themselves in the years to come, as America's estimated 76 million Baby Boomers prepare to hang up their work clothes and settle into what they hope will be a more leisurely existence.

To an insurer's advantage, the number and finances of current and soon-to-be seniors have increased with society's greater attention to old age and the risks that go along with it. Many Americans in their 50s and early 60s have experienced harsh realities involving their parents' physical, mental and fiscal declines. They have wrestled with the choice to put their fathers in nursing homes or assisted-living facilities and have witnessed the intensive care an elderly person often requires. Some have watched mothers who lived through the Great Depression—and who seemed to put away every penny they ever earned—gradually spend their entire savings on health care and ultimately need public aid. They have spent countless hours trying to secure adequate care for an older relative and have often made major sacrifices to independently look after that relative.

The Baby Boomers have loved their parents enough to confront these disheartening situations, and they love themselves and their children enough to want to avoid repeating those sad events when they, themselves, grow older. Of course, the Boomers will never be able to bypass the aging process, but they hope to go through it as comfortably as possible, both for their own sake and the sake of the loved ones they might leave behind.

Armed with an assortment of products—including coverage for long-term health needs—insurance producers can help consumers fend off fears related to retirement savings and health care costs. As is the case with most things in life, there are no guarantees attached to these products. However, items such as insurance policies can play a significant role in improving the quality of life for seniors and granting peace of mind to families.

Insurance professionals may even make the case that they have a social responsibility to reach out to older people and make them aware of potentially beneficial risk management tools. The potential for necessary service is particularly an issue in regard to health care and the various restrictions built into government assistance programs such as Medicare and Medicaid.

That ethics-based responsibility, though, can work in different ways depending upon the prospect's individual situation. Indeed, insurance products can save people from having to experience financial devastation, but some tragic tales over the years have featured elderly people who not only had insurance but, in fact, had multiple policies. These stories prove it is not good enough to merely purchase insurance products. Instead, a producer must help a person choose the proper product based on the individual's goals, needs and financial means.

Too often, younger people dismiss a senior citizen's investment blunders and attribute those mistakes to the person's advanced age, as if human beings necessarily grow less intelligent the more they see and the more they experience in life. The truth is that the financial products geared toward older people are some of the most complex items offered by banks, lenders and insurance companies. Making sense of all the available options and ultimately making the best choice can be complicated enough to confuse the best-educated and the most-alert people among us, regardless of age.

Understanding these products is made even more difficult by those insurance workers, bank employees and financial planners who either take advantage of people's age-related fears and make sales in bad faith or are nearly as uninformed about product suitability as their clients.

We have even reached a point in our society where some insurance regulators advise older consumers to be suspicious of anyone who gives senior seminars or claims to have earned such special distinctions as "senior adviser."

These warnings incorporate some gross oversimplifications but are still too frequently true, thanks to the unethical conduct showcased by some agents, brokers, financial planners and bank executives. To the detriment of the many trustworthy and knowledgeable senior-focused professionals in business today, these people treat older clients as if everyone who is at or near retirement age is identical and needs the same products as every other citizen.

These salespersons might insist, for example, that long-term care (LTC) insurance is a necessity for all people. This coverage could certainly be helpful in many circumstances. However, whether it is practiced for selfish, commission-conscious reasons or for mere lack of knowledge about individual customers and products, a "one size fits all" approach to insurance sales for any age group is illogical and ethically questionable.

No matter how much salespersons want to believe in age-related stereotypes and wish to lean on those unproven generalizations to market goods and services to older clients, the senior population's size is simply too large for these stereotypes to breed the highest success for insurance producers. Among the 35 million current seniors and the 76 million Baby Boomers, some will be concerned about immediate health issues and will need help supplementing their Medicare benefits. Others will be thinking about a more distant future and be wondering how they will be able to afford an extended stay in a nursing home or in some other care-focused facility. Some seniors will want to protect as many personal assets as possible in order to pass those

valuables on to a loved one or favorite charity when they die. Another group might not have any obvious heirs or many assets and might only express interest in enhancing their income so that they can pay for basic necessities like housing, food and prescription drugs. Many senior clients will have a combination of these concerns, as well as other worries we have not addressed here.

The senior adviser and anyone who sells an insurance product to an older consumer must view each client as an individual and must understand the person's unique situation before going into a sales presentation.

An insurance professional who wants to serve older clients in an ethical way must understand the benefits and drawbacks of various LTC policies, life settlements, reverse mortgages and more. No matter their own age, individual insurance producers should know the basics of Medicare and Medicaid, what the government will cover through those programs and what seniors might have to pay for out of their own pockets.

Because customers have become more knowledgeable about senior issues through their personal experiences with family and friends, the questions they pose to their trusted advisers are bound to be more specific than they might have been ten years ago. Many current and future seniors will want to know about particular features, options and risks related to a specific insurance policy or investment opportunity.

This course aims to serve insurance professionals by exposing them to the often-complex product known as long-term care (LTC) insurance and helping them apply that product to the needs of a remarkably diverse community. The student will not only learn about the basics of the policies but also be alerted to situations when the policies might or might not suit a given customer. Once the student processes this information and is able to determine what products might suit customers, he or she can then focus on tailoring marketing materials and sales presentations that have the best chances of resonating with people and getting them to confidently buy the appropriate products with trust in their insurance professional.

Although this material is carefully constructed and includes numerous expert opinions regarding LTC insurance and product suitability, the presented information is meant to be used as a helpful guideline and as food for thought. As stated previously, every customer's situation is unique, and one should not give serious advice to a potential buyer solely on the basis of one text. Furthermore, this course is not a substitute for thorough and continued study of legal issues related to Medicare and Medicaid or any applicable insurance laws and regulations in the student's community.

This material is, however, a wide-ranging introduction to the insurance market that repeatedly emphasizes the importance of selling the proper products to the right people. Personal experiences and further study might help the insurance professional develop his or her own approach to senior-related sales, but we hope the general guidelines and information presented here will remind students to incorporate a respect for ethics and product suitability into whatever approach they ultimately choose for themselves.

Chapter 2: Addressing Health Needs Through Medicare

Many Americans of all ages assume incorrectly that, once they retire, the government will pick up the tab for most of their medical expenses. Medicare, the government health care program serving most seniors and the disabled, was not designed to cover all senior care and includes co-payments, co-insurance fees and coverage gaps.

Though there is constant debate in political and medical circles regarding Medicare's future, such arguments are not the focus of this course. If insurance professionals are to serve clients well in the present, they need to know what Medicare does and does not cover, be able to explain the program's current features to their clients and assist the public in selecting the most appropriate products to compensate for the program's limitations.

Nearly every citizen or permanent resident of the United States is eligible for Medicare upon turning 65. Though the retirement age for full Social Security benefits has risen to 67 for many Americans, age requirements for Medicare have not changed. You can enroll in Medicare and continue to work full time, and you can receive Medicare benefits without also receiving Social Security benefits.

Medicare has four parts, which are generally known by their own letter (A, B, C or D). Each part has its own set of rules and covers its own variety of treatments and services. Everyone who is eligible for Medicare can choose to be covered through Part A.

Part A is sometimes known as "hospital insurance" because it covers inpatient services but not office visits. Patients are insured through Part A when they're admitted to a hospital or nursing home. This portion of Medicare also pays for hospice care (in just about any environment) and can even pay for care in a private residence under limited circumstances.

Part A usually requires patients to satisfy a deductible and make copayments for covered services, but most people don't pay any premiums for it. As long as you or your spouse has paid Medicare taxes for at least 10 years during your lifetime, you won't need to pay a premium for Part A after turning 65. Minus the deductibles and copayments, Part A is also free for people with end-stage renal disease or another disability.

Whether they pay a premium for Part A or not, patients receiving hospital care are responsible for certain deductibles and copayments. The amounts owed by Medicare recipients depend on where a person is in regard to his or her "benefit period."

A benefit period begins when a patient starts receiving care under Part A at a hospital or nursing home, and it typically stops when the person hasn't been hospitalized or in a nursing home for 60 consecutive days. (If you're in a nursing home but aren't receiving care that can only be provided by a medical professional, your benefit period would've ended when you stopped receiving that special level of care.) There is no limit to the number of benefit periods you can have in your lifetime.

Each new benefit period resets the Part A deductible and copayment requirements. In 2014, patients were responsible for a $1,216 deductible during each benefit period. After beneficiaries satisfied the deductible, Medicare paid for 100 percent of hospital care for the first 60 days of each benefit period. Following those first 60 days, patients made a $304 per-day copayment for days 61 through 90.

If a benefit period lasts beyond 90 days, hospitalization will continue to be covered by Part A if the person has any remaining "lifetime reserve days." Everyone in Part A starts with 60 lifetime reserve days. As their name suggests, these

days will need to last a lifetime and cannot be regained. Once a person's lifetime reserve days have been used up, Medicare stops paying for hospitalization until the start of a new benefit period. In 2014, patients paid a $608 per-day copayment for hospitalization during each lifetime reserve day.

In addition to paying for hospitalization, Part A will pay for a specific portion of a patient's stay in a nursing home. In Medicare terminology, nursing homes are known as "skilled nursing facilities."

Part A's nursing home coverage isn't as long-lasting as its hospitalization coverage. As a result, many insurance advisers believe people who are close to enrolling in Medicare should also consider purchasing long-term care insurance.

For your stay at a nursing home to be covered by Medicare, a doctor must authorize that you need "skilled care." Skilled care is treatment that can only be provided or supervised by a specially qualified nurse or therapist. It can include tasks like changing bandages, inserting feeding tubes or providing physical therapy. It doesn't include custodial tasks like bathing, dressing or normal feeding, but custodial care might be covered if a patient also needs skilled care.

Since nursing homes can be expensive, Medicare will only pay for one when providing skilled care in another setting is impractical. The care also needs to be necessary on an everyday basis, although care that's needed five times a week can suffice if it involves physical, occupational or speech therapy.

Nursing home care won't be covered by Medicare unless the patient has satisfied a few requirements related to hospitalization. First, the person needs to have been hospitalized for at least three days. Next, the reason for needing nursing home care usually needs to be related to the patient's hospitalization. For example, if someone spends three days in a hospital because of a heart attack, those three days normally can't be used to get the person nursing home care on account of a broken leg. Finally, the minimum three days of hospitalization need to have occurred within 30 days prior to the person's entry into the nursing home. For the purpose of an example, let's imagine you were hospitalized for a stroke for five days. You then qualified for care at a skilled nursing facility and stayed in one for two weeks. Now, after returning home for 45 days, you and your family determine that you really should be back in a nursing home. But because you've been back home for more than 30 days, your return to the facility won't be covered by Medicare unless you go back into the hospital for another three days.

Via Part A, Medicare pays for the first 20 days spent at a skilled nursing facility. In 2014, a patient paid $152 daily for days 21 through 100 of skilled care and all costs after that. If a patient needed a blood transfusion during the year, all but the first three pints were covered under Part A as long as the patient had not exceeded the 150-day limit for hospitalization.

People who qualify for Medicare Part A have the option of paying a monthly premium for Part B coverage, which generally pays for visits to physicians' offices and for outpatient hospital services. Monthly premiums for Part B are based on a person's income and tax-filing status.

All Part B enrollees must pay a yearly deductible before Medicare picks up 80 percent of the amount that the federal government allows for a given service, which may or may not be equal to what a doctor actually bills for care.

Americans interested in enrolling in Medicare Part B can choose between the standard Part B plan, with the benefits, co-payments and deductibles summarized above, or they can enroll in Medicare Part C, which combines parts A and B and is administered by a private insurer in a managed care system at a (potentially) reduced cost to both the government and the patient.

Medicare Advantage was created under the assumption that paying private insurers to administer Medicare benefits would save the government money and improve services for seniors. Since most Advantage plans are set up as managed-care systems (like an HMO or PPO), they generally require or encourage patients to seek treatment from a narrower range of providers. Unlike original Medicare, an Advantage plan might require that a patient receive a referral from a primary care physician before seeing a specialist. Alternatively, it may charge the patient more for seeing a provider who is not part of the insurer's network. Theoretically at least, these limits on access are supposed to ensure that a patient's status is more centrally monitored and that costly procedures are only ordered when they're medically necessary.

In exchange for giving up broader access to providers, members of Advantage plans are supposed to receive benefits beyond what's available in original Medicare. Sometimes these extra benefits involve coverage of treatment or services that are usually not part of original Medicare, such as eye exams, hearing exams or gym memberships. At other times, an Advantage plan will cover the same things as original Medicare but require less cost-sharing from patients.

Medicare Advantage plans generally must cover at least the same kinds of care as original Medicare, but the specifics can be different between the two programs. Whereas original Medicare might require patients to pay a 20 percent coinsurance amount to see a physician, an Advantage plan might require a flat $10 copayment for each visit. There might also be differences in the size of deductibles and the number of times a patient will be insured for a particular kind of treatment. Although some aspects of an Advantage plan can require higher out-of-pocket expenses than original Medicare, the overall benefit package from the private plan must be at least as good as what's available from the government.

Choosing between original Medicare and a Medicare Advantage plan is one of the most important decisions a senior will have to make. Advantage plans are particularly popular among relatively young Medicare recipients who don't have many health issues. Here are some of the reasons why:

- A Medicare Advantage plan might cover items or treatments that original Medicare won't. Examples often include eyeglasses, hearing aids, dental care and gym memberships.
- Medicare Advantage plans often require copayments, such as $10 or $20 for each office visit. These fees may be smaller, or at least more predictable, than the percentage-based coinsurance fees in original Medicare.
- Medicare Advantage plans must have a cap on a patient's out-of-pocket expenses.
- Since many Advantage plans cover prescription drugs, patients often don't need to purchase a separate Part D plan for their medications. (You'll read more about the Part D program in a little while.)
- Depending on the plan and the services provided, deductibles in Medicare Advantage might be lower than in original Medicare.
- Someone enrolled in Medicare Advantage might pay lower premiums than someone in original Medicare who tries to obtain similar coverage. (To

obtain similar coverage, the person in original Medicare might need to pay the Part B premium, a Part D premium and a Medigap supplemental insurance premium.)

In spite of those positive benefits, most people choose not to enroll in Medicare Advantage. Here are some reasons why original Medicare might be preferred:

- Many Medicare Advantage plans require that patients see doctors who are in the insurer's network. This can be a problem if a patient spends time in multiple parts of the country or simply wants more choices.
- Insurers with Medicare Advantage plans can decide to leave the market. This is a common concern whenever federal subsidies to Advantage plans are changed.
- Many Medicare Advantage patients need referrals before they can see specialists.
- People in Medicare Advantage plans generally don't have access to Medigap policies that could act as supplemental insurance.
- Since there's very little standardization in Medicare Advantage, consumers may have a hard time comparing available plans.
- Although premiums might be lower in Medicare Advantage, seriously ill patients might have lower medical bills overall if they have original Medicare and a Medigap policy. Cost differentials will depend on the specifics of an Advantage plan and the kind of needed care.

In 2006, Medicare began extending prescription drug benefits already available under many private insurers' Part C programs to all seniors with standard Part A and Part B. The prescription drug program, termed "Medicare Part D," is administered by private insurers and other companies approved by the government. Recipients cannot be denied coverage for Part D due to age, health or income, but each prescription plan covers its own variety of medicines, called a "formulary," and Part D insurers base premiums partially on the costs of these drugs. The plans generally do not cover diet pills or sleep aids.

In addition to their differing formularies, Part D plans also vary from state to state and from county to county. So, a smart consumer and a helpful senior adviser will take an inventory of the medications a client currently needs or might need in the future and will select a Part D plan accordingly, based on availability and price concerns.

Again, the costs of these medicinal benefits are dependent on the drugs covered and the geographical coverage area. But for the sake of a general overview, it might be helpful for the reader to know that among 43 plans available to Illinois residents at the end of 2009, monthly premiums ranged from $26.50 to $105.90. Annual deductibles for those plans ran as low as $0 and as high as $310. In addition to premiums and deductibles, Part D beneficiaries are also responsible for prescription co-payments, which can be as small as a few dollars for generic drugs and much more for name-brand, specialty medications.

Medicare Part D has helped millions of seniors afford their medicine, but it also has a significant coverage gap. The gap, known as the "doughnut hole," will get progressively smaller on an annual basis because of health care reforms that were enacted in 2010. But the gap isn't scheduled to be entirely closed until 2020.

Someone in a Part D plan usually has to pay a deductible before their insurer will cover any drugs. Once the deductible has been satisfied, the plan will temporarily pick up a significant portion of the person's drug costs. During this period, the insured will be responsible for a copayment (such as $10 or $15) or a coinsurance fee (such as 25 percent of the cost). Once the plan's expenses and the person's out-of-pocket expenses for prescription drugs reach a certain amount for the calendar year, the person falls into the doughnut hole.

Coverage in the doughnut hole has undergone important changes since 2011. During the first five years that Part D was offered, the insured was responsible for all drug costs while in the doughnut hole until he or she had reached the plan's annual out-of-pocket limit. Once the annual out-of-pocket limit was reached, the person qualified for "catastrophic coverage" and was only responsible for a small copayment or small coinsurance fee for the rest of the calendar year. In 2010, the gap between regular Part D coverage and catastrophic coverage cost many seniors nearly $2,000.

In 2011, seniors in the doughnut hole received a 50 percent discount from drug manufacturers on brand-name drugs and a 7 percent discount from the federal government on generics. Those discounts are scheduled to increase gradually until 2020, when the doughnut hole is expected to be closed. At that point, Medicare beneficiaries in Part D will be insured for at least 75 percent of drug costs.

Chapter 3: Filling in the Medigaps

Seniors who want protection from costs that Medicare does not cover but who don't want to be on a Medicare Advantage plan can supplement their standard Medicare benefits with a private insurance product commonly known as a "Medigap" policy. To induce desirable employees to join their firms, some companies offer Medigap insurance as part of their retirement packages, but most of these policies are purchased by individual senior citizens to meet their private needs. These policies are as old as Medicare itself and have been sold by banks and retirement organizations, including the American Association of Retired Persons (AARP), as well as by insurance professionals.

For decades, the states and the federal government struggled to keep the Medigap market safe for consumers, many of whom had little understanding of these policies. Insurance agents who were either uninformed about Medicare or interested primarily in snagging high first-year commissions took advantage of a scared customer base that was willing to pay high prices for poor coverage as long as a policy claimed to offset some senior health expenses. When the elderly passed away, their families would sometimes learn their departed loved ones had bought several Medigap policies that served little or no purpose for the cash-conscious consumer. Many policies either duplicated coverage the buyer already possessed through another Medigap policy or duplicated benefits seniors were already entitled to receive through Medicare.

In part to protect seniors against predatory salespersons, the government began standardizing Medigap policies in 1992, ensuring that seniors receive the same basic benefits from a particular Medigap plan regardless of the insurer. Anyone who sells Medigap policies must disclose all instances when Medigap benefits overlap with Medicare benefits. The government's stricter regulation of the Medigap market has made these policies increasingly attractive to many seniors who are neither rich enough to pay for the estimated 45 percent of services not covered by Medicare nor poor enough to rely on public assistance through Medicaid.

Medigap plans are usually referred to by a particular letter (Plan A, Plan B, etc.) Since these plans are standardized by the federal government, all consumers who have the same lettered plan are entitled to the same basic benefits.

As of June 1, 2010, the 10 standardized Medigap plans and their corresponding mandatory benefits are as follows:

- **Plan A**: This plan covers all hospital copayments for Medicare Part A and pays for an additional year of hospitalization if the insured has used up his or her lifetime reserve days. It also covers most coinsurance fees or copayments that are required in Part B and for the first three pints of blood needed during hospitalization. If a patient is in hospice care, copayments for prescriptions and respite services are covered, too. All insurers in the Medigap market must sell Plan A.
- **Plan B**: In addition to the benefits available through Plan A, this plan covers a patient's Part A deductible.
- **Plan C**: In addition to the benefits available through Plan B, this plan covers what the patient would normally pay for days 21 through 100 at a skilled nursing facility under Medicare Part A. It also covers the person's Medicare Part B deductible and includes foreign travel benefits. Other than in emergency situations near the border, Medicare does not pay for medical services rendered outside the United States. Plan C fills in some of that coverage gap by paying for 80 percent of foreign medical expenses in an emergency during the first 60 days of a foreign trip. (There's a $250 deductible and a $50,000 lifetime limit for foreign travel benefits.) Insurers that sell Medigap plans other than Plan A must also sell Plan C or Plan F.
- **Plan D**: In addition to the benefits available through Plan B, this plan includes the previously mentioned foreign travel benefits and pays the patient's portion of days 21 through 100 at a skilled nursing facility.
- **Plan F**: In addition to the benefits available through Plan C, this plan covers amounts charged by a non-participating provider that are in excess of Medicare's assigned charge. (For a review of non-participating providers and assigned charges, please refer back to the section "Charges and Assignment.") People with Plan F have the option of receiving these benefits at a reduced cost in exchange for a high deductible. Insurers selling Medigap plans besides Plan A must also sell Plan C or Plan F.
- **Plan G**: In addition to the benefits available through Plan D, this plan covers amounts charged by a non-participating provider that are in excess of Medicare's assigned charge.
- **Plan K**: This plan covers hospitalization copayments and provides an extra year of hospitalization coverage for people who use up their lifetime reserve days. It also covers 50 percent of (1) Part B copayments and coinsurance fees; (2) a patient's first three pints of blood; (3) hospice coinsurance and copayments; (4) skilled nursing care for a limited number of days; and (5) the Medicare Part A deductible. When a person's annual out-of-pocket expenses for services in Plan K reach a certain amount ($4,660 in 2012), the plan will pay for 100 percent of covered care.
- **Plan L**: Plan L covers the same things as Plan K, but it pays for 75 percent of most covered care instead of 50 percent. When a person's annual out-of-pocket expenses for services in Plan L reach a certain amount ($2,330 in 2012), the plan will pay for 100 percent of covered care.
- **Plan M**: Plan M includes almost the same benefits as Plan D, but it only covers half of the Part A deductible.
- **Plan N**: Plan N includes almost the same benefits as Plan D, but it makes the person responsible for as much as $20 for each office visit and $50 for each outpatient trip to the emergency room.

You probably noticed that the preceding list of Medigap plans skipped a few letters. Plans E, H, I and J were offered years ago but are no longer available to insurance applicants. Seniors who had already purchased one of these plans had the option of keeping it or switching to a plan on the list.

In some states, Medigap insurance can be obtained through a Medicare SELECT plan. A Medicare SELECT plan is a Medigap plan with its own network of providers. It's similar to an HMO plan and is often less expensive than a regular Medigap plan.

Be aware that the benefits listed above are required by the federal government. Each state may institute additional requirements for Medigap insurance policies.

The standardized Medigap plans contain significant benefits for most seniors, and many of these supplemental policies are available at relatively low prices if the prospective insured takes the time to shop around. However, Medigap policies

have several drawbacks and, despite their name, do not fill all the big holes in the Medicare system.

Eligibility problems might make some seniors decide against Medigap coverage and entice them to join a typically less-restrictive Medicare Advantage plan. As long as a senior applies for a Medigap policy within six months of signing up for Medicare Part B, an insurer generally cannot charge a person more because of health or deny an application because of health. An insurer can, however, impose a one-time waiting period on the insured, during which no benefits will be offered for treatment of pre-existing conditions.

The waiting period for coverage of pre-existing conditions can last up to six months and can be applied to any health problem that the insured had during the six months prior to purchasing a Medigap policy.

If a person was recently covered by other health insurance and is now applying for a Medigap policy, the old insurance can help reduce or even eliminate the waiting period for pre-existing conditions. The waiting period under the Medigap policy will be shortened by the amount of time the person was previously covered.

Old insurance that reduces a waiting period for pre-existing conditions is called “creditable coverage.” The use of creditable coverage has kept many sick people away from financial disaster, but it has its limits. If people allow themselves to go uninsured for more than 62 consecutive days, their old insurance can’t be used anymore as creditable coverage.

If consumers shop the market, they might learn that the same standardized policy can cost significantly more when bought through one insurer as opposed to other companies. Some disparities result from the different ways insurers set rates for Medigap coverage. Some insurers determine their prices by examining cumulative health statistics that factor in all policyholders. Others adjust prices based on a senior’s age at the application stage.

Perhaps the least popular Medigap policies among senior customers are those that rise in cost as the insured person grows older and presumably more prone to major health problems. Many seniors purchase their supplemental health insurance through the AARP, which receives a commission from favored insurers for policies bought by its members and has traditionally endorsed health plans with premiums that are not dependent on the insured’s age.

Yet, even among insurers who underwrite policies without regard to age, Medigap rates can be comparatively low in one state or community and comparatively high in another, depending on health statistics, environmental hazards, the kinds of care practiced in the area and the amount of money local medical professionals charge for services.

In a broader context, some politicians and insurance experts have questioned the societal benefits and risks presented by supplemental insurance for Medicare. A faction concerned about Medicare’s future as an adequate source for widespread senior aid has argued that Medigap policies ultimately hurt the United States by draining more of Medicare’s resources than is truly necessary. If a senior does not need to pay much for care because federal and private insurance handles most bills, that senior might be more inclined to seek out non-essential medical attention. Unless a senior’s Medicare premiums amount to more than what physicians charge the government for care, the federal system loses money.

Some industry professionals have noted a vicious, supply-and-demand cycle that, in general terms, could create crises in any other insurance line as well. At one point in the cycle, health care costs go up, and policy rates rise as a result. These rate increases become too unreasonable for healthier seniors who feel they do not receive enough coverage for the cost, and these seniors consequently decide to drop Medigap coverage. Of course, the people most likely to put up with the rate hikes are those seniors who need coverage the most. Faced with a smaller and sicker customer base, insurers struggle to make adequate profits on the policies and sometimes see no other choice than to raise rates even higher.

From a less abstract standpoint, however, the biggest flaw in the Medigap market is its often unsatisfactory coverage of the skilled, intermediate and custodial care that does not require hospitalization but might still be necessary on a long-term basis. Medicare and Medigap insurance products generally only pay for nursing and home care costs following hospitalization, and what little coverage Medicare and Medigap patients receive in this regard usually only applies to short-term needs.

With their time limits and their insistence that lower levels of care can only be covered after a patient receives a higher level of care, the government and Medigap insurers avoid addressing the logical progression of old age and thereby put the people they are trying to protect at significant financial risk. Consider the following hypothetical example, which involves the general, gradual decline in health many seniors experience:

A 65-year-old widow lives alone, needs reading glasses and feels an occasional assortment of aches and pains now and then, but she still lives an active and independent life. Fifteen years later, she has thicker glasses, takes a few prescribed pills throughout the day, keeps a close eye on her blood pressure and sometimes uses a cane to get from one place to the next, but she is still mentally sharp and capable of living on her own without her children worrying too much about her. She does, however, have trouble balancing herself after a long sit, and her physical strength is far less than what it used to be. These factors are particularly problematic when she bathes herself. She fell getting out of the shower at one point, sustaining some bruises, and there have been a few occasions when she has sat in her bathtub and struggled to pick herself up. She and her family decide to hire a caregiver to help the woman with basic tasks in the morning, including bathing. But because her problems are due to aging instead of an incident that required prior hospitalization, the assistance is not covered by Medicare or her Medigap plan. After five more years, she struggles when walking short distances and is starting to have problems with her memory. One of her children recalls visiting her and noticing that the woman had forgotten to turn off one of the burners on her stove. The senior and her family decide she needs someone to be near her on a regular basis, and the woman moves to an assisted-living facility, where staff members are always nearby and where she no longer needs to trouble herself with cooking, cleaning or doing her own laundry. But, like the custodial care she received in the past, her stay at this facility is not covered by Medicare or her Medigap policy. Five more years go by, after which the woman becomes confined to a wheelchair and begins to lose strength in her arms and hands, so much so that she needs significant help at meal times. Still, Medicare and her Medigap insurer have not been obligated to pay for her care, and the woman’s savings, once amounting to hundreds of thousands of dollars, may be nearly or completely depleted.

Situations such as this one are realities for many of today’s seniors, and with life expectancy on the rise and the Baby Boomers coming of age, the future is bound to produce millions more seniors with drained bank accounts unless aging individuals explore different avenues leading toward financial safety.

Chapter 4: Addressing the Need for Long-Term Care Insurance

Though mainly thought of as a senior citizen's product, long-term care (LTC) insurance can help consumers fill holes in health coverage at any age. In general, LTC policies absorb the costs of skilled, intermediate and custodial care that a chronically ill or recovering patient requires outside of a hospital environment for more than 90 days. In Illinois, an LTC insurance policy must cover at least one year of treatment.

Since debuting in the 1970s, LTC policies have evolved from pure "nursing home insurance" into flexible risk management tools that allow policyholders to receive health services in other settings, including assisted-living facilities, life centers and private homes. Illinois law defines "long-term care insurance in the following, specific manner:

"Long-term care insurance" means any accident and health insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for 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 term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.

On the surface, LTC insurance that covers medical needs brought on by the aging process might seem like an easy product to sell. Agents and brokers certainly have plenty of statistics to suggest such coverage is a wise investment. Whereas a 1988 report by the San Francisco Chronicle said only 5 percent of the elderly resided in nursing homes (at an average annual cost of $22,000), the Health Insurance Association of America has since estimated that 40 percent of seniors will eventually need care at a nursing home. The price for a private room in that environment currently, according to the MetLife Mature Market Institute, averages out to about $75,000 a year, and, if the history of nursing costs is any indication of future numbers (one study found the cost of living at a nursing home increased by 5.7 percent between 2004 and 2005), that estimate could inflate to six figures in a few years. Whereas three years seemed like a particularly long stay in a nursing facility back in the 1980s, experts say the average stay today is 2.5 years.

By applying one statistic to the other, we can estimate the average person who enters a nursing home and stays in a private room will end up spending at least $187,500 for LTC. Even if we assume the person started receiving care after hospitalization and has 100 days paid by Medicare and Medigap insurance, the person would still have a bill of $166,952.05. News items and studies from the 1990s reported residents at nursing homes used up their entire savings, on average, after only 13 months.

Insurance professionals know that most adults care about protecting personal assets and about making sure loved ones are financially secure. Why else do people purchase optional health and life insurance and often buy more coverage for their cars and property than laws or mortgage agreements demand? People insure their homes against fires and their automobiles against major traffic accidents, and they are probably very wise to do so. But the probabilities and costs of property damage and auto wrecks seem quite small compared to a person's 40 percent chance of staying in a nursing home and the high cost for the average stay. With that in mind, it would seem we can logically assume that Americans are likely to purchase coverage for perils (such as long-term health problems) if they know their risk potential is statistically high and that the financial effects of the risk are typically severe.

Yet as far as LTC insurance is concerned, that kind of assumption has been proven wrong. Insurance insiders have waited several years for LTC policies to explode on the market, with one observer even predicting in 1998 that LTC coverage would ultimately become as common as car insurance. But growth has either been big but temporary, or steady but unremarkable. Since coverage became widely available 15 to 20 years ago, the percentage of U.S. adults with LTC insurance has hovered around 5 percent and 10 percent. In 2006, National Underwriter reported 8 percent of Americans 45 and older had the coverage, including only 16 percent of seniors.

Even when LTC sales go through upswings, the market for policies remains relatively small, typically benefiting the most popular insurers and leaving the rest of the industry to fight over the remaining share of prospective insureds. According to the trade publication Employee Benefit Plan Review in 2002, the top five LTC insurers shared more than 60 percent of the market, even though similar coverage was available from over 120 other companies.

Though market share is certainly a valid business concern, the relatively small percentage of customers who own LTC policies and the inability of most companies to become competitive in the market suggests the insurance community might need to band together and embark on a temporary campaign that alerts consumers to LTC risks and advertises the general product rather than any specific policy or seller.

The public's timid response to LTC insurance suggests complex issues pertaining to the product and hints at the unique challenges insurance producers might face when trying to sell the coverage to customers. Early on, LTC insurers suffered from image problems thanks to a small but scary minority of companies who took elderly people's money and paid out few, if any, benefits. As frightened as some seniors were of becoming ill and not having money for LTC, a portion of them became even more worried about spending good money on sham policies.

In time, the industry seemed to welcome stricter regulation of these products, perhaps realizing that a publicized market cleanup would increase consumers' confidence in the companies that had been offering quality coverage all along. Highly reputable insurers have debuted increasingly extensive coverage that caters to various senior preferences, including care at home and at assisted-living centers as well as at the traditional nursing facility.

Those trust issues, though, were probably always secondary concerns, even when LTC insurance scams were most common. The main barriers agents and brokers face when trying to sell these policies relate to the general concept of

LTC insurance. People either believe the insurance is a valuable tool for managing major risks in other people's lives but refuse to acknowledge those risks in their own lives, or they recognize the risks but determine that buying insurance will not solve their potential problems.

The salesperson may become frustrated when consumers use these rationales to avoid the purchase of needed coverage, but that frustration should not necessarily discourage producers. After all, if we consider human emotions and various facts as they pertain to LTC coverage, we may come to understand the public's negative reactions to the product, thus allowing us to better serve needs.

Nearly all our insurance purchases result from fear. We buy life insurance because we fear the negative financial effects our death might have on the people we leave behind. We buy health insurance because we worry about becoming ill or injured. We buy auto insurance because we fear car accidents and thieves. Yet, particularly in the LTC business, this fear element can also have a detrimental effect on our insurance decisions. When faced with an insurance offer, we are forced to confront our fear that bad things will happen to us and will therefore make a proposed policy useful. A person might recognize the benefits of life insurance but put off purchasing coverage because doing so would require him or her to address mortality. Perhaps exemplifying society's reluctance to face death-related fears in the eye, the Arizona Republic cited a study conducted by FindLaw.com, which concluded 55 percent of adults had neither a will for their property nor a legal agreement with a trusted adult to look after their children in case of a parent's death or incapacitation.

At least with most life insurance and wills, however, mortality can present itself in a somewhat vague manner. Indeed, a life insurance purchase is an acknowledgment on our part that we will eventually die, but, unless a policy is designed to only cover a specific illness or disaster, it does not necessarily force us to focus on the exact way we will perish. As depressing as any death-related thoughts might be, life insurance tends to cover so many possibilities that we may struggle to become fixated on a single, specific morbid possibility. We might experience a painful death or a peaceful passing, and good life insurance is likely to cover us either way.

LTC insurance, on the other hand, forces us to face fears that are much easier to visualize, especially if we have had personal experiences with such care from interacting with elderly loved ones. As much as LTC policies have changed to serve seniors in a variety of residential setups, any acknowledgment on our part that we may need LTC is unlikely to put us in a good mood. No matter the circumstances, LTC requires people to surrender some independence; such a highly valued concept in our society. No matter the circumstances, LTC is also likely to signify loneliness. When we think of LTC, we think not only about physical discomfort, but also about outliving our spouse or other loved ones or perhaps about being separated from them while we receive care.

It is difficult for many people to look at the positive and overcome the fear of needed LTC. Most likely, if we ultimately require LTC insurance, we will have reached a point in our lives where our health is not destined to ever improve very much, simply because improved health at a certain age would contradict natural law. Most likely, if we ultimately require LTC insurance, our death will be slow, in the sense that we will be gradually losing our strength and our control over our bodies. For those of us who have observed this process as it did its work on our parents, grandparents and others, the very real possibility that we might end up going through the process ourselves can be very scary, even if we truly believe our later years can also be filled with joys too wonderful to put into words.

Also, because of the high risk potential and costs involved with LTC, people who are at all interested in the insurance will do themselves few favors if they buy the lowest-costing coverage and rely on easily revocable policies with long waiting periods, high deductibles and low maximum benefits. For LTC insurance products to serve their purposes effectively, buyers must consider a worst-case scenario. When given the choice of either addressing those possibilities by buying LTC coverage or turning LTC salespersons away from their doors, how many people would not be greatly tempted to opt for the latter?

When soliciting among those adults who do not try to hide themselves from the societal realities involving LTC, insurance salespersons are likely to face rejection from prospects who firmly believe their financial situations during senior years will be different from those of the millions who could benefit from coverage. In some cases, these people will be correct. But at other times, candidates will be making poorly analyzed assumptions without discussing matters seriously with loved ones who factor into their plans. For this reason and more, insurance professionals have an incentive and an ethical duty to make LTC risk management a collaborative endeavor that involves families as well as the individual client.

Some adults believe LTC insurance is not for them because they think a family member will care for them as their health deteriorates. This outcome is possible but hardly absolute in modern times. On one hand, members of extended families might have enough close relatives to share a caregiver's responsibilities, but the average smaller family might determine that providing adequate care to even one relative is an overly challenging experience. The days when the typical household featured one adult who stayed home and another who worked are gone, and they have been replaced by an era populated by many latchkey kids with two working parents and by single mothers and fathers who do not have as much time as they would like to spend with their family, even when everyone's health is relatively good.

Despite various calls for equality and shared responsibilities among the sexes, females are disproportionately put in charge of family care, no matter their professional and personal ambitions or their other familial and business obligations. Even if we assume males are just as willing as females to drastically restructure their lives to perform caregivers' duties, other factors (such as adult children's increasingly common decision to relocate far away from their parents) can make family-administered care an unrealistic option.

Regardless of what they feel they owe their elders, adults who decide to handle a senior's LTC on a private basis must make tremendous sacrifices that will affect their career goals, social lives and fiscal resources. Families must have serious and honest talks about one another's realistic expectations, desires and commitments. The potential caregivers need to decide if they are truly willing to make all those sacrifices, and the potential care recipients need to decide if they feel comfortable asking their loved ones to accept those sacrifices.

If the two sides agree to live under those terms, they then need to tackle the issue of expertise. Up to a point, an average adult can look after an elderly loved one adequately, perhaps bathing, feeding and dressing the senior and ensuring that prescribed medications are taken at the proper times. But LTC recipients typically develop needs that are beyond an untrained person's capabilities. Even helping someone in and out of a bed or wheelchair can be an unwise activity for a novice if the senior's bones are especially fragile. Unless a committed caregiver has a nursing background, even family members with patience, compassion and other good intentions might get to a point

where their best efforts are not enough to meet their patient's needs.

According to a study conducted by Life Insurance Market Research Association International, Inc. (LIMRA), 75 percent of Americans age 55 and older believe neither they nor their family will need to pay for LTC. The wording of that statistic can lead us to only two logical conclusions. The first of those is that the respondents believe they will not have to pay for care because they will never require it in the first place. In this regard, insurance professionals need to be careful when they try to appeal to potential buyers by quoting certain statistics, and they should prepare themselves for quick rebuttals from their audiences.

Suppose, for example, an agent banks his or her sales presentation on the assumption that a customer will be startled by the previously mentioned Health Insurance Association of America's claim that 40 percent of seniors will spend time in a nursing facility. The reluctant consumer has an easy out in this case because, obviously, the person still stands a greater chance (60 percent) of not entering a facility. When insurance professionals present LTC policies and consumers consider those offers, both parties can be honest with each other, admitting that, in truth, nobody knows what the future holds and that factors such as life expectancy, the changing lifestyle of the typical senior and the future discoveries bound to be made in the scientific community could all instigate major shifts in the ways Americans perceive and receive health care for chronic conditions.

The public is being exposed to more examples of active senior citizens than ever before. Bringing to mind the cliché about only being as old as you feel, some Baby Boomers are likely to recognize that, although they once considered a 50-year-old to be ancient, they have personally passed that age and are still going on long hikes, familiarizing themselves with the latest gadgets and engaging in various other activities they do not associate with being "old." Today, what are the odds of a 50-year old or even a 60-year-old man sensing that it is time to prepare for LTC in a nursing home by buying some insurance? The agent or broker may have a tough time getting through to these Baby Boomers who believe they can defy the aging process.

On second thought, maybe the 60-year-old should listen more carefully to the LTC insurance salesperson. Though people are living longer, healthier lives and Baby Boomers might have even higher life expectancies than their parents (many of whom have either passed 90 or are close to doing so), living longer may mean a greater likelihood of the eventual need for long term care. Medical advances might allow tomorrow's seniors to live longer lives, but at what point will those advances surpass improvements in the quality of life for the elderly? Maybe future seniors will enter nursing homes at the same age their parents did and just end up staying there for an average of five years as opposed to today's average of 2.5 years.

No matter a prospective purchaser's exact decision regarding a proposed LTC policy, insurance professionals ought to be able to understand why it is not an easy one to make. However, enough experience has told our society that the benefits available through LTC policies can serve many immensely important purposes. Perhaps, as more LTC claims are filed and as more buyers provide feedback about the policies, insurance producers will become increasingly capable of tailoring specific LTC plans to specific individuals, thereby increasing customer satisfaction and the potential for industry profits.

Chapter 5: Avoiding Myths and Promoting Truths About Medicaid

The second logical conclusion we can make based on the LIMRA study is that people believe neither they nor their families will need to pay for LTC because a third party, most likely the government, will cover the expenses. Some insurance producers who are intent on making LTC sales regardless of product suitability tend to distort facts and try to manipulate consumers through fear by implying that, unless a senior has LTC coverage, he or she could eventually run out of money and end up either on the street or in a substandard facility with inferior caregivers and uncomfortable surroundings.

The truth about LTC insurance and government is this: If seniors can initially afford LTC insurance, they are almost certainly taxpayers who are generally entitled to share in the benefits provided through public assistance programs such as Medicaid once their personal assets drop below a certain amount. KiplingerForecasts.com reported payments made by Medicaid to LTC facilities in 2002 amounted to $82.1 billion and accounted for a third of the program's costs.

Instead of being made to fear destitution, seniors deserve to know the truth about what Medicaid will pay toward LTC and the sometimes difficult process an individual must go through to become eligible for coverage.

Seniors and their families might worry about the effects Medicaid assistance can have on the quality and availability of health care. This concern is valid in the sense that once people are approved for Medicaid, they risk losing some personal choices in regard to their treatment and living conditions. For obvious reasons, the government is unlikely to pay for a private room in a selective assisted-living center with the most luxurious living quarters, the best meals and the most extensive list of exciting group activities. It is also true that individual states have reimbursed care providers and LTC facilities in ways that could affect the availability of some services to low-income citizens.

According to Consumer Reports, some states' Medicaid programs pay facilities and caregivers the same amount of money with minimal regard to the degree of rendered care, while other states have higher reimbursement rates for advanced care. Some Medicaid critics have suggested that the equal payment systems discourage facilities from accepting patients in need of high-level care and have also argued that the higher reimbursement rates for advanced care discourage facilities from accepting low-maintenance patients.

Yet, to use Medicaid as a scare tactic in an LTC sales presentation would involve making gross overgeneralizations and might inadvertently dissuade government officials and the public from focusing on and solving some of the program's specific flaws. Medicaid has been known to pay for nearly half of all LTC in the United States, and though individual cases of patient neglect and substandard treatment deserve our attention, denouncing the totality of public assistance for LTC would imply that nearly half of today's nursing home and life center residents do not receive proper attention from staff and do not receive decent medical treatment.

Relying on scare tactics and misinformation also tends to involve ignoring the legal and ethical ways for citizens to receive Medicaid benefits and still possibly avoid becoming neglected victims with few choices. People who worry about not getting into a quality facility once they go on Medicaid can do themselves a great favor by researching reputable facilities' Medicaid acceptance policies and by moving into a favored environment while they still possess a respectable amount of personal, financial assets.

Many onsite LTC providers—particularly those affiliated with religious organizations—accept Medicaid payments for seniors who are already permanent residents. The government might not pay an amount equal to what the facility charges, and seniors transitioning from private payment to Medicaid might need to give up such luxuries as a private room. But many of these organizations can make up for the smaller reimbursements with the money they make from their privately billed residents and generally will not order a Medicaid patient to leave the premises. Many medical professionals employed daily by these businesses and non-profit organizations are not told which patients are paying their own way and which ones are receiving government aid, so the standard of day-to-day medical care at the same facility is unlikely to change based on one's finances.

However, many other senior communities do not accept Medicaid, and the ones who do take it usually try to limit the number of public-aid patients they will serve. If a senior lives in a facility that does not accept Medicaid and suddenly needs LTC, he or she might have to move to a different facility that will accept government payments, and the destination could be dependent on which Medicaid-friendly facilities have the beds and the money to accept the transfer. Seniors who live in private homes and lack enough assets to pay for any kind of extended stay at an LTC facility could face these problems, too, if they ever require onsite care from trained nurses. It is perhaps worth noting, however, that Medicaid might reimburse family members for providing LTC in private homes under some circumstances in some states.

Medicaid Eligibility

The most obvious downside to Medicaid, and one of the reasons many people purchase LTC insurance, is that a person must be nearly wiped out financially to qualify for benefits from the needs-based program. Exact eligibility requirements differ among states, but, in general, a Medicaid recipient can only possess a few thousand dollars in personal assets to qualify for public assistance.

In most cases, a person's private home and car are exempt from Medicaid eligibility requirements, meaning that the government cannot force someone to sell these items or surrender them in some other fashion before he or she can receive public aid. Under federal law, however, a home's exempt status does not apply if the Medicaid applicant's home equity (not necessarily the equity of any additional owners) exceeds either $543,000 or $814,000, depending on state choice n 2014. Note that these figures are adjusted periodically for inflation and that they might not apply in cases where a spouse, blind child, disabled child or a child under 21 is residing in the home.

Any income a Medicaid beneficiary earns is generally supposed to go toward medical expenses, but some states enforce more-lenient income requirements while strictly enforcing compliance with personal asset rules. Even in states where income requirements are strictly enforced, Medicaid beneficiaries are entitled to a small, monthly allowance, which the person can use to pay for non-covered expenses, such as phone and television services. The recipient may also keep some funds designated specifically for funeral costs.

Until the passage of the Spousal Impoverishment Act in 1988, Medicaid required married couples to jointly spend down their shared assets before either the husband or wife could benefit from the system. In some extreme cases that received significant media attention, relatively healthy spouses who wanted to keep themselves above the poverty line opted to divorce their unhealthy spouses who needed Medicaid assistance.

The government responded to these cases by passing the Spousal Impoverishment Act, which typically allows healthy spouses to keep one-half of any jointly held assets up to a certain dollar amount. In 2014, the maximum amount of jointly held assets that could be exempt from Medicaid eligibility rules was $117,240, and the minimum was $23,448. The exact numbers differ from state and are adjusted periodically for inflation.

Income earned solely by healthy spouses does not factor into unhealthy spouses' Medicaid eligibility. However, any current or past joint assets that have been structured within a certain timeframe to reduce a Medicaid applicant's share of those assets might affect eligibility. Each state also has the right to allow exceptions to Medicaid eligibility rules in cases of undue hardship.

With Medicaid as a backstop regardless of its imperfections, consumers and even some insurance professionals question whether or not LTC policies are necessary for certain buyers. On one hand, financial experts over the years have said—based on high premiums and health care costs—people who are not poor but who do not have more than $50,000 in assets (excluding a home and automobile) are better off paying for LTC themselves until Medicaid kicks in, rather than paying LTC insurance premiums. Other experts have supported higher asset requirements for suitability purposes, such as $100,000 and $200,000. In a more general form of advice regarding cost-effectiveness, some experts say LTC insurance should not be bought if the premiums will be coming out of the principal portion of someone's personal savings, rather than interest earnings.

On the other hand, it can also be argued that once a person needs LTC, the individual's expenses will be almost exclusively related to health care, making preservation of a personal nest egg potentially pointless at that stage. It is unlikely, for example, that a woman in a nursing home will be using her money to buy a car or a trip to Europe for herself. For many Americans, LTC is one of those risks that entice people to save money in the first place. So why not put all that accumulated wealth to good use during an obvious time of need?

Some insurance customers will find themselves attracted to LTC policies for reasons of principle rather than concrete dollars and cents. Perhaps their pride makes applying for public assistance through Medicaid an unacceptable option. Many Americans have been financially independent throughout their adult lives and might view a boost from the government as a sign of failure on their part, a fall from the fiscal graces they had worked so hard to maintain. Others might have experienced poverty, conquered it in their own lives and believe Medicaid assistance would signify a return to square one; proof (in their minds, at least) that their perseverance was ultimately worthless.

More commonly though, people who prefer LTC coverage over Medicaid will profess a desire to pass their wealth on to their children, other loved ones or favorite charities. Here, again, is a reason for LTC insurance salespersons to involve families in the decision-making process.

Pretend, for a moment, you are entering retirement and have a grandson with serious medical problems. Your spouse passed away years ago, and you do not have any plans to treat yourself by buying anything extravagant for the rest of your life. The money you possess could pay for a semi-private room in a reputable nursing home for a little over a year, good enough to secure you a spot in the home before you run out of funds and would need to apply for Medicaid. But you ultimately want to pass along as much money as possible to your child so that your grandson's care becomes less of a financial strain on the family. Even if LTC insurance ends up costing you thousands of dollars over the years in premiums, a comprehensive policy might cover your health needs and still allow your loved ones to inherit some much-needed assets. Despite your ever-advancing age, your focus

is still on taking care of your family, and you want that care to continue in some way, no matter when your days on this earth come to an end.

The preceding example involves special circumstances, but, regardless of need, many adults will want their assets to go to a favored individual or organization as an expression of love or as a building block for a lasting, fruitful legacy. Also, many potential beneficiaries will very much want to protect their possible inheritances and might believe an LTC insurance policy will aid in the preservation of a senior's assets.

The possibilities for emotional discomfort are numerous if a senior and potential inheritors decide to discuss topics related to illness, weakness, death and beneficiaries. But, if LTC insurance is being considered, this conversation could lead to a relatively easy decision about possible coverage. If children's wealth greatly exceeds their parents' wealth, there might be fewer reasons for seniors to bother with LTC insurance for inheritance purposes, as opposed to steadily spending down their assets and applying for Medicaid. Likely beneficiaries might also feel very strongly that—regardless of their own financial situations—the money a senior earned throughout a working lifetime should be used by that senior to enjoy as comfortable a latter-day existence as is possible. This type of spending could be exemplified by taking up residence in a non-Medicaid environment and purchasing an LTC policy. Or it could involve the senior moving to the best Medicaid-eligible facility available and enjoying life there with the knowledge that because the senior moved in and paid for services while he or she could do so, he or she might never have to move anywhere else.

Insurance customers hoping to protect their assets for inheritance purposes should keep in mind that buying an LTC policy—though certainly increasing the likelihood that money will be available to beneficiaries upon a senior's death—is not an impenetrable shield against savings depletion. As the reader will learn later in this course, policy limits and restrictions can still force a person to use up carefully accumulated funds and to require coverage through Medicaid.

Medicaid Planning

Families focused on asset protection must also be aware of the legal and ethical issues involved with a popular estate concept called "Medicaid planning." For years, some financial advisers have made their livings by helping clients take advantage of loopholes in the Medicaid system through asset transfers and other financial maneuvers, all designed to allow people to become eligible for public aid without giving up much of their money. These financial plans have become common enough for the government to deem them abusive and to enforce increasingly strict laws that close many of those loopholes.

In general, the government audits financial statements dating back five years (referred to as the "look-back period") before a person applies for Medicaid. If these statements show that a person transferred or surrendered personal assets for less than fair market value, the state may refuse Medicaid benefits for a period equal to the amount of time it would take the person to spend down those assets. For institutionalized care, this waiting period is calculated by dividing the total value of unlawful transfers by the monthly average cost of nursing home care in the area. Waiting periods for care rendered outside of an institutional environment cannot last longer than the waiting period for institutionalized care.

Medicaid rules regarding asset transfers do not apply when the transferred asset is a home and the recipient is the person's spouse, a minor son or daughter, a blind or disabled adult child or an adult child who lived in the home for at least two years prior to the person's move to a nursing facility and who acted as a caregiver during those years. Nor do these rules generally apply when assets were transferred completely to a spouse, to trusts set up for a spouse, a disabled son or daughter or another disabled individual under the age of 65. Other kinds of trusts, particularly those that provide money for Medicaid recipients, might cause eligibility problems.

Initially, the laws passed to restrict Medicaid planning were instituted with penalties and criminal charges that mainly affected the applicant. These rules have since been revised to transfer significant responsibility for unlawful Medicaid planning to the financial advisers behind the criminal acts.

Regardless of the legality involved with Medicaid planning, financial planners and their clients face an ethical issue when they consider ways to protect assets while at the same time becoming eligible for public aid. Medicaid, which began operating in the 1960s, was designed as a needs-based program of last resort for poor adults and their children, and the program continues to cover many more medical needs that do not relate to LTC. Although life expectancy and the costs of care have forced formerly upper-class and middle-class Americans to apply for public assistance, the system is not and never was intended to support citizens who could pay for adequate treatment with their own money.

Opponents of Medicaid planning wonder if financially comfortable individuals who protect their assets and apply for Medicaid will end up taking money and quality care away from the poor citizens who must truly rely on the government for necessary medical assistance. If citizens question the quality of care currently available through Medicaid, how can they not believe that the quality of care will decrease in the future as more middle-class and upper-class Americans dip into the Medicaid budget? Debates seem constant in any country with public assistance programs funded by tax dollars. But passionate people on both sides of these issues—meaning those who firmly believe the wealthy among us should pay taxes to support a welfare state and those who believe the wealthy should pay no taxes to support the poor—might ironically find common ground in the belief that taxpayers should not be paying money into a Medicaid system in order to help protect someone else's inheritance.

On the other hand, many Americans see nothing wrong with legal Medicaid planning. They have worked nearly a lifetime to support themselves and their families, and they believe they are entitled to hang onto the fruits of their labor. They have supported government programs, such as Medicaid, for years via payroll deductions and other taxes, and they might feel they deserve some reciprocated support from the government after all these years of contributions. Americans who criticize fellow citizens for "hiding" assets from the government might have a change of heart when the assets in question belong to them or their parents, rather than to complete strangers.

This section has summarized some of the federal rules regarding state Medicaid programs and transfers of personal assets. Treatment of these assets is detailed in Title 42, Chapter 7, Subchapter XIX, Section 1396p of the U.S. Code in the following manner:

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in

subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to-

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to-

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to-

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced-

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless-

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless-

(i) the annuity is-

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from-

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity-

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B),

a State may determine the period of ineligibility applicable to such individual under this paragraph by-

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage-

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that-

(A) the assets transferred were a home and title to the home was transferred to-

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets-

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to-

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust-

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

(B) In the case of an irrevocable trust-

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income-

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if-

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer

from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if-

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that-

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action-

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

Estate Recovery

A final and relatively new Medicaid issue that might shape a person's LTC insurance decisions is estate recovery. Several decades ago, when the Social Security Act was passed, one section of the law made it permissible for states to recover money spent on Medicaid beneficiaries by putting liens on homes and other property, even if these kinds of property were exempt from Medicaid's eligibility requirements.

Though estate recovery is a complex process, a simple generalization that the layperson can understand is this: A Medicaid recipient might not be able to leave a private home to a beneficiary upon death. This situation can occur in cases where the property owner did not purchase any LTC insurance, as well as in cases where a person purchased some, but not enough, LTC insurance to remain financially independent from Medicaid.

Estate recovery has been part of federal law for many years, but it did not receive much attention until the early 1990s. When Medicaid began, it was generally believed that people receiving public aid either owned homes with low equity or did not own homes at all. So, the incentive for the government to recover money from people's estates was minimal. By October 1993, only 28 states had implemented estate recovery systems, and many of those systems continue to limit the government's ability to recoup money from heirs. Some state programs have limited estate recovery to situations in which home equity is above $25,000. Others have stipulated that, although the government may recover money from estates, it cannot recover that money by putting a lien on residential property. (Bear in mind that a person's "estate" may be loosely defined as anything of value in a person's name, including but not limited to land or buildings.)

But, faced with budget deficits and worries about Medicaid's financial future, the federal government declared in the fall of 1993 that every state must set up an estate recovery program. Some state lawmakers wondered aloud about the hardships this mandate might cause for poor families and initially refused to cooperate with the decree. In a bit of a twist, the states that complied with the mandate allegedly recouped more money in the next year than the U.S. government had hoped, and some of the hold-out states wondered if the high nationwide returns might allow their communities to get away with non-compliance.

Ultimately, the federal system continued to put pressure on those states that disagreed with the estate recovery concept. When West Virginia refused to implement a program, for example, the federal government threatened to cut off funding for Medicaid in the area. At the time of this writing, every state had passed estate recovery legislation.

Perhaps recognizing the delicacy of the issue, the writers of the Estate Recovery Act and related federal laws seem to have focused mainly on the methods of repayment states cannot engage in, rather than the methods that are permissible. For example, the U.S. government has put heavy restrictions on any state's ability to put liens on property while the Medicaid recipient is still alive. In order for such liens to be lawful, the following conditions must apply:

- The person has received Medicaid benefits in excess of his or her needs.
- The person is using all income and liquid assets to pay for in-patient health care and is not expected to return to a private residence.
- No spouse, minor child, blind or disabled adult child, or a sibling (with equity in the home who lived on the property dating back to at least one year prior to the Medicaid recipient's move to a nursing facility) continues to reside on the property.

After death, liens on people's homes in the name of estate recovery are not permissible if any of the following conditions apply:

- A surviving spouse is still alive.
- The deceased has a child who has not reached the age of 21.
- The deceased has a child of any age who is blind or disabled.
- A sibling of the deceased, who has equity in the home and lived in the home at least one year prior to the Medicaid recipient's move to a health care facility, continues to reside in the home.
- An adult child, who lived on the property and acted as a caregiver to the Medicaid recipient for at least two years prior to the recipient's move to a health care facility, continues to reside in the home.

Despite the anger brought on by estate recovery laws and programs, the funds states recover through these programs generally amount to less than 1 percent of annual Medicaid expenditures, and the federal government allows states to make exceptions based on an individual's financial needs and his or her relationship to the deceased.

Some of the federal rules regarding estate recovery conclude this section and can also be found in Title 42 of the U.S. Code. It is worth noting, however, that the information provided in this course regarding Medicaid is meant for general purposes. LTC insurance customers who are concerned about Medicaid eligibility and estate recovery—not to mention agents and brokers who intend on dispensing facts about these topics—should consult with a legal professional who specializes in elder law:

a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except-

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual-

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home, except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if-

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or

recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of-

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources-

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who-

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that 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 such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time-

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when-

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year

immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual-

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)-

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review

the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

Chapter 6: Picking the Proper LTC Policy

Having established the possibility that LTC coverage might not always be the best tool an insurance producer can offer to every customer, we will leave spirited debate behind for now and focus on what agents and brokers can do to best serve clients who are appropriate candidates for LTC policies. Before they can advise clients regarding their purchasing decisions, insurance producers must understand the basic components of all legally recognized LTC policies in the state.

Standard Exclusions

Above all else, agents and brokers must know what kind of care insurance companies may exclude from LTC coverage, and they must communicate these uncovered risks to potential clients. Federal and state governments generally do not require insurers to cover LTC associated with the following circumstances:

- Pre-existing conditions: Insurers in Illinois may not use a definition of "pre-existing condition" that is any more restrictive than "the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment. Or a condition for which medical advice was recommended by, or received from a provider of health services, within six months preceding the effective date of coverage for an insured person."

  Though applicants are unlikely to obtain any long-term care insurance when they have pre-existing cases of AIDS, multiple sclerosis, muscular dystrophy, cirrhosis or Parkinson's disease, many insurers will grant coverage to applicants with other pre-existing conditions—such as diabetes or a heart problem—as long as the policyholder agrees to pay out of pocket for all treatment related to the condition within a specified time frame. For example, a consumer might need to pay for the first six months of diabetic care before the policy applies benefits to those services.

- Mental illnesses or nervous disorders: This exclusion typically does not apply to organic forms of mental illness. An insurance company cannot deny coverage for Alzheimer's disease unless it was a pre-existing condition. Alternatively, people with mental illnesses or nervous disorders might qualify for disability insurance available through Social Security.

- Drug addiction: In addition to illegal drug dependency, this exclusion also applies to alcoholism.

- Acts of war: Treatment for injuries sustained in an incident deemed an "act of war" by insurers and the federal government might not be covered, even if the injured person is a civilian.

- Self-inflicted injuries: This exclusion applies to suicide attempts as well as to serious yet non-life-threatening incidents.

- Military injuries: In 2001, the federal government introduced TRICARE for Life, a lifetime insurance program meant to replace veterans' Medigap policies. The Department of Veterans' Affairs is usually responsible for giving cash grants to military personnel who are injured during active duty.

- Aviation injuries: This exclusion applies when the insured is not a paying passenger in an aircraft.

- Care covered by other insurance plans: This exclusion applies to treatment that would otherwise be covered by either private or public insurance plans, including Medicare and workers' compensation. Depending on the existence of local no-fault laws, this might also apply to injuries sustained in automobile accidents. Illinois specifically permits LTC insurance companies to exclude coverage for any treatment that could be handled through an individual's existing health insurance plan or through any of the person's additional LTC policies.

Benefit Triggers

Assuming that care does not relate to the mentioned standard LTC insurance exclusions, buyers and sellers need to understand what must occur for a policy to start paying benefits. Back in the days when LTC insurance was synonymous with nursing home insurance, some policyholders received no benefits unless they spent at least three days in a hospital. Limiting coverage in that way is now illegal throughout much of the United States, including in Illinois.

More commonly, policy benefits go into effect when the insured person can no longer perform specific "activities of daily living" (ADLs). Though insurers have the right to add additional ADLs as benefit triggers, Illinois requires its LTC policies to contain at least the following six ADLs:

- Bathing: Including the ability to move in or out of a shower or tub, clean oneself, and dry oneself.

- Dressing: Including putting on clothing and any medical accessories, such as leg braces.

- Eating: Including chewing, swallowing and using utensils.

- Transferring: Including moving in and out of beds, cars and chairs.

- Toileting: Including being able to get to a restroom facility and perform related, basic personal hygiene.

- Continence: Including controlling the bladder and bowels and performing related, basic personal hygiene.

Most LTC policies feature ADL-related triggers that are contingent on the insured's inability to perform at least two of the six standard activities. Illinois does not allow ADL triggers to be contingent on the insured's inability to perform four or more ADLs.

The ADL concept is not a terribly difficult one for buyers to grasp, but they and their trusted advisers sometimes forget to view ADLs from both a physical and mental perspective. Suppose, for example, a woman in the 1980s insisted on an LTC policy that did not exclude care for Alzheimer's patients. Nothing in her chosen policy specifically mentioned the disease, but the policy's ADLs were limited to the standard physical tasks mentioned above. Years later, the woman was diagnosed with Alzheimer's and needed to be looked after, but, because the ailment had not prevented her from independently performing various physical tasks, the LTC policy gave her and her family no financial relief.

Maybe the insurance salesperson knew all along about the loopholes in the policy and was more concerned about making the sale than about customer satisfaction. Or maybe, like the woman, the seller simply did not connect the necessary dots that could have formed a clear picture of the uninsured risks. Either way, the buyer made a very costly error in both a monetary sense and a medical sense.

Insurers and state governments have tried to rectify these kinds of situations by including multiple benefit triggers within LTC policies. Though not required to do so by law, a small number of insurers include triggers based on a person's inability to perform specified "instrumental activities of daily

living" (IADLs), which might involve mental capabilities as well as physical ones. Common IADLs over the years have included the following:

- Taking medication at prescribed times.
- Meal preparation.
- Performing housework.
- Paying bills.
- Balancing check books.
- Shopping.
- Using a telephone.

In order to more firmly ensure coverage for physically healthy but mentally inhibited policyholders, Illinois requires all LTC policies to feature "cognitive impairment" as a benefit trigger. This term could make coverage mandatory for Alzheimer's treatments, but it might also apply to less-specific ailments that have caused patients to lose their memory, misjudge place and time, struggle to reason and put them in potentially dangerous predicaments.

A few policies contain a third benefit trigger that allows policyholders to receive covered care for general reasons of "medical necessity," as agreed to by the insurer and a licensed physician. This third trigger, rarely addressed by LTC insurance salespersons in trade publications, could sometimes work in the policyholder's favor if he or she can still perform specified ADLs but suffers from a cognitive impairment that is difficult to diagnose. Conversely, this trigger may be too vague in some cases and could prompt heated debates between insurers and physicians about what care is truly "medically necessary."

The definition of "medical necessity" is the basis for coverage of treatment within nearly any health insurance plan. Several court cases over the years have involved the differing interpretations of the term among patients, doctors and insurers, with some people insisting it relates merely to care that keeps the person alive. Others claim medical necessity incorporates any treatment designed to ease a patient's pain. A third group says the term should be limited to care that improves the quality of a patient's life, and another group believes the valid definition of "medical necessity" exists as some mixture of these stricter viewpoints. Courts have upheld laws that permit a patient to instigate an independent review of claims denied on the basis of medical necessity, but those rulings only help the consumer if the insured person bothers to challenge an unpaid claim.

Perhaps in an attempt to lessen legal battles over medical necessity, Illinois has enacted LTC insurance laws that require insurers to define such potentially vague words as "customary" and "reasonable" within policies and policy summaries. Also, all benefit triggers must be listed and explained within a policy under an independent paragraph titled "Limitations or Conditions on Eligibility for Benefits." This paragraph must also include the identity of the person who will decide when and if the policyholder has satisfied eligibility requirements. In some cases, the insured's private physician may make permissible evaluations related to ADLs and cognitive impairment. In other situations, a medical professional employed by an insurance company as a care manager is responsible for making these determinations. This section summarizes many of the details regarding benefit triggers, as they appear in Title 50 of the Illinois Administrative Code. Relevant portions of the Administrative Code appear below:

Section 2012.128 Standards for Benefit Triggers

a) 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 3 of the activities of daily living or the presence of cognitive impairment.

b) Insurers may use activities of daily living to trigger covered benefits as long as they are defined in the policy. Activities of daily living shall include but not be limited to the following, as defined in Section 2012.40 of this Part and in the policy:

1) Bathing;
2) Continence;
3) Dressing;
4) Eating;
5) Toileting; and
6) Transferring.

c) 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 subsections (a) and (b) of this Section.

d) For purposes of this Section the determination of a deficiency shall not be more restrictive than:

1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
2) 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.

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

f) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

g) The requirements set forth in this Section shall apply as follows:

1) Except as provided in subsection (g)(2) of this Section, the provisions of this Section apply to a traditional long-term care policy issued in this State.
2) For certificates issued under a group long-term care insurance policy as defined in Section 351A-1(e)(1) of the Code, the provisions of this Section shall not apply.

Benefit Periods and Elimination Periods

The ultimate question receptive LTC customers must ask themselves is, "How much coverage should I buy?" The person's eventual answer to that question is spelled out in a policy's "benefit period" and "elimination period."

The benefit period addresses how long coverage will last. This figure is often discussed in terms of time, with most benefit periods lasting a few years, and with some more expensive policies lasting a lifetime.

The time element within the benefit period arises because many policies pay for LTC on a day-by-day basis. This may be done either through an indemnity system or an expense-incurred system.

In an indemnity setup, the policyholder receives a specific amount of money for each day's care no matter how much the caregiver charges. For example, a policy might pay the insured party $100 each day for LTC expenses over the span of two years. In an expense-incurred arrangement, services

are rendered, receipts or bills are passed along to the insurer, and money is paid based on the specific charge.

Whenever a benefit period is directly or indirectly limited to a specific dollar amount, the prospective insured will want to consider how inflation might influence a policy's future effectiveness. If, for example, a 50-year-old buys an LTC policy with an indemnity feature and does not require LTC until 25 years down the road, health care costs will probably rise significantly during the interim, and the policy might not pay out enough benefits in order to satisfactorily cover necessary health services. The problems surrounding the seemingly inevitable rises in health care costs and the adequacy of LTC benefits may be tackled via inflation protection features, which increase benefits annually by at least 5 percent. The reader will learn more about these features in a later section of this course.

Elimination periods are essentially LTC insurance deductibles that are expressed chronologically rather than as concrete dollar amounts. These features spell out how long an insured person must pay for LTC services before a policy's benefits can be used.

Some LTC policies have no elimination period and allow a policyholder to receive benefits immediately after being deemed an LTC patient. Most policies, though, feature elimination periods that last somewhere between one month and six months.

The producer can do the prospect a great ethical service by explaining exactly how the insurer treats elimination periods. For example, it may be important for people with a 30-day elimination period to know how an insurer treats intermediate care that a patient receives once a week. The elimination period might include those six remaining days of the week, meaning that coverage will begin after a month, or it might require the policyholder to pay for 30 days of actual care (which would amount to a 30-week wait) before the insurance benefits go into effect.

Obviously, the longer the elimination period, the lower the premiums are likely to be. Because costs for LTC services can vary significantly from one region to the next, insurance producers and their prospective LTC purchasers should research prices based on a insured's geography and any relocation plans before choosing benefit periods and elimination periods.

Residential Options for LTC

The place where an insured person hopes to receive LTC ought to play an immensely significant role in the analysis of a proposed policy. Most early LTC insurance products did not give the buyer many residential options, usually reserving coverage solely for stays in nursing homes. But many of today's LTC policies cover what can generally be referred to as "community care benefits," which allow insureds to receive care in nursing homes, their own homes, assisted-living centers and other environments.

When faced with a number of residential options, clients might find it easier to confront their LTC fears. People can acknowledge, for example, that LTC recipients who are still living in their own homes or who are receiving care at an assisted-living facility still possess some degree of independence and are not necessarily completely incapacitated.

Given choices, some clients will prefer coverage that is as broad as possible, while others will want to limit coverage so they do not end up paying for benefits they would never care to use. According to the Health Care Financing Administration, senior facilities across the United States offered 44 different kinds of care to their clientele in 1995. Basic summaries of some of the most common LTC residential options appear next:

- Nursing homes: Probably the most commonly recognized LTC option and almost certainly the most expensive one, a nursing home is designed to provide patients with the most intensive medical care and assistance they can receive outside of a hospital. In addition to providing custodial and intermediate care, nursing homes can offer skilled care on a 24-hour basis. Sometimes these facilities will separate patients based on similar medical needs. One wing of a nursing home, for example, might be reserved for Alzheimer's patients.

  Despite stereotypes related to these environments and the elderly, a significant portion of nursing home residents are non-seniors who are in the middle of working their way back from an extended hospital stay to an independent life.

  Nursing home costs (averaging somewhere near $75,000 per year for a private room at the time of this writing) will often include meals and supervised activities for patients. According to a study from Duke University's Center for Demographic Studies, the number of nursing home patients in this country has decreased in recent years, as more elderly people have opted for care at home or in an assisted-living environment.

- Assisted-living facilities: Assisted-living facilities are very popular among the senior community, at least in part because they offer some necessary medical and personal assistance while still preserving enough of the individual freedoms that the person might give up in an institutional environment. Residents in assisted-living communities are typically free to come and go as they please, are given meals at specified times and can ask for assistance with ADLs at any time throughout the day. Some skilled care, however, might not be available unless a health care practitioner is making a scheduled visit to the facility.

  The cost of assisted-living care is much lower than the price of services rendered at a nursing home. According to the Illinois newspaper the Pantagraph in 2004, one health care association estimated the average annual cost for assisted-living in the United States was $24,000. Despite the continued increases in health care costs, it is possible that the competitiveness within the assisted-living industry will help keep price increases relatively low and will encourage facilities to enhance services in an effort to gain more residents.

  State governments have noted the popularity and savings involved with assisted-living centers and have even offered temporary financial support to nursing homes that choose to convert themselves to assisted-living; thereby not only increasing the availability of beds for middle-class seniors, but also allowing government programs such as Medicare and Medicaid (which cover some nursing home stays but usually do not cover assisted-living) to save money. Due to the demand for such care and the fact that most assisted-living facilities do not accept Medicare or Medicaid, administrators will typically pre-screen potential residents by looking into any possible social, physical or financial risks that an applicant might pose to the organization.

  From an LTC insurance perspective, assisted-living facilities must be approached with care. Many LTC policies will cover some kind of assisted-living care, but "assisted-living" is a surprisingly generic term with definitions that can vary from state to state or from one facility to the next. Illinois, for example, did not begin to specifically license assisted-living facilities until after the year 2000, and though many policies base coverage on a facility's licensure by the state, others might have stricter or looser conditions for covered care. For these reasons, neither the insurance producer nor the insured

should assume that all businesses that call themselves "assisted-living" centers will be reimbursed for services through an LTC policy.

- Life centers (continuing care communities): If clients wish to remain in one place no matter how dependent they might become on caregivers, they might want an LTC policy that specifically covers assistance received at a "life center" or "continuing care community," which typically serves a wide range of seniors in need of varying levels of supervision and medical assistance, all in one large facility or in neighboring buildings. Life centers house largely independent seniors and provide them with meals, activities and housekeeping services. They also serve assisted-living residents by helping with ADLs and can take care of patients who need full-fledged nursing home assistance.

  With most life centers operating as non-profit organizations (many are affiliated with religious groups), residents are generally assured of receiving quality care no matter how long they remain at the center or how low their assets might drop over the course of several years. In return for this later-day security, life center residents will often make a major down payment for their care when they enter a facility and will also pay monthly fees similar to those paid by assisted-living or nursing home residents. If a life center resident dies or moves to another facility, a portion of the entry fees might be refundable, but this would likely depend on the length of the person's stay at the center. As much as these facilities try to find an acceptable balance between private-paying residents and formerly private-paying residents now on public assistance, bed shortages in advanced wards of life centers might force someone to move to an affiliated care community that can meet skilled care needs.

- Home care: Most Americans would understandably prefer to receive LTC in their own homes—for reasons of comfort, convenience, pride and familiarity—as opposed to moving to a nursing facility.

  Federal and state insurance laws have enhanced this coverage's flexibility and provided some consumer protection to buyers. Though coverage limits under the same policy may differ for institutionalized care and home care, an LTC insurer that covers home care must at least do so in an amount equal to at least one-half of the value of the policy's institutionalized coverage. Unlike past policies, modern LTC insurance cannot force a policyholder to first receive care at a nursing home before at-home benefits go into effect. In an attempt to address patients' custodial needs, lawmakers do not allow Illinois insurers to sell policies that limit coverage solely to medical services or to services performed by licensed or registered nurses. Laws in some areas also allow LTC policyholders to tap into their home care benefits in order to pay for nursing home care if they have exhausted their institutionalized benefits.

  Although many Americans assume nursing homes are the most probable settings for senior abuse, studies have shown the elderly are more likely to be abused in a private residence, where the abuser has fewer witnesses to worry about. This information is not presented for the purpose of demonizing the majority of home caregivers, who perform admirable tasks for people in need; but concerned families might find some comfort in knowing that the less private environment of a nursing home or assisted-living center might be more apt to deter the few rotten apples in the bunch from committing extremely unethical and possibly dangerous acts.

  Many LTC policies with home care benefits also cover respite services that are available at an adult day care center. On one hand, this seems more like a family benefit than a policyholder benefit, because it ensures that home-based caregivers have opportunities to conduct personal business, spend time with other loved ones or merely take a break from their nursing responsibilities. At the same time, however, one could argue that this respite care ultimately benefits the patient, because any reduction in stress experienced by family caregivers is likely to keep the chronically ill or physically disabled individual in the comforts of home for a longer period of time.

  More than 3,000 adult day care centers operate in the United States, with many of them catering specifically to people with special needs, such as people with physical impairments, people with cognitive impairments, people with chronic conditions and people recovering from illnesses or injuries. For a variable daily cost, adult day care centers will usually feed visitors, dispense medication at prescribed times and engage the person in group activities. Some centers also offer counseling services designed for caregivers.

Mandatory LTC Policy Provisions

Benefit periods, elimination periods and residential settings all allow for consumer choices and professional advice, but some provisions in LTC policies are non-negotiable and have been mandated by Illinois law in order to promote consumer protection throughout the LTC market. Mandatory provisions for all LTC policies recognized by the state are as follows:

- Skilled, intermediate and custodial care: An insurer must offer coverage that is not limited to skilled nursing care. An insurer cannot offer to cover a lower level of care in a facility only after the patient receives a higher level of care. The state addresses these issues in its insurance statute and in its Administrative Code, both of which follow:

(215 ILCS 5/351A-6) Prior hospitalization; institutionalizations.

(a) On and after the effective date of this amendatory Act of 1989, no long-term care insurance policy may be delivered or issued for delivery in this State if such policy:

(1) conditions eligibility for any benefits on a prior hospitalization requirement; or

(2) conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(b) Beginning one year after the effective date of this amendatory Act of 1989, a long-term care insurance policy containing any limitations or conditions for eligibility other than those prohibited above in subsection shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(1) A long-term care insurance policy containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

(2) A long-term care insurance policy which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days for which benefits are paid.

Section 2012.70 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

a) A long-term care insurance policy or certificate may not, if it provides benefits for home health care or community care services, limit or exclude benefits:

1) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;

2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community or institutional setting before home health care services are covered;

3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

4) 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;

5) By requiring that the insured/claimant have an acute condition before home health care services are covered;

6) By excluding coverage for personal care services provided by a home health aide;

7) 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;

8) By limiting benefits to services provided by Medicare-certified agencies or providers;

9) By excluding coverage for adult day care services.

b) 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.

c) 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.

- Renewals: Years ago, elderly customers were the only people who could qualify for guaranteed renewable coverage. But Illinois now bars insurers from including renewal provisions other than “guaranteed renewable” or “non-cancelable” in all individual LTC policies. Insurers can only use the term “guaranteed renewable” within the context of a policy with benefits that will not change as long as the buyer pays premiums on time. The term does not apply to policies that feature guaranteed premium rates. If a policy’s benefits and its premiums are guaranteed, insurers may only then use a term such as “non-cancelable.” Customers must be alerted to the meaning of “guaranteed renewable” and to the possibility of rate increases somewhere on an LTC policy’s first page.

- Inflation protection: Although the American Association of Retired Persons has said only 40 percent of LTC policyholders opt for the feature, all Illinois LTC insurers must offer inflation protection to customers that annually increases the policy’s daily benefit by at least 5 percent. This policy feature can be immensely important due to seemingly inevitable increases in the cost of health care. Many consumers decline the protection because of its effect on premiums, and older buyers might not be as worried about increasing care costs over time as younger buyers might be. The required 5 percent benefit can certainly help policyholders deal with the rising costs of services over time, but it is worth noting that health care costs have sometimes risen at an annual rate above 5 percent. Inflation-conscious policyholders might prefer additional protection if the insurer offers it and if it is sold at a reasonable cost. Policyholders can also take other financial steps, unrelated to their insurance policies, that can ease inflation problems.

  Some insurers might offer additional inflation protection, but, based on Illinois law, protection that exceeds 5 percent might be cancelled because of the policyholder’s age, the benefits received from the policy or the length of time the policy has been in effect. Inflation protection of only 5 percent cannot be cancelled under those circumstances. Again, most LTC insurance customers decline inflation protection, but insurance producers must include a visual representation of how the feature might affect the policy over a 20-year period, either within the policy summary or as an attachment to the policy summary. Furthermore, an applicant who does not want inflation protection must actively refuse it by signing a waiver. The preceding sentences summarize Illinois’ Administrative Code, which reads as follows:

Section 2012.80 Requirement to Offer Inflation Protection

a) 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:

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.

b) Where the policy is issued to a group, the required offer in subsection (a) shall be made to the group policyholder; except, if the policy is issued to a discretionary group, as defined in Section 351A-1(e)(4) of the Code other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

c) The offer in subsection (a) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

d) Insurers shall include the following information in 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.

3) An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

e) Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

f) An offer of inflation protection which 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.

g) Inflation protection as provided in subsection (a)(1) of this Section 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 by this Section. The rejection may be either in the application or on a separate form. 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 plan(s) _____, and I reject inflation protection.

- Non-forfeiture benefits: Because LTC insurance involves such a big financial commitment by the buyer, with even lower priced policies adding up to major dollars over several years, there has always been a concern on the consumer's side that some policyholders will end up wasting their money on coverage they will never use.

  Some consumer advocates have expressed concerns about allegedly high lapse rates for LTC policies. When a significant amount of people decide to give up a particular kind of policy, there are bound to be worries regarding market conduct and sales tactics. If an unethical insurance producer misrepresented facts to a buyer who does not realize the problem for several years and after thousands of dollars have been spent on premiums, the buyer might not have a way to recover lost money without successful legal action. In fairness to the insurance industry, some professionals on the business side say lapse rates are skewed or misinterpreted. They claim these high lapse rates include instances when generally satisfied customers upgrade their policies, essentially allowing the old policies to lapse in exchange for new ones. In fact, some insurers who have struggled to profit from LTC policies have said their troubles relate to their companies' unexpectedly low lapse rates. With more people holding onto their policies than some insurers predicted, companies must reserve more money to pay potential claims, resulting in lower profits.

  Ultimately, concerns about high LTC lapse rates have led to states requiring mandatory inclusion of non-forfeiture benefits in LTC policies. These provisions provide benefits even after the insured stops paying premiums and surrenders the policy. Many consumers prefer non-forfeiture provisions to consist of cash refunds or a "return of premium" based on the amount paid for the policy and any benefits already received through the contract. Many insurers, however, prefer that non-forfeiture benefits consist of reduced care that will continue without the customer needing to pay additional premiums. For example, an insurer might keep all paid premiums but allow the former policyholder to receive an $80 daily indemnity for future LTC rather than the $150 daily indemnity the policy would normally pay if the customer continued to pay premiums. Federal law states that LTC policies that are eligible for tax breaks (which we will discuss in greater detail later) can only provide non-forfeiture benefits to policyholders or designated beneficiaries if the policyholder dies, cancels the entire policy or utilizes the non-forfeiture benefits to specifically rid oneself of unwanted coverage or to reduce the cost of the insurance.

- Free-look periods: Some states, including Illinois, require all LTC policies to feature a 30-day "free-look period," during which a new policyholder can reconsider an insurance purchase and receive a full refund of any paid premiums with no questions asked. An explanation of the free-look period must exist either on the policy's first page or on an attachment to the first page. The state's insurance statute reads as follows:

(215 ILCS 5/351A-7) Right to return.

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

(b) A person insured under a long-term care insurance policy or certificate issued pursuant to a direct response solicitation shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded directly to him or her if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the policy or certificate attached thereto stating in substance that the insured person shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. This subsection also applies to denials of applications, and any refund must be made within 30 days of the return or denial.

Additional Policy Provisions

Over the years, competitive LTC insurers have included additional benefits within their policies, which may be available at no extra cost to the buyer or may be offered in exchange for higher premiums. Some of the most popular additional benefits, which are not mandated by Illinois or federal laws, are as follows:

- Alternative plan of care: In essence, this benefit is a recognition by the insured and the insurer that LTC options could grow as scientists make medical breakthroughs and as businesses providing LTC adapt to new consumer demands. Generally, this provision allows care that is not mentioned in the policy to be covered as long as the insured, the healthcare provider and the insurance company all determine that the treatment or service in question is a valid component of modern LTC.
- Ambulance benefits: Some LTC policies will cover medically necessary transportation to hospitals. From a buyer's standpoint, this provision might be irrelevant in some circumstances. Though the government has reduced the amount of money it pays to ambulance service providers in recent years, Medicare might still cover an ambulance trip in a senior emergency or in cases when an ill or injured person is confined to a bed. In some communities, residents pay for ambulance services through local taxes, thereby allowing ambulance charges for the uninsured to be written off.
- Bed reservation: Though laws may differ among states, some LTC facilities have the right to put a bed back on the market if a resident is absent from the community for an extended period of time. This benefit allows the policyholder to take a long vacation, stay with family or friends for awhile or endure a long stay at a hospital or other health care facility without losing personal space in a nursing home, assisted-living establishment or life center.
- Future purchase option: Viewed in some contexts as a cheaper alternative to inflation protection, this benefit allows the policyholder to increase LTC benefits later in life without needing to medically qualify for the additional coverage. This option does not, however, prevent insurers from basing premiums for the upgraded policy on a customer's age at the time of the upgrade.
- Home modification: An option particularly suited to policyholders who intend on receiving LTC in their private residences, this benefit covers property improvements that address the needs of the sick or injured person. Covered modifications and products might include the installation of wheelchair ramps, shower chairs and bars used for support in bathrooms.
- Non-cancelable coverage: Though rare at the time of this writing, non-cancelable policies are one step ahead of being guaranteed renewable. These insurance contracts guarantee that benefits will remain the same throughout a policy's lifespan and that premiums will not rise above a certain amount.

Cancellations and Denied LTC Claims

Though generally unpleasant on a personal level, situations arise in which insurance companies decide they must cancel a client's policy or deny a policyholder's claim. LTC insurers may cancel policies if they can reasonably contend that a policyholder did not complete an application honestly, with a few exceptions. LTC policies eligible for federal tax breaks (discussed later in this material) must comply with national guidelines related to incontestability. Illinois allows companies to contest active policies and otherwise valid claims if applicants misrepresented facts to the point of affecting the coverage given to them, but the policies must have been in effect for less than six months. In cases of policies that have been effect for a period between six months and two years, companies may only contest policies and claims if the applicant misrepresented facts that pertain to an allegedly abused policy benefit. In disputes involving policies older than two years, the state says insurers can contest policies and claims only if the applicant knowingly and intentionally misrepresented facts related specifically to one's health. These allowable cases for cancellation do not guarantee that an insurer will receive reparations for benefits they have already paid to the former client or on the client's behalf. Upon written request from the policyholder, insurers must explain denied claims in writing and deliver any related information to the insured within 60 days of the request.

An insurer may also cancel policies due to non-payments, but exceptions apply in these situations, too. Illinois LTC policies must offer a feature called "reinstatement for cognitive impairment," which allows a person to regain a policy that was cancelled due to non-payment of premiums if the policyholder was cognitively impaired at the time of a premium due date. Reinstatement for cognitive impairment is possible within five months after a cancellation. Determining methods for cognitive impairment and the definition of a cognitive impairment in these circumstances may not be any more restrictive than the methods and definition used to trigger benefits.

Due to the mental lapses possible among the cognitively impaired and the inability among some customers to manage their finances, Illinois LTC insurers must make room on an application for the name of at least one third party who will receive notice of any unpaid premiums or policy penalties. This "third-party notice" provision does not make the named individual legally responsible in any way for payment of premiums, and policyholders may decline third-party notice by signing a waiver. However, at least once every two years, an insurer must alert all LTC policyholders to their option to either add or remove the names of people set to receive the notice. Insurers must allow a grace period of 30 days for non-payments, which begins five days after notice is mailed to the policyholder and any designated third parties. Reinstatement for cognitive impairment does not excuse the client from having to pay any premiums that led to the initial cancellation. The preceding paragraphs summarize many points within Illinois' Administrative Code regarding unintentional lapses. A portion of the code appears below:

Section 2012.55 Unintentional Lapse

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

a) Notice before lapse or termination.

1) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant 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 traditional long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30

days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." The insurer shall also notify the insured of the right to change this written designation, no less often then once every 2 years.

2) *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 subsection (a)(1) need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.*

3) *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 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subsection (a)(1), 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 shall not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.*

In addition to the requirements of subsection (a), 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 5 months after termination and shall allow for the collection of past due premium when 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.

Chapter 7: Of Premium Concern

Let us assume, at this point, that you—the insurance producer—have convinced some prospects that purchasing LTC insurance would be a wise choice. You have also identified specific policies that should adequately meet your prospect's needs and desires. You have done an excellent job in more ways than one, yet you still must face one more challenge, perhaps the biggest barrier to widespread LTC insurance market penetration: the high premiums.

Deductibles and coverage limits influence LTC insurance prices, as do such features as inflation protection (an immensely important element if the buyer assumes health care costs will continue to rise). But because an older person is more likely to need LTC and not likely to make as many payments on policies as a younger person, the most dramatic and ethically complex factor affecting LTC insurance costs is the insured's age at the application stage.

Documented price differentials change from year to year and from study to study, but they consistently seem to showcase the higher rates LTC insurers tend to impose on people over 50. To cite just two of several available sources, KiplingerForecasts.com reported in June 2005 that LTC coverage with compounded-interest protection of 5 percent cost a 40-year-old $890 a year, cost a 50-year-old $1,134 a year and cost a 65-year-old $2,346 a year. According to the Chicago Tribune in 2004, lifetime LTC coverage cost 55-year-olds $3,500 a year and cost 65-year-olds $5,200 a year. Finding an LTC insurer who will take on 85-year-olds as clients is not as close to impossible as it was some years ago, but those seniors still need loads of luck and savings on their side to obtain the coverage they prefer.

Exemplifying the challenges in the LTC market from a cost perspective, the Families United for Senior Action Foundation conducted a study and reported in 1990 that 84 percent of seniors could not afford the average LTC policy, and 73 percent could not afford the cheapest ones available. According to the Washington Post in 1991, U.S. Reps. Ron Wyden and Edward R. Roybal (the latter of whom chaired the House Subcommittee on Aging) looked into LTC insurance and determined, "seniors are wasting $3.5 billion of the $6 billion they spend on these policies and … long-term care insurance is of questionable value and not a good buy."

Buying at the Right Age

Using a dated assessment within our exploration of the current market might be a bit unfair to the insurance community. But, after all this time, it is still obvious that insurance professionals face a practical and ethical challenge even when their ultimate goal is to sell the best, most-affordable products to LTC customers. In theory, and perhaps in practice, LTC insurance salespersons should not be targeting their products to seniors. Instead, they should be marketing to younger applicants, thereby minimizing risk to insurance companies and giving consumers the chance to purchase LTC insurance at significantly lower prices.

Yet despite the several factors suggesting LTC needs will become increasingly common at an even higher price in future generations, the probability of needing care is still not equal to that of needing to save—in a general sense—for retirement. It is rarely poor advice to tell Americans to start putting pennies away for senior years as early as their 20s. But with many variables to consider, is it ethically sound to put pressure on young people to specifically purchase LTC insurance?

Even if the answer to that question is yes, how can an ethically comfortable salesperson expect to catch the attention of younger prospective clients who are likely to either only need the coverage 40 or 50 years from now or not need any coverage at all?

According to National Underwriter in 2006, the average age of an individual LTC policyholder was 59, and the average age of a person covered by an employer's group plan was 46. It is the independent LTC insurance professional's choice and responsibility to decide whether or not to go after the 40-something crowd or an even younger demographic. As in all parts of this course material, however, students are encouraged to consider various perspectives and facts before, during and after making their presentations.

It is certainly important to consider the fact that younger applicants are likely to pay lower LTC premiums than older applicants and the fact that most LTC policies do not have costs that increase directly in relation to the insured's age once the person has bought the policy. It is important to consider that, the younger the applicant, the better the person's chances are of being eligible for coverage regardless of premiums. It is also admittedly important to recognize that, exact prices aside, a younger applicant will ensure a longer stream of payments to an insurance company than a senior citizen might be able to provide.

If the circumstances present themselves, agents and brokers can ease some customers' price concerns by telling them that most LTC policies do not require the policyholder to pay premiums once benefits go into effect. They can suggest clients purchase the insurance in a lump sum so that the transaction can be put to bed, and so that the potential for repeated bouts of buyer's remorse is lower than if the coverage is bought through recurring premiums. Sellers can also stress possible discounts for married couples who want coverage for both spouses.

All those considerations, factors and strategies can make insurance producers feel comfortable selling LTC coverage to both younger and older customers. But agents and brokers who are trying to decide when it is ethically proper to sell these products should probably also consider several cost-related perspectives that might discourage sales. Unlike many seniors, who are finished with their work lives and are slowly spending down their assets, people in their 20s, 30s, 40s and even 50s are still trying to build up their savings and cannot say for certain how much money they will have available to live on once they retire. With this in mind, it is debatable as to whether or not LTC insurance (which many people believe is only suitable for customers who possess a particular level of wealth) should be sold to people who still have decades ahead of themselves in which they can potentially make a lot of money, lose a lot of money or face both of those situations.

Unlike most seniors, middle-aged Americans are still raising families. They might be able to save money down the road if they buy an LTC policy today instead of when they are 65, but it is also possible that, by then, they will have finished helping their children get through the increasingly expensive U.S. education system, paid off their mortgage and have a comparatively simplified list of expenses that would allow them to address LTC insurance without having as many immediate financial obligations tugging at their wallets.

At the end of the day, no matter the individual circumstances of their audience members, successful LTC insurance sales professionals who target non-seniors need to show how buying coverage now will ultimately save people money. If buyers care about nothing but math, this can be an easy process. Clients can probably sense the savings involved with paying $200 each year for an LTC policy at age 50 rather than buying the same policy at age 80 with an annual premium of $11,000, and sellers can break down the numbers for them in order to prove a major selling point and to project honesty.

Let us assume, for example, that a man is destined to need LTC one way or another beginning at age 90, at which point, insurance benefits will go into effect, and premium payments on his LTC policy will no longer be necessary. If the man buys his LTC policy at age 50 with an annual premium of $200, he will end up paying $8,000 total for coverage. If, however, the man declines this initial offer but reconsiders and accepts the same policy when he is 80 and when the annual premiums are set at $11,000, he will end up paying $110,000 over 10 years for the insurance, basically having lost an opportunity to save over $100,000. This example boldly assumes, of course, that the insurance company will be offering the same policy after three decades, but the reader can still discern the point being made here.

The savings formulated in that example are obvious, and the math in other examples will usually showcase a true bargain rather than disguise a bad deal. Many people who decided to purchase LTC insurance early (or had it purchased for them) have been saving money for years.

But numbers can and do sometimes deceive consumers who put too much trust in either a self-interested salesperson or an honest seller who has not taken the time to measure every angle. Consider the LTC statistics cited earlier from KiplingerForecasts.com. At first glance, paying $890 a year for LTC coverage beginning at age 40 might seem like a better idea than paying $2,346 each year beginning at 65. If a man will need care at age 90, he would save money by following the general insurance logic and purchasing the policy early. But what if the man needs care when he turns 80? In that case, buying a policy at 40 would cost him $35,600 overall, whereas buying it at 65 would actually save him more than $400, with an overall price of $35,190.

Younger buyers should also consider the potential effects of inflation on their benefits. A policy that would pay sufficient benefits today might not pay sufficient benefits 20, 10 or even five years from now if health care costs rise steadily over time.

Premium Requirements

No matter an LTC applicant's age, an Illinois insurer may not raise premiums on an LTC policy without giving buyers 45 days of notice. Also, any Illinois insurer selling an LTC policy with premiums that are subject to change must give customers a premium rate schedule containing the following information:

- Statement of the potential for increased premiums.
- Any options available to the buyer if and when premiums rise.
- The current premium and the deadline to pay current premiums.
- The time when possible rate increases might occur (such as on the first day of a new year or on the policy's anniversary date).
- A 10-year history of any rate increases for the policy or a similar policy.

Exact disclosure requirements related to premium disclosures exist in Illinois' Administrative Code, which appears, in part, below:

Section 2012.62 Required Disclosure of Rating Practices to Consumers

(a) This Section shall apply as follows:

(1) Except as provided in subsection (a)(2), this Section applies to any long-term care policy issued in this State on or after January 1, 2003.

(2) For certificates issued on or after July 1, 2002, under a group long-term care insurance policy as defined in Section 351A-1(e)(1) of the Code that was in force prior to July 1, 2002, the

provisions of this Section shall apply on the policy anniversary following July 1, 2003.

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

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(A) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(B) The right to a revised premium rate or rate schedule as provided in subsection (b)(3) of this Section if the premium rate or rate schedule is changed;

(5) Required Rate Information

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

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) 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.

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

(C) 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.

(D) 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 July 1, 2002, or the end of a 24 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 subsection (b)(5)(A) of this Section.

(E) If the acquiring insurer in subsection (b)(5)(D) of this Section files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subsection (b)(5)(D) of this Section, the acquiring insurer shall make all disclosures required by subsection (b)(5)(A) of this Section, including disclosure of the earlier rate increase referenced in subsection (b)(5)(D) of this Section.

(c) An applicant shall sign an acknowledgment 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 subsections (b)(1) and (5) of this Section. If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(d) An insurer shall use Exhibits F and J to comply with the requirements of subsections (b) and (c) of this Section.

(e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (b) of this Section when the rate increase is implemented.

Chapter 8: Alternative Funding for LTC

Some insurance producers may believe that LTC planning is so important that people should find creative ways to pay for the insurance, even if general apprehension or small savings are roadblocks to a sale. Creative ways to finance LTC insurance include spending the interest made on certificates of deposit specifically on LTC insurance, accumulating extra money through part-time or temporary employment and convincing family members to reduce their risk of becoming default caregivers by sharing LTC premium costs with seniors or with one another. Some of the more common methods of non-traditional funding for LTC premiums are explained in this chapter.

Life Insurance and the LTC Rider

Older insurance customers interested in transferring at least some assets to loved ones upon death have other risk management options that can either work hand in hand with LTC coverage or preserve a financial legacy independent of that product. Life insurance policies, perhaps the most obvious tools Americans can use to pass wealth on to family members and other beneficiaries, tend to receive little attention in the senior market, particularly compared to health coverage for the elderly. To an extent, the minimal focus is justified.

Many people purchase life insurance to guarantee that a dependent (such as a child) will experience minimized financial hardships in case the policyholder dies and can no longer give support to the dependent via work-related income. Most seniors have retired and are usually not the source of financial support for others. Some of them have accumulated significant wealth over many years, but their fresh sources of income—probably a combination of investment gains, Social Security checks and pension benefits—are generally considered modest. The new money they can share with a dependent might not be substantial enough to warrant a major life insurance policy. If seniors want to provide for a dependent, they can arrange for their savings to go to that person via a will or through some other legal arrangement that might not require repeated premium charges or a significant one-time payment.

This assumes, of course, that someone would struggle financially if the senior dies, an increasingly unlikely scenario as people age. If a senior has children, they are likely to be living independently of the parent, earning their own money and perhaps taking out insurance policies on themselves to protect a spouse or their own children. A person could even argue that older Americans are more likely to depend on their grown children for financial support, rather than the other way around. If we leave emotions out of the situation, we can guess confidently that the average 50-year-old woman will not be monetarily devastated by her 80-year-old father's death.

Obviously, we are dealing with generalities here. Generalities serve a positive purpose by allowing us to create guidelines for conduct. What we must guard against are guidelines that are not flexible enough to cater to many exceptions. Even if statistics show older people have far less use for life insurance than middle-aged Americans, the use—small as it might be—still exists, and life insurance professionals owe older clients the same quality service they would give to their younger clients.

Seniors and younger clients who are hesitant to purchase a pure LTC policy might be attracted to a life insurance policy that can pay for LTC costs through a "living benefit" or "accelerated death benefits" rider. Living benefit riders allow a policyholder to dip into a portion of a life policy's cash value in order to pay for various immediate expenses.

Many buyers like these riders because of their flexibility. People with pre-existing medical conditions might find that they have a better chance of being approved for an LTC rider than a standard LTC policy. Meanwhile, the life portion of the insurance ensures that a beneficiary can receive tangible benefits from the contract, even if the policyholder never needs LTC. Also, if a person buys an LTC rider and later decides the added benefits are no longer necessary, the rider portion of the policy can be cancelled with relatively little hassle involved and with less money already spent on LTC coverage.

Of course, the consequence of buying LTC coverage as a rider attached to a life insurance policy is that any benefits paid for LTC are subtracted from the life insurance's cash value, making the contract less beneficial to heirs. With this in mind, Illinois requires all insurers who sell LTC riders to send monthly statements to policyholders who are receiving living benefits. These statements must disclose the type of LTC service that was covered by the rider during that time, the amount of money that has been subtracted from the policy's value and the value of the policy after the subtraction. The American Council of Life Insurers has established model regulations to help insurance providers with life-product experience sell LTC riders in a relatively uniform and responsible manner.

Annuities and LTC Benefits

Annuity contracts can also contain LTC-related provisions. At its most basic level, an annuity is an individual or group product that aims to create a steady income for clients over a long period of time through one or several investments. That income stream might be necessary in the immediate future when personal savings, Social Security checks and other sources of funds do not adequately cover a retired individual's expenses, or it might be one component of a working person's retirement strategy.

Almost every annuity can be categorized in two different ways, depending on how the corresponding funds are invested and when the owner expects to dip into the annuity for payments. An annuity may be either fixed or variable, and it can be deferred or immediate.

We will now briefly review these two basic groupings and examine how they relate to consumers' risk tolerances and one's desire to nurture either long-term financial growth or immediate and long-lasting financial stability.

Fixed annuities experience gains in popularity when the stock market dips or goes through volatile periods. Regardless of market fluctuations, people who care more about saving money than engaging in high-risk, high-return ventures tend to prefer fixed annuities over variable annuities because fixed contracts contain fiscal guarantees.

The traditional fixed annuity guarantees a return of all money given to the insurance company and also credits interest to a person's account. The insurer usually promises minimum returns near 3 percent or 4 percent, though contractually guaranteed rates will almost certainly be above those numbers during the annuity's early years.

The risk to the fixed annuity purchaser is minimal because the insurance company invests the client's premiums in conservative, long-term bonds. The consumer generally shoulders no responsibility for the annuity's performance. However, people who buy fixed annuities could lose some of their principal if catastrophes or poor fiscal management force their insurer into insolvency.

Variable annuities increase in popularity when the financial markets are noticeably strong. They appeal to investors who are willing to risk losing some of their principal if the insurance company also gives them opportunities for potentially significant returns.

Variable annuities feature few or no guarantees, but the interest credited to variable accounts can greatly exceed the returns promised in fixed contracts. The owner shoulders the responsibility of investing his or her money in one or several mutual funds made available to the insurer's clientele, and the annuity's account balance will go up or down based on the funds' performances.

Unlike those who buy fixed annuities, people who purchase variable annuities protect their money from an insurance company's creditors. However, variable annuity owners must pay various fees, typically on an annual basis, that do not factor into fixed annuity purchases.

Many people try to balance their portfolios by purchasing fixed annuities and variable annuities. Others buy only one of the two and base their choice on the kinds of financial assets they already possess.

The annuity shopper's choice between an immediate or deferred annuity will depend on when the person plans to receive payments from the insurance company. Most of the annuities sold today are deferred.

A "deferred annuity" serves clients who do not need consistent, additional income at the time of purchase but envision needing the money years into the future. Deferred annuities go through an accumulation period, during which the owner's account is expected to grow without affecting the person's tax situation.

When people buy a deferred annuity, their goal at that moment is to watch their principal expand for several years. Presumably at a much later date, they will cash in their deferred annuity for a lump-sum payout or divided payouts that will be disbursed throughout someone's remaining lifetime. Still, a deferred annuity contract might allow the owner to begin receiving regularly scheduled lifetime payouts as early as one year after the sale date.

An "immediate annuity" creates an income stream for the owner soon after the sale date. In general, the owner starts receiving payouts within one year of entering into the contract, and most immediate annuities can put money into a person's pocket within 30 days.

Although both fixed and variable immediate annuities allow for growth of an investor's principal funds, these products do not go through a traditional accumulation period because the money is being taken out of them at the same time that they are growing in value. Opportunities for tax deferral with an immediate annuity are relatively minimal because taxation on any annuity always begins at the same time as the payouts.

One of the drawbacks to buying an annuity is that the owner may have to pay a steep surrender charge to the insurer if he or she wants access to the invested funds after a few years. However, many annuities feature a "crisis rider" or "crisis waiver," which can be used to support the owner or annuitant during specific financial emergencies, such as those involving a disability, a chronic health problem or unemployment.

Though some crisis waivers only waive surrender charges for withdrawals below a certain dollar amount, others let the owner make a clean break with the insurer without penalization. A crisis rider, on the other hand, can do more than just eliminate a surrender charge. These contract add-ons might either increase payouts if the annuitant experiences a crisis but has already annuitized or may incorporate an insurance policy into the contract. In the latter case, the owner would basically be getting a discount for buying two insurance products at once.

Considering the annuity's status as a popular product for older consumers and retirees, it makes sense for them to feature LTC waivers and riders that can help pay for institutional or at-home care. But annuities that contain LTC benefits must be evaluated and purchased with caution.

Although state governments have adopted minimum benefit triggers and have forced LTC insurers to include various other contract provisions within their policies, the laws associated with these traditional LTC items might not apply to an annuity's LTC crisis waiver, which merely nullifies surrender charges and does not force the issuing company to pay directly for anyone's care. LTC riders that merely increase payouts to annuitants might not need to meet various statutory requirements either, because they, too, do not force the issuing company to pay directly for health care. Like crisis waivers, they merely put owners and annuitants in a potentially better position to handle LTC costs on their own.

Unlike a traditional LTC insurance policy, which only covers LTC services for insured parties, LTC waivers and some riders might be triggered even if the person in need of care is neither the owner nor the annuitant. At least one company has let owners make penalty-free withdrawals or receive enhanced payouts if someone close to them, such as a spouse, requires care.

But eligibility for LTC benefits within an annuity is far from guaranteed, particularly due to the link between people's age and their susceptibility to long-term health problems. Some insurance companies only offer LTC waivers and other health-related add-ons to annuity owners who have not had health problems, and the opportunity to withdraw funds specifically for health reasons might expire as the owner or annuitant grows older.

Viatical and Life Settlements

We have already touched on some cases in which seniors might want to purchase LTC coverage as a rider to life insurance, but for cash-strapped or merely cost-conscious people who bought life policies years ago and no longer have any dependents, the policies can sometimes seem like unnecessary and costly assets. A relatively recent investment option has allowed some policyholders to recoup premiums paid for unwanted life policies and possibly use the obtained cash to finance LTC insurance policies. Companies called "viatical settlement brokers" or "life settlement brokers" act as middlemen between investors, who share death benefits when a claim is made, and the original policyholder, who surrenders the death benefits in exchange for shareholder payments that are usually equal to a decent percentage of the policy's cash value.

Viatical arrangements first received significant attention in this country during the 1980s, when AIDS patients with life insurance but without much of a chance to live very long sold their policies to investors in order to pay for immediate health needs. Terminal cancer patients eventually went down the same financial road and so, in the last few years, have some seniors. Seniors need not be terminally ill to engage in this sort of transaction. They merely need to be close enough to their life expectancy for their policy to appear attractive in investors' eyes.

These age-dependent transactions are often called "senior settlements" or "life settlements." Though viatical and life settlement companies aren't insurance companies, some seniors have used these kinds of settlements to pay for comprehensive LTC policies.

To some readers, the idea of buying and trading life insurance policies among strangers—as if someone's death was an investment opportunity on par with stock in a software company—might seem strange or even unethical. Perhaps this explains why senior settlements are merely one interesting option for elderly policyholders and not close to becoming the most popular alternative. Despite incorporating some consumer protection provisions, senior settlements have not always received as much regulatory attention as

viatical agreements involving the terminally ill, and even those latter deals have not been free of scandals and scams. For these reasons, as well as private concerns, some agents and brokers might not feel comfortable suggesting the option, even if advocating viatical settlements might ultimately produce more LTC sales. At the very least, insurance producers who raise this issue might want to do so in a way that guarantees input from a senior's family.

Reverse Mortgages

A less-controversial and increasingly common option for seniors in search of additional money for LTC insurance is a "home-equity conversion loan," also known as a "reverse mortgage." In this arrangement, a homeowner receives a lump sum, a line of credit or, most likely, a steady flow of payments from a financial institution for as long as the person lives on the property. In exchange for providing these payments, the mortgage lender receives a portion of the proceeds from the eventual real estate sale plus interest when the borrower either dies or relocates. Reverse mortgages are structured to ensure that the amount of money owed to the lender does not exceed the property's value, and any proceeds left over from a sale after the lender has been repaid will go to a senior's chosen beneficiary.

Payouts to the homeowner are based on the property's value and the person's life expectancy at the application stage. Obviously, a lender who agrees to pay the applicant a monthly fee throughout occupancy does not want to end up paying more money over several years than the lender is contractually allowed to receive upon sale. Perhaps with this in mind, most mortgage lenders, as well as the Department of Housing and Urban Development, reserve reverse mortgage opportunities solely for people who are at least in their early 60s.

Individual lenders may have their own policies regarding closing costs, interest rates and additional fees. In most cases, the homeowner remains responsible for insurance costs and property taxes. An applicant does not necessarily need to have completely paid off any outstanding mortgage on the home to be eligible for a reverse mortgage, but owning the home outright does enhance one's chances of receiving a favorable rate.

Admittedly, regardless of how the money is spent, homeowners with small retirement accounts can benefit from reverse mortgages if they stay in the home long enough. But this is yet another financial option that probably demands serious thought from a client's family members. If a senior is close to needing LTC at a skilled facility, giving up home equity might not be a smart move. If a couple decides to leave cold Midwestern winters and maintenance obligations behind and move to a Florida condominium two years after qualifying for a reverse mortgage, it is likely that the lender got a much better deal than the homeowners.

Insurance professionals need to keep the idea of a reverse mortgage within a proper perspective and understand the seriousness involved with relinquishing home equity. Some Americans have moved from one residence to another so often that they have come to view a house merely as a place to sleep, keep warm and store various belongings. For other people, a house is a home in the warmest sense of the word; a place filled with memories of good times, bad times and everything in between. Particularly in the cases of less-wealthy seniors, a home might be the only significant asset people can leave behind for a beneficiary when they die, and though it is probably true that a mortgage lender would not mind keeping a property in the family as long as all debts are paid by the relatives, seniors might find it more reasonable to spend down other assets to become eligible for Medicaid and then exercise their right to keep their home, rather than using a reverse mortgage to finance LTC insurance. But if the homeowner knows potential beneficiaries care more about the senior's health and enjoyment than they do about property, a reverse mortgage might be what is best for everyone involved.

Chapter 9: Applying and Underwriting for LTC Insurance

Another price concern buyers deserve to know about is the inability of some insurers to underwrite LTC policies properly. In spite of the perceivably high premiums for even the average policy, some companies apparently misjudged health care costs, life expectancy and other factors and sold policies at rates that were too low for businesses to make adequate profits. Some of these evaluators have decided to stop offering policies and have left the LTC market. Others have avoided rules that forbid rate increases based on an individual's age or health and have raised premiums for all LTC policyholders in a particular age group after originally charging lower premiums.

Early LTC policies were generally underwritten in a form similar to that of disability insurance, and LTC risk management on the insurer's side has since grown to include elements of health and life underwriting. As they gain more experience with the product, insurers who sell LTC coverage are exploring multiple ways to underwrite policies fairly for both the buyer and the provider. Underwriting, to many insurance professionals, constitutes a trade secret, so specifics about the topic are not always readily available. However, it is no secret that some insurers turn to memory tests and mathematical exercises in order to judge an LTC applicant's cognitive skills, use physicians' statements to determine pre-existing conditions and utilize the insurance application in different ways in order to elicit very general and very specific information from the applicant. Illinois LTC insurance applications must, at the very least, include the following questions, with optional but minimal modifications to their wording:

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

Illinois LTC insurers have the right to ask an applicant about the person's complete medical history, and any LTC insurance applicant who is 80 or older may need to provide an insurer with a report of a recent physical examination, a determination of cognitive ability, an attending physician's note or copies of other medical records. If an insurer probes into a person's prescription history, that inquiry must involve retrieving the names of prescribed medicines. If applicants disclose all the medications they take or if an insurer should have known that a disclosed medication might be a sign of a particular pre-existing condition, the company cannot deny claims for treatment of that ailment, unless the ailment was deemed a pre-existing condition when the policy first went into effect.

These legal requirements serve as safeguards against a practice known as "post-claims underwriting," in which an insurer digs deep into an applicant's medical history only after the policyholder needs benefits. Post-claims underwriting is generally illegal, but some companies accused of engaging in it have claimed they were acting within their rights when they denied claims, because an applicant either falsified or withheld pertinent information

from the company at the application stage. To avoid unpleasant surprises down the road, consumers owe it to themselves to complete insurance applications clearly and carefully. Except in the case of guaranteed-issue contracts, all LTC applications in Illinois must include a disclaimer near the signature line that reads, "Caution: If your answers on this application are incorrect or untrue, (the insurance company) has the right to deny benefits or rescind the policy." Delivered, approved policies must contain the following disclaimer:

- *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.*

Insurance companies and their representatives have several delivery responsibilities during various stages of the LTC sale. By the time an insurer delivers an approved policy, the buyer must have received at least one copy of the completed application form. In most cases, agents and brokers must give prospective clients an outline of coverage that lists basic benefits, coverage limitations, exclusions, conditions for renewability and cancellation, conditions for refunds, a statement of the policy's federal tax status and a disclaimer that alerts the person to the fact that the outline is not an actual insurance policy. When engaged in a personal sale, an insurance representative must give the outline to the customer at the time of solicitation and before giving the person an application. In a direct-response situation, such as a sale conducted through the mail, the outline must arrive no later than the same time as the application. Group plan enrollees do not need to receive this outline, but the information usually included in the outline must be given to the group member in some form, and the state can request to examine the group's distributed materials.

Potential buyers must also receive a state-approved consumer guide—usually based upon the model produced by the National Association of Insurance Commissioners (NAIC)—, as well as an explanation of premium payment requirements and a personal worksheet created by the NAIC, either before they receive an application during a personal sale or at the time they receive an application in a direct-response sale. Delivery of the consumer guide and the personal worksheet might not be required if the buyer is interested only in life products with LTC riders. The personal worksheet is meant to help buyers and sellers determine product suitability, and the information collected from these documents may not be sold to another entity. In addition to delivering and receiving these assorted documents, insurance producers must disclose the existence of any current health policies they have sold to the applicant as well as any other health policies they sold to the person that have been in effect within the previous five years.

Chapter 10: LTC Insurance at the Workplace and in a Marriage

LTC often seems like a personal or family issue, but the business community has slowly realized how family health care problems negatively affect the workplace. The National Alliance for Caregiving has estimated that 11 million to 16 million Americans will assume some caregiver responsibilities for an elderly person during the first decade of the 21st century, regardless of the caregiver's employment status. In 1997, MetLife concluded that elder care cost businesses roughly $11.4 billion to $29 billion. In a roundabout way of itemizing those costs, another study found that relatives acting as caregivers spend a cumulative total of one full day each week performing LTC duties. These duties may be as complex as dressing the person each morning or as simple as coordinating doctor appointments over the phone.

In addition to a potential loss of focus and a shifting of priorities among employees who care for relatives, businesses must cope with the aftermath of reduced staffing as a result of LTC obligations. "The MetLife Study of Employed Caregivers: Does Long-Term Care Insurance Make a Difference?" found that college-educated people who look after a relative are 40 percent more likely to hold onto their jobs if the relative owns LTC coverage.

Both in response to business concerns and as a method of attracting desirable job candidates to their doors, several companies have instituted group LTC insurance plans, which typically cover five or more enrollees, often extend benefits to employees' spouses and parents and sometimes offer such benefits as home care and respite care. Other employee benefits might include emotional and financial counseling for caregivers. Assuming the plan complies with federal standards (which will be addressed later in this material), a business might have the ability to deduct the administrative costs for tax purposes.

From the employee's point of view, group LTC policies can serve as helpful risk management tools because they entail a very basic pre-screening process and do not put up many barriers to keep people with pre-existing conditions out of the programs. Individual policies, on the other hand, are denied to an estimated 20 percent of applicants for various reasons. Group policies also boast discounts in the neighborhood of 15 percent, with the larger pool of insureds helping to keep premiums down.

On the downside for the consumer, most employer-sponsored LTC plans are paid for entirely with employee contributions, minus administrative costs. Membership is often restricted to executives, and the employees who are eligible for group insurance often have fewer care options than they would receive under an individual policy. Optional benefits may only be offered at the group administrator's discretion, and an insurance company's care manager is often heavily involved in mapping out how insured members will receive treatment.

Illinois and federal laws have made group LTC policies portable, meaning that people have the ability to retain the coverage for themselves and their relatives, as long as the insurance company receives premiums on time and as long as people had been covered by a group plan for a full six months prior to leaving the organization.

Somewhat halfway between individual policies and group plans, some LTC contracts allow spouses to share benefits. Benefits within these policies can be split and delivered in several ways. Suppose a husband and wife purchase a single LTC policy worth $90,000. The policy might divide the coverage into thirds, with $30,000 reserved for the husband, $30,000 reserved for the wife and $30,000 available to either spouse. Or the policy may be split down the middle, with

$45,000 reserved generally for each person but with a provision that allows one partner to dip into the other partner's half if necessary. In a third option, the $90,000 may not be divided upfront at all, and both spouses could receive benefits as needed until the total available benefits have been exhausted.

Like group LTC plans, policies with shared spousal benefits typically cost between 10 percent and 15 percent less than individual policies. Spousal contracts may also include a survivorship benefit that waives premiums for one spouse when the other dies. An increasing number of insurance companies are extending these or similar benefits to non-married domestic partners.

Chapter 11: Government Encouragement of LTC Planning

Prospective customers who resist an LTC purchase because they believe Medicaid will be an adequate safety net should consider the likelihood of benefits continuing under the program in future years. Though it would probably be premature to predict either a total end to Medicaid or a major overhaul of the system that could limit LTC options for millions of Americans, it is obvious that the federal and state governments want citizens to take greater personal initiative in planning for their own LTC.

LTC Insurance Tax Considerations

Arguably the most obvious sign that the federal government wants more citizens to consider LTC policies and wants these policies to be attractive to consumers was its passage of the Health Insurance Portability and Accountability Act (HIPAA). Among several other things, this law declared that certain LTC policies should receive the same federal tax treatment as accident or health insurance contracts.

To the consumer's benefit, this generally means that premiums paid for these LTC policies are tax-deductible if the policyholder is spending more than 10 percent of adjusted gross income for health care and is itemizing his or her tax returns. Also, benefits paid out of these policies are not taxed if they are less than or equal to the cost of rendered care.

It is important to note that tax-qualified LTC policies have undergone some federal standardization and must comply with standards that might or might not coincide with the rules for some policies sold in Illinois that are not eligible for tax breaks. In particular, you should be aware that policies without tax benefits are likely to have more lenient benefit triggers than tax-qualified plans. For example, a tax-qualified policy might not allow a policyholder to qualify for benefits on the basis of medical necessity or on the basis of being incapable of performing an IADL (as opposed to an ADL) or on being incapable of performing just one ADL.

The tax-qualified information that follows is a general summary of minimum policy definitions and requirements that apply to tax-qualified policies across the United States. Each individual state may pass stricter consumer protection laws, if it so desires.

Tax-qualified policies cover "qualified LTC services," which the federal government defines as "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." In an important addition, the government has also defined a "chronically ill individual" as someone who is expected, by a licensed health care provider, to be unable to perform at least two ADLs for at least 90 days, or as someone who needs assistance or supervision for health or safety reasons due to a cognitive impairment.

Before the U.S. government passed HIPAA, the NAIC had created the NAIC Long-Term Care Insurance Model Act and the NAIC Long-Term Care Insurance Model Regulation, which suggested ways to standardize the market and promote fair consumer protection. But in 1991, a Government Accountability Office study found that 41 of 44 sampled outlines of LTC coverage did not satisfactorily meet the suggested NAIC standards. Via HIPAA, the federal government addressed this issue by requiring all tax-qualified policies to meet specific requirements spelled out in both the model act and the model regulation. Tax-qualified policies in all states must meet particular minimum requirements found in the January 1993 versions of these models, but states have the right to ignore or include additional or updated standards within their own laws and regulations. The U.S. government does not require states to sell tax-qualified policies, but states that choose to offer such coverage must ensure that the tax-qualified policies contain the following features:

- The definition of a "pre-existing condition" may be no more restrictive than "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."
- Non-coverage for pre-existing conditions cannot last longer than six months.
- The policy must be guaranteed renewable.
- Coverage cannot duplicate benefits available under the Social Security Act.
- The policy's list of ADLs can exclude only one of the six standard ADLs (eating, bathing, dressing, transferring, toileting and continence).
- The insurer must offer a non-forfeiture feature that does one of the following:
    - The insurer reduces the financial amount of covered care but does not affect the chronological benefit period.
    - The insurer extends normal policy benefits for a brief window of time after cancellation.
    - The insurer allows the policyholder to receive normal policy benefits at any point in the future but shortens the benefit period once care is required.
    - Each state may offer additional non-forfeiture benefits, but policies cannot feature a return of premium benefit that allows the policyholder to borrow money from the policy or use the policy as collateral for a loan.
- Approved policies must be delivered to policyholders or group representatives within 30 days of acceptance.
- Denied applicants must receive a refund of any premiums within 30 days of disapproval.
- Upon written request from the policyholder, insurers must explain, in writing, any reasons for denial of claims and must deliver all information related to the denied claim to the policyholder within 60 days of the request.
- Both an outline of coverage and the policy itself must state that the insurance is eligible for federal tax breaks under HIPAA. Illinois also requires all

non-tax-qualified policies sold in the state to mention that they are not eligible for federal tax breaks under HIPAA. States may offer local tax breaks to LTC policyholders regardless of HIPAA requirements.

The federal government's detailed definition and requirements for tax-qualified policies appear in Title 26, Subtitle F, Chapter 79 of the U.S. Code and read as follows:

§7702B. Treatment of qualified long-term care insurance

(a) In general

For purposes of this title-

(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

(b) Qualified long-term care insurance contract

For purposes of this title-

(1) In general

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),

(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).

(2) Special rules

(A) Per diem, etc. payments permitted

A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) Special rules relating to medicare

(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

(C) Refunds of premiums

Paragraph (1)(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 includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

(c) Qualified long-term care services

For purposes of this section-

(1) In general

The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which-

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) Chronically ill individual

(A) In general

The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as-

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

(B) Activities of daily living

For purposes of subparagraph (A), each of the following is an activity of daily living:

(i) Eating.

(ii) Toileting.

(iii) Transferring.

(iv) Bathing.

(v) Dressing.

(vi) Continence.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an

individual is a chronically ill individual described in subparagraph (A)(i) takes into account at least 5 of such activities.

(3) Maintenance or personal care services

The term "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).

(4) Licensed health care practitioner

The term "licensed health care practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

(d) Aggregate payments in excess of limits

(1) In general

If the aggregate of-

(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

(B) the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured,exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101(g)) at the time the payment is received.

(2) Per diem limitation

For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of-

(A) the greater of-

(i) the dollar amount in effect for such period under paragraph (4), or

(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over

(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

(3) Aggregation rules

For purposes of this subsection-

(A) all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and

(B) the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other such persons in such manner as the Secretary shall prescribe.

(4) Dollar amount

The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

(5) Inflation adjustment

In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

(6) Periodic payments

For purposes of this subsection, the term "periodic payment" means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

(e) Treatment of coverage provided as part of a life insurance or annuity contract

Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract or an annuity contract-

(1) In general

This title shall apply as if the portion of the contract providing such coverage is a separate contract.

(2) Denial of deduction under section 213

No deduction shall be allowed under section 213(a) for any payment made for coverage under a qualified long-term care insurance contract if such payment is made as a charge against the cash surrender value of a life insurance contract or the cash value of an annuity contract.

(3) Portion defined

For purposes of this subsection, the term "portion" means only the terms and benefits under a life insurance contract or annuity contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

(4) Annuity contracts to which paragraph (1) does not apply

For purposes of this subsection, none of the following shall be treated as an annuity contract:

(A) A trust described in section 401(a) which is exempt from tax under section 501(a).

(B) A contract-

(i) purchased by a trust described in subparagraph (A),

(ii) purchased as part of a plan described in section 403(a),

(iii) described in section 403(b),

(iv) provided for employees of a life insurance company under a plan described in section 818(a)(3), or

(v) from an individual retirement account or an individual retirement annuity.

(C) A contract purchased by an employer for the benefit of the employee (or the employee's spouse).

Any dividend described in section 404(k) which is received by a participant or beneficiary shall, for purposes of this paragraph, be treated as paid under a separate contract to which subparagraph (B)(i) applies.

(f) Treatment of certain State-maintained plans

(1) In general

If-

(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and

(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,

such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

(2) State long-term care plan

For purposes of paragraph (1), the term "State long-term care plan" means any plan-

(A) which is established and maintained by a State or an instrumentality of a State,

(B) which provides coverage only for qualified long-term care services, and

(C) under which such coverage is provided only to-

(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),

(ii) the spouses of such employees, and

(iii) individuals bearing a relationship to such employees or spouses which is described in any of subparagraphs (A) through (G) of section 152(d)(2).

(g) Consumer protection provisions

(1) In general

The requirements of this subsection are met with respect to any contract if the contract meets-

(A) the requirements of the model regulation and model Act described in paragraph (2),

(B) the disclosure requirement of paragraph (3), and

(C) the requirements relating to nonforfeitability under paragraph (4).

(2) Requirements of model regulation and Act

(A) In general

The requirements of this paragraph are met with respect to any contract if such contract meets-

(i) Model regulation

The following requirements of the model regulation:

(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

(II) Section 7B (relating to prohibitions on limitations and exclusions).

(III) Section 7C (relating to extension of benefits).

(IV) Section 7D (relating to continuation or conversion of coverage).

(V) Section 7E (relating to discontinuance and replacement of policies).

(VI) Section 8 (relating to unintentional lapse).

(VII) Section 9 (relating to disclosure), other than section 9F thereof.

(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

(IX) Section 11 (relating to minimum standards).

(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(ii) Model Act

The following requirements of the model Act:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(B) Definitions

For purposes of this paragraph-

(i) Model provisions

The terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

(ii) Coordination

Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

(iii) Determination

For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

(3) Disclosure requirement

The requirement of this paragraph is met with respect to any contract if such contract meets the requirements of section 4980C(d).

(4) Nonforfeiture requirements

(A) In general

The requirements of this paragraph are met with respect to any level premium contract, if the issuer of such contract offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

(B) Requirements of provision

The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

(i) The nonforfeiture provision shall be appropriately captioned.

(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and 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 appropriate State regulatory agency for the same contract form.

(iii) The nonforfeiture provision shall provide at least one of the following:

(I) Reduced paid-up insurance.

(II) Extended term insurance.

(III) Shortened benefit period.

(IV) Other similar offerings approved by the appropriate State regulatory agency.

(5) Cross reference

For coordination of the requirements of this subsection with State requirements, see section 4980C(f).

Additional tax-qualified requirements appear elsewhere in the U.S. Code:

§4980C. Requirements for issuers of qualified long-term care insurance contracts

(a) General rule

There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

(b) Amount

(1) In general

The amount of the tax imposed by subsection (a) shall be $100 per insured for each day any requirement of subsection (c) or (d) is not met with respect to each qualified long-term care insurance contract.

(2) Waiver

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

(c) Responsibilities

The requirements of this subsection are as follows:

(1) Requirements of model provisions

(A) Model regulation

The following requirements of the model regulation must be met:

(i) Section 13 (relating to application forms and replacement coverage).

(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

(iii) Section 20 (relating to filing requirements for marketing).

(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

(v) Section 22 (relating to appropriateness of recommended purchase).

(vi) Section 24 (relating to standard format outline of coverage).

(vii) Section 25 (relating to requirement to deliver shopper's guide).

(B) Model Act

The following requirements of the model Act must be met:

(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

(ii) Section 6G (relating to outline of coverage).

(iii) Section 6H (relating to requirements for certificates under group plans).

(iv) Section 6I (relating to policy summary).

(v) Section 6J (relating to monthly reports on accelerated death benefits).

(vi) Section 7 (relating to incontestability period).

(C) Definitions

For purposes of this paragraph, the terms "model regulation" and "model Act" have the meanings given such terms by section 7702B(g)(2)(B).

(2) Delivery of policy

If an application for a qualified long-term care insurance contract (or for a certificate under such a contract for a group) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the contract (or certificate) of insurance not later than 30 days after the date of the approval.

(3) Information on denials of claims

If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

(A) provide a written explanation of the reasons for the denial, and

(B) make available all information directly relating to such denial.

(d) Disclosure

The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

(e) Qualified long-term care insurance contract defined

For purposes of this section, the term "qualified long-term care insurance contract" has the meaning given such term by section 7702B.

(f) Coordination with State requirements

If a State imposes any requirement which is more stringent than the analogous requirement imposed by this section or section 7702B(g), the requirement imposed by this section or section 7702B(g) shall be treated as met if the more stringent State requirement is met.

Clarification Regarding LTC and Federal Taxes

Despite the often extensive details found in HIPAA and other related documents, many LTC tax issues were not immediately resolved through the initial law. Though HIPAA set up tax-qualified requirements, it did not satisfy inquiring minds who wanted to know how the legislation affected specific kinds of policies. The federal government eventually issued final regulations regarding tax-qualified contracts, which apply to policies that were either in effect as of January 1, 1999 or issued after December 10, 1999. Some of the issues clarified between the passage of HIPAA and the final tax-qualified guidelines were as follows:

- Insurance contracts issued prior to HIPAA but still meeting HIPAA requirements are tax-qualified policies.
- If a state has passed insurance laws that at least uphold HIPAA requirements and apply to all LTC policies in the area, all LTC policies issued in the area are tax-qualified policies.
- Group LTC policies that adhere to HIPAA requirements are tax-qualified policies.

- Life policies with LTC riders are only tax-qualified policies if the rider *independently* satisfies HIPAA requirements.

LTC Partnership Programs

A second major sign of federal and state governments' concern for the nation's LTC needs is the establishment of the Partnership for Long-Term Care Program, which has attempted to ease financial burdens on Medicaid by providing non-traditional LTC coverage to residents in certain states. Though dependent on geography, partnership policies generally allow people to exempt more of their personal assets from Medicaid eligibility requirements if they purchase a certain amount of LTC insurance.

Initially funded through grants from the Robert Wood Johnson Foundation, pilot programs involving LTC partnerships were originally proposed in eight states and established in Connecticut, California, Indiana and New York. The partnership policies are sold by private insurance companies, but state governments dictate some policy and eligibility requirements. Most of the plans require that the buyer purchases inflation protection, and many of the setups comply with HIPAA, making the policies eligible for federal tax breaks.

Most states offering partnership policies operate their programs on a dollar-for-dollar system. For example, if a person purchases an LTC partnership policy worth $50,000, he or she would be able to keep an additional $50,000 in personal assets and still receive Medicaid benefits when the policy reaches its limit. However, in New York, partnership policies have allowed people to purchase a set amount of LTC coverage in exchange for overall asset protection. Total-asset programs such as this tend to have stricter requirements than their dollar-for-dollar counterparts. At one point, for example, New York required all partnership participants to purchase LTC coverage equal to three years of nursing home care or six years of home care.

On August 16, 2007, Illinois passed the Illinois Long-Term Care Partnership Program Act, which strived to reduce people's dependence on Medicaid for LTC and encourage more citizens to consider their LTC insurance options. Under the act, anyone who purchases a qualified LTC partnership policy would be able to keep $1 for every dollar paid out in LTC benefits and still qualify for eventual coverage under the state's Medicaid program. Some additional requirements for Illinois Partnership policies appear below:

- If an applicant is 75 or older, the policy must include inflation protection. (The specific kind of required protection will differ by age.)
- The policy must be tax-qualified.
- An insurer that begins offering Partnership policies must allow its existing LTC insurance customers to convert their existing policy to Partnership policy. The offer must be made within one year of the insurer entering the Partnership market and must last for at least 90 days. Although or this offer must be made regardless of a person's age or health, the insurer might be allowed to charge the person more for the Partnership policy.

At the very least, LTC partnership programs are an intriguing option, particularly for consumers who either have unspectacular amounts of personal assets or who are worried about buying traditional LTC coverage due to their relatively young age. Though they do not shield a person from having to spend income on LTC when he or she has maxed out a policy and needs public assistance, the policies do make the "spend-down" requirements for Medicaid benefits more acceptable, and they might greatly reduce the possibility of estate recovery liens.

Industry insiders have expressed concerns, however, regarding the portability of partnership contracts. If a California resident buys a partnership policy at age 40 but moves to Nebraska 25 years later, how might the person's insurance and Medicaid eligibility be affected? Reciprocity among different partnership states has increased (or at least become clearer over the years), meaning that it is possible for a policy bought in one state to cover care rendered in another state. But the portability of the benefits seems to get foggier and more complex when the policy runs its course and the buyer needs care under another state's Medicaid system.

Judging the success of the partnership programs on statistics can be tricky and subject to interpretation. On one hand, according to the Wall Street Journal, the number of LTC policyholders in partnership states had grown by an additional 23 percent compared to growth in states without partnership programs between 1993 and 2001. On the other hand, in the populous state of New York in 2001, according to LIMRA's Market Facts Quarterly, only 18 insurers offered LTC partnership policies, and only 11 percent of the policies sold by those companies were partnership policies. Other statistics that may seem large to some readers and small to others include the following:

- By the middle of 2003 (roughly 10 years after the state's partnership program began), New York insurers had sold 40,000 partnership policies, according to Knight Ridder Tribune Business News.
- Between 1988 and the middle of 2004, Indiana insurers sold approximately 31,000 partnership policies, according to Knight Ridder.
- Between 1994 and 2004, insurers across the country sold approximately 160,000 partnership policies, according to National Underwriter.

The Long-Term Care Security Act of 2000

An assortment of political leaders over the years has advocated some semblance of a national health care system—beyond Medicare and Medicaid—that would include LTC coverage. Although such an overhaul of the health care system has yet to arrive, the Long-Term Care Security Act of 2000, signed into law September 19th of that year, allowed for the creation of a federal LTC insurance program for U.S. government employees. With oversight from the Office of Personal Management, the government may choose one or more private insurers to administer the federal employee plan and initially gave contracts to John Hancock Financial Services and MetLife to run the consortium Long-Term Care Partners LLC. As a massive group plan, the federal program is funded by employee contributions but generally allows individuals to pay less for coverage than they would probably spend in the private market.

Roughly 20 million Americans were eligible for the program, which made its proper debut in 2002, and government prognosticators expected roughly 300,000 employees to opt for coverage. But by the time of a March 31, 2006 report from the Government Accountability Office, only 219,000 workers (approximately 5 percent of all federal employees at that moment) had enrolled. Still, some lawmakers hope any eventual, indisputable success with the federal program will either allow the government to expand the system to other Americans or—through public awareness—increase the number of quality LTC policies sold in the private sector.

Chapter 12: Making the Legal and Ethical LTC Sale

Many criminals, no matter the details of a deception, view older people as easy targets for scams, and with so many seniors concerned about insuring their health and protecting their assets, it would make some sense for a few people to view the insurance community as one of the most perilous business environments for older shoppers. According to the Los Angeles Times in 2005, frauds perpetrated against senior citizens accounted for 25 percent of all consumer complaints handled by the California Department of Insurance. These statistics—though not intended as a judgment of insurance workers as a whole—must be presented to the reader in order for the good-intentioned majority to become more informed and concerned about significant problems caused by a minority of their peers at various levels of the business.

LTC Marketing and Advertising

Marketing campaigns for insurance products have deceived consumers via mailings that make an advertisement look like an official government document related to Medicare or some other government entity. Supposed senior organizations (such as one called the National Association of Retired Persons, one word away from the much-trusted American Association of Retired Persons) allegedly confuse consumers, emphasize problems with Medicare, use Washington D.C. return addresses and sell respondents' names and contact information to insurance companies.

Actions like these have prompted the government to take increasingly firm stances against such campaigns, and insurance producers are hereby warned that disclosures in their advertising materials might not be enough to protect them from prosecution if regulators believe a company has abused the Medicare name or has distributed material that implies any connection to the government.

Some marketing campaigns and sales presentations have tried to appeal to the general public by referencing past and present celebrities who might or might not have benefited from LTC insurance, such as paralyzed actor Christopher Reeve and Parkinson's research advocate and actor Michael J. Fox. Marketers and sellers who mention these famous people are unlikely to confirm whether or not a particular celebrity ever owned an LTC policy or believes in the quality of the products being sold. Subliminally or otherwise, these sellers might be suggesting some form of celebrity endorsement and could find themselves on slippery ground in both ethical and legal contexts.

At one point, popular financial adviser Suze Orman put her name behind LTC coverage marketed primarily on the shopping-focused television channel QVC. A few consumer advocates questioned the ethics involved with the partnership between celebrity and insurer, but the marketing was legal and ethically acceptable to Orman and the affiliated company because she was a licensed insurance agent in 49 states and received commissions from sold policies rather than an endorsement fee.

Associations and Seminars

Subtle, ethically questionable behavior in a relatively organized guise tends to capitalize on the trust many seniors put in various associations and alleged experts, who might have some interest in helping the elderly but who do not properly disclose potential conflicts of interest. Millions of seniors are members of retirement organizations and purchase insurance products that receive endorsements from these groups. The products may, in fact, be excellent risk management tools for consumers and may deserve endorsements. Yet an interesting survey of older insureds might try to determine how many of them consciously realize insurance companies not only compete with one another for many of these endorsements but sometimes also pay commissions to these organizations, based on the number of policies bought by group members.

Again, the ethical issue here is not the favored policies, which members can typically purchase at a discounted price. Instead, the questions about such dealings revolve around the trust that members have in these groups and whether that trust is justified in a commission-collecting environment.

Senior seminars are another organized example in which conflicts of interest are too often ignored or disguised. As is the case with association-endorsed insurance policies, senior seminars can be wonderful tools for older customers and their families. They can help people confront important responsibilities, such as estate planning and LTC risk management. The problem with the seminars is that too many of them are conducted by self-interested salespersons rather than by trustworthy advisers.

Obviously, these events help gather a target market for insurance products, and many of them are instigated by agents and brokers who contact local senior groups, assisted-living facilities and other organizations that might be populated with potential buyers. There is not necessarily anything wrong with a salesperson approaching groups who might have an interest in his or her products, but problems arise when seminars become more and more like massive sales presentations, as opposed to forums for experts and concerned citizens to exchange thoughts and information.

Instead of exposing an audience to the variety of insurance options that an audience member could explore through an insurer of his or her choice, ethically suspect presenters might overemphasize the public's alleged need for a specific insurance product; suggesting, for example, that everyone in the audience should buy an LTC policy, or implying that the speaker's employer is the only insurance company offering proper coverage. Overly eager salespersons might bill themselves as "senior advisers" or use some other generic designation to appear knowledgeable to an audience when, in fact, they have merely taken one or two continuing education courses related to senior citizens and have not had years of valuable, specialized experience in the field.

Rather than bending the truth or adhering to a profit-driven agenda, insurance professionals can nurture mutually beneficial relationships with listeners at these seminars by promoting honest awareness of senior issues and showcasing trustworthy behavior. By doing so, they give consumers the tools to convince themselves that a particular product should be bought from a particular person rather than implying that buyers lack the intelligence and free will to make their own choices.

Personal LTC Sales

As we turn away from organized situations involving potentially unethical conduct and toward abuses committed by individual insurance producers, the lapses in judgment, honesty, good faith and service become even more specific, blatant and often infuriating. Industry professionals have to be disappointed with agents who go door-to-door, claim to represent Medicare, suggest to unsuspecting seniors that their health benefits are in jeopardy and attempt to sell people Medigap policies. (Medicare, by the way, says its representatives never make house calls.)

Since the 1970s, the U.S. government has recruited volunteers to go undercover, pose as senior insurance customers and report back about their treatment. These studies have shown that there have been too many insurance agents who would gladly take advantage of a seemingly clueless, little, old lady with sufficient coverage, as long as a big commission might be in the works. Regarding a

report on LTC sales to seniors, which included data gathered by seven undercover volunteers who approached 14 insurance agents, U.S. Rep. Ron Wyden said in a 1991 hearing, “Every single agent—every one—selected at random, either misrepresented their policy, engaged in abusive sales practices or flat-out lied.”

These examples involving seriously questionable sales practices perhaps explain why some people advocate laws that would ban the selling of annuities to people over 85 or at least require a third party to witness a sale. It is perhaps cases like these that caused states and the federal government to create the Health Insurance Counseling and Assistance Program and to require applicants for government-insured reverse mortgages to attend a counseling session with an approved expert before making a final commitment to a lender.

Insurance professionals can argue amongst themselves and with regulators about whether such programs and requirements are collectively having any real impact toward ending corruption. Both arguments suggest, however, that some of the problems associated with government intervention could be solved if the insurance industry does a better job of policing itself. Most states and many insurance companies operate fraud hotlines that allow concerned producers and consumers to anonymously report possible wrongdoings. The NAIC operates the Web site http://www.insureuonline.org, which allows insurance salespersons and customers to file complaints and access information about questionable products and companies.

Regardless of the ethics involved in their business dealings, LTC insurance producers in Illinois cannot engage in the following activities:

- “Twisting” or “churning,” which occurs when a producer induces consumers to cancel or replace an insurance policy or other financial product and replaces it with a new one that does not serve a beneficial purpose for the consumer.
- Using high-pressure tactics.
- Distributing marketing material that is technically a solicitation for insurance but is designed or formatted to appear otherwise.
- Misrepresenting facts.

Specifically, the state’s Administrative Code addresses standards for marketing LTC in the following manner:

Section 2012.122 Standards for Marketing

a) Every insurer, as defined herein, marketing traditional long-term care insurance coverage in this State, directly or through its producers, shall:

1) Establish marketing procedures and producer training requirements to assure that:

A) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

B) Excessive insurance is not sold or issued.

2) Display prominently by type or 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 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."

3) Provide copies of the disclosure forms required in Section 2012.62(c) and Exhibits F and J of this Part to the applicant.

4) Inquire of a prospective applicant or enrollee for long-term care insurance, and otherwise make every reasonable effort to identify, whether the applicant or enrollee 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.

5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

6) The insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder of the Senior Health Insurance Program (SHIP) that such a program is available and the most current name, address and telephone number of the program. The current address and toll-free telephone number is 320 W. Washington Street, Springfield, Illinois 62767-0001, 1-800-548-9034.

7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 2012.50(a)(3) of this Part.

8) Provide an explanation of the contingent benefit upon lapse provided for in Section 2012.127(d)(2) of this Part and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 2012.127(d)(3) of this Part .

b) In addition to the practices prohibited in Article XXVI of the Code, the following acts and practices are prohibited:

1) 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.

2) 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.

3) 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.

4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

c) With respect to the obligations set forth in this subsection, the primary responsibility of an

association when endorsing or procuring 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 should provide information regarding long-term care insurance policies or certificates to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being sold by the insurer.

1) *The insurer shall file with this Department the following material:*
   - A) *The policy and certificate,*
   - B) *A corresponding outline of coverage, as referenced in Exhibit C of this Part, and*
   - C) *All advertisements requested by the Department.*
2) *The association shall disclose in any long-term care insurance solicitation:*
   - A) *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 the endorsement or sale of the policy or certificate to its members, and*
   - B) *A brief description of the processes under which such policies and the insurer issuing such policies were selected.*
3) *If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.*
4) *The board of directors of associations shall review and approve such insurance policies as well as the compensation arrangements made with the insurer.*
5) *With respect to long-term care insurance contracts, the association shall also*
   - A) *Engage the services of a person with expertise in traditional long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies including its benefits, features, and rates and update such examination thereafter in the event of a material change.*
   - B) *Actively monitor the marketing efforts of the insurer and its agents; and*
   - C) *Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.*
6) *No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with this Department the information required in this subsection (c).*
7) *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 subsection (c).*

Connecting With the LTC Customer

Very often in life, our most unpleasant experiences have a great impact on how we conduct ourselves, as we hopefully pattern our own behavior in contrast to negative treatment we may receive. Similarly, insurance professionals can learn a lot from the preceding depictions of unethical conduct by simply doing their jobs in an opposite manner.

Still, as long as people acknowledge mistakes and learn from them, they do not need to focus solely on such negativity. Nor must we always delve into the details of the mistakes other people have made before we allow ourselves to benefit from the lessons others have learned and shared. So, let us examine the effective and positive ways an insurance professional can sell LTC coverage and other products to older customers, based on general advice from numerous experts.

Many ethical guidelines that are applicable to senior sales seem just as useful without any regard to a customer's age. Professionals can first take an inventory of customers' existing insurance policies so that the agent or broker does not leave people underinsured or over-insured. They can have a sample policy prepared for prospective buyers to take home and read carefully.

A producer's first instinct might be to go straight for the sale before the customer has a chance to leave the room, but allowing the potential client to take some time to read and think about a policy serves two purposes that ultimately benefit the seller as well as the buyer. First, the agent or broker displays confidence that the buyer will be getting a fair deal. It shows the seller does not need to rely on the subliminal power that someone behind a desk has over the person in front of one and does not need to depend on fine print to conceal unattractive terms and conditions. Secondly, by allowing the customer to take the sample policy home, insurance producers suggest they empathize with the buyer and realize that any choice related to a large investment or an insurance policy should involve great care and thought.

People want to have supreme confidence in their advisers' abilities, but no one enjoys being made to feel stupid. By paying attention to both verbal and non-verbal responses that occur throughout any interaction with a customer, professionals can at least try to find and maintain a balanced tone in their presentations that explains concepts clearly without making the speaker sound like a condescending showoff. Similar advice applies to visuals, which can help demonstrate important points but can also distract, confuse and annoy an audience when a presentation becomes too tightly packed with material.

Whether they are explained verbally or visually, statistics should not become a part of a presentation if the seller must twist numbers to serve an agenda. For example, one consulted source for this material pointed out that the average stay in a nursing home for people who stay in a facility for more than 90 days is three years. This statistic might frighten some people into buying LTC coverage, but it is unnecessarily complex and arguably deceptive depending on the context. Unless a customer has asked for that specific statistic, an LTC agent can simply mention the length of the average nursing home stay for all patients, which is 2.5 years.

The 90-day statistic utilized by the consulted expert might help buyers decide how much coverage they should purchase, because treatment lasting less than 90 days is generally not considered LTC. However, when insurance producers cite the average nursing home stay for all patients—meaning those staying for a day as well as those staying for several years—they allow customers to more accurately judge their overall vulnerability to LTC risks.

When insurance producers report on their experiences with older clients, many of them emphasize trust. Even if all the numbers are on the seller's side, the senior customer who cannot get a grip on the producer's character might still turn down a good offer.

This need for trust gives the insurance producer an even greater incentive to examine the senior's pre-existing coverage. Engaging customers in a detailed discussion about the risks they face forces potential buyers to talk about their lives, their families, their worries and their goals; all very personal topics that can help the professional express genuine concern and humanity. An insurance producer and a client certainly are engaged in a business relationship, but when it comes to protecting the people we love, our own health and our savings, insurance can be a very personal business.

Part of exemplifying trustworthiness involves being available to clients when they have questions or problems regarding a policy, a claim or some other business matter. For the busy professional, it is often easy to fall behind schedule and to allow some responsibilities—such as returning a phone call from a person with a relatively non-serious question—to slip down one's list of priorities.

No one looks forward to waiting days for a returned call, but, when dealing with seniors, a person might want to pay special attention to these delays. Long waiting periods might suggest the professional does not care enough about the client's problem, and, if the client is retired, he or she might have more free time than a working person to think about the problem and to feel abandoned by the trusted expert.

Trust issues extend beyond the one-on-one level. Older people are likely to value their children's opinions in serious matters. So, if agents can somehow earn the trust of a 40-year-old daughter and convince her that LTC coverage is a good investment, her 70-year-old father might be more inclined to come to that same conclusion.

This does not mean, however, that older buyers typically lean on other people to make their decisions for them. Many agents have given what they thought was a flawless presentation but still faced firm resistance because a senior had a bad experience with an agent 30 years ago. Experts who have encountered this sort of situation say it is best to respect a senior's firmness and to move on to another investment strategy. Older people have generally passed their risk-taking years and do not want to feel like guinea pigs in someone's complicated financial experiment, no matter how simple or sound a professional's recommendations might truly be.

Generally, seniors also trust one another. This can create challenges for sellers if a senior has a friend who bought an inadequate and expensive LTC policy. But that negative is sometimes outweighed by the positive opportunities for referrals from satisfied senior clients.

Like most human beings, seniors have social lives that are populated with people close to their own age, and the leisure time provided by retirement can be filled with club activities, association meetings and casual, community-sponsored get-togethers. A senior who trusts his LTC insurance agent might brag about the person at one of these gatherings and help keep the knowledgeable, service-oriented agent busy for years to come. Conversely, if an insurance producer oversells a product by pressuring the senior into a decision or by using extreme scare tactics that offend the customer, the people at those social gatherings are likely to hear about the experience and will either take their business elsewhere or make it even more difficult than usual for other insurance producers to earn the public's trust.

Fair Warnings to LTC Insurance Companies and Insurance Producers

In order to demonstrate legally and ethically acceptable market conduct, LTC insurance companies and their sales associates must submit assorted information to state regulators and comply with professional licensing requirements. Among other company responsibilities, Illinois LTC insurers (other than those solely selling coverage as a rider to a life policy) must develop suitability standards that they use to determine whether or not a given customer is an appropriate candidate for a policy. These standards, at a minimum, need to relate to a potential client's finances, reasons for interest in LTC coverage and pre-existing insurance policies. Companies are required to submit these suitability standards to the state upon request and are responsible for training sales representatives to give factually accurate presentations and to not over-insure customers. In annual reports to the state commissioner, an insurance company must disclose the number of people it deemed unsuitable for LTC coverage, the company's annual LTC lapse and replacements rates and the rates of denied tax-qualified policy claims by class. The state addresses many of these suitability issues in its Administrative Code:

Section 2012.123 Suitability

a) This Section shall not apply to life insurance policies that accelerate benefits for long-term care.

b) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

1) 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;

2) Train its insurance producers in the use of its suitability standards; and

3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Director.

c) To determine whether the applicant meets the standards developed by the issuer:

1) The insurance producer and issuer shall develop procedures that take the following into consideration:

A) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

B) 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

C) 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.

2) The issuer, and where an insurance producer is involved, the insurance producer shall make reasonable efforts to obtain the information referenced in subsection (c)(1) of this Section. The efforts shall include presentation to the applicant, at or prior to application, of 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 Exhibit F of this Part, in not less than 12 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 Director.

3) *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 traditional long-term care insurance to employees and their spouses.*

4) *The sale or dissemination outside the company or agency by the issuer or insurance producer of information obtained through the personal worksheet in Exhibit F of this Part is prohibited.*

d) *The issuer shall use the suitability standards it has developed pursuant to this Section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.*

e) *Insurance producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.*

f) *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 found in Exhibit G of this Part, in not less than 12 point type.*

g) *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 suitability letter similar to the one found in Exhibit H of this Part. 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.*

h) *By June 30, the issuer shall report annually to the Director 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.*

Agents and brokers are also held accountable for their individual LTC lapse and replacement rates. By June 30, each company must identify affiliated sales representatives whose lapse and replacement rates are among the highest 10 percent in the organization. This disclosure does not automatically spell trouble for the named individuals and does not necessarily signify any wrongdoing. Illinois LTC insurance producers must complete an eight-hour “Traditional Long-Term Care Policy” education course that meets state approval, and individuals must prove their completion of the course to the state.

At the time of this writing, any insurance producer who was found to be in non-compliance with any aspect of Illinois LTC insurance laws or regulations could be punished with a fine that was the greater of $10,000 or three times the sum of commissions earned from improperly sold, serviced or canceled policies.

Conclusion: The Future of LTC Insurance Sales

It will be interesting to see how many of the lessons learned about insurance sales to older people ring true for senior Baby Boomers and the seniors that follow them. Much of the supposedly expert advice available to insurance producers at the time this course goes to print seems to still incorporate experiences producers have had with customers born in the early 1930s or earlier. People in this age group are usually old enough to remember the Great Depression, which historians generally say lasted at least until the United States’ entry into World War II in 1941. The Baby Boomers, on the other hand, have only read about the breadlines, the failing banks and the makeshift slums of that era in history books or heard about them in family stories. One wonders if the senior Baby Boomers’ overall inexperience with massive poverty will have any effect on the value they place on insurance or on the trust they give to its producers.

As people of all ages—including today’s seniors—become increasingly accustomed to the impersonal benefits of the internet, automated phone systems and ATMs, maybe the emphasis older clients now put on the buyer-seller relationship will eventually shift more toward the products themselves, with consumers doing more independent research and expecting insurers to meet specific needs quickly instead of presenting generic policies at a comfortably slow pace. If such changes do occur, insurance producers will need to understand product suitability issues for reasons that will relate to more than mere ethics, professionalism and human decency. In a highly competitive market with high consumer expectations, the ability to analyze clients’ LTC needs correctly might become part of what separates the financially successful insurers from the failures.

It is also possible that every generation views itself as one that moves to the beat of a different drum, when, in reality, all generations end up valuing many of the same things their predecessors treasured at an older age. From a sales perspective, the tools, technology and products associated with insurance are bound to change, as may the details of what a new generation wants for itself. But the fundamental concerns of the older consumer are likely to remain the same from one era to the next. After all, no generation wants to experience economic hardship. No generation embraces physical deterioration or disease. And, despite how broadly some societal critics might frown at today’s world, no generation lacks the capacity to love others and to hope for their security. There will always be risks in the world; potential dangers that civilization will inevitably need to confront and manage. Luckily for readers and their clients, those are two of the things insurance professionals do best.

Below is the Final Examination for this course. Turn to page 48 to enroll and submit your exam(s). You may also enroll and complete this course online:

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FINAL EXAM

1. It is important for any insurance producer selling LTC insurance policies to also be familiar with _____.
   A. the basics of Medicare and Medicaid eligibility and coverage
   B. the potential customer's body type
   C. the contact information for all local nursing facilities
   D. all previous claims filed by the potential customer under any type of insurance policy

2. Which of the following kinds of health care is covered under Medicare Part A?
   A. Visits to physicians' offices
   B. Hospital stays
   C. Regular vision care
   D. Prescription drugs

3. Medicare Part B generally pays for _____.
   A. hospital stays
   B. visits to physicians' offices and outpatient hospital services
   C. prescription drugs
   D. private nursing

4. Which of the following is now commonly called "Medicare Advantage"?
   A. Medicare Part A
   B. Medicare Part B
   C. Medicare Part C
   D. Medicare Part D

5. A person covered by a Medigap policy _____.
   A. would definitely benefit from buying additional Medigap policies
   B. should also enroll in a Medicare Advantage plan
   C. is insured against certain health care costs not covered by Medicare
   D. is ineligible for coverage under an LTC policy

6. A senior who applies for a Medigap policy within _____ of signing up for Medicare Part B generally cannot be denied membership into a plan based on pre-existing medical conditions.
   A. six months
   B. nine months
   C. one year
   D. five years

7. An LTC insurance policy covers care received _____.
   A. only in a person's home
   B. in various settings, including a nursing home, an assisted-living facility and a private home
   C. in various settings, only if preceded by hospitalization
   D. in all settings except nursing homes

8. In general, LTC insurance covers skilled, intermediate and custodial care when a person requires such care for more than _____.
   A. three weeks
   B. one month
   C. 50 days
   D. 90 days

9. In Illinois, an LTC insurance policy must cover at least _____ of treatment.
   A. one month
   B. 90 days
   C. one year
   D. five years

10. In most cases, a person's _____ are exempt from Medicaid eligibility requirements, meaning that these items need not be surrendered in order for the person to receive Medicaid benefits.
    A. savings accounts
    B. private home and car
    C. stock portfolios
    D. 401(k) plans

11. The Spousal Impoverishment Act of 1988 _____.
    A. requires that a husband and wife spend down all of their shared assets before either person may qualify for Medicaid benefits
    B. made all seniors eligible for Medicare Part A
    C. typically allows a spouse to keep one-half of any jointly held assets up to a certain dollar amount without jeopardizing the other spouse's right to receive Medicaid benefits
    D. applies only in those states that have chosen to adopt it

12. Treatment for injuries sustained in an incident deemed an "act of war" _____.
    A. will always be covered by an LTC policy
    B. will only be covered by an LTC policy if the injured person is in the military
    C. will only be covered by an LTC policy if the injured person is a civilian
    D. might not be covered by an LTC policy

13. Illinois requires its LTC policies to contain at least six _____.
    A. ADLs
    B. IADLs
    C. policy exclusions
    D. definitions of "cognitive impairment"

14. Most LTC policies feature benefit triggers that are contingent on the insured's inability to perform at least _____ ADLs.
    A. one
    B. two
    C. three
    D. four

15. An LTC policy's benefit period _____.
    A. addresses how long coverage will last
    B. is essentially an LTC insurance deductible
    C. may last for less than one year
    D. must last for at least five years

16. In a(n) _____ arrangement, services are rendered, receipts or bills are passed along to the insurer, and money is paid based on the specific charge.
    A. stipend
    B. estimated reward
    C. indemnity
    D. expense-incurred

17. _____ periods are essentially LTC insurance deductibles that are expressed chronologically, rather than as concrete dollar amounts.
    A. Benefit
    B. Elimination
    C. Takeout
    D. Removal

18. Residents at assisted-living facilities _____.
    A. are not allowed to come and go as they please
    B. do not receive meals at specified times
    C. cannot ask for assistance with ADLs
    D. might not have 24-hour access to all kinds of skilled care

19. A long term care facility which provides varying levels of supervision and assistance and allows a resident to remain for life, regardless of the degree of care required, is called a(n) _____.
    A. life center or continuing care community
    B. assisted-living facility
    C. nursing home
    D. multi-level nursing center

20. All Illinois LTC insurers must offer inflation protection to customers that annually increases the policy's daily benefit by at least _____ .
    A. 3 percent
    B. 5 percent
    C. 10 percent
    D. 15 percent

21. Inflation protection _____.
    A. may not exceed 15 percent in an LTC policy.
    B. has no effect on the price of LTC policies
    C. can protect the policyholder from future increases in health care costs
    D. may not be rejected by the buyer

22. A free-look period _____.
    A. allows the LTC insurer to cancel a policy without needing to pay benefits to the buyer
    B. allows a new policyholder to reconsider an insurance purchase and receive a full refund within a specified period of time
    C. allows for free insurance coverage
    D. is not included in an LTC policy unless the buyer requests one

23. How long must an LTC policy's free-look period last in Illinois?
    A. One week
    B. Two weeks
    C. 30 days
    D. 90 days

24. A bed reservation provision in an LTC policy _____.
    A. is not allowed in Illinois
    B. allows the insurer to delay coverage until the policyholder obtains a confirmed reservation in an LTC facility
    C. protects the insurer from payment of false claims by policyholders who might otherwise receive benefits without actually residing in an LTC facility
    D. protects the policyholder from being removed from an LTC facility following a long absence

25. A provision in an LTC policy which allows the policyholder to increase benefits later without needing to medically qualify for the additional coverage _____.
    A. is a required option in Illinois
    B. is termed a “future purchase option”
    C. prevents basing premiums for the upgraded policy on a customer’s age at the time of the upgrade
    D. is not an option for Illinois policyholders

26. Senior (life) settlements _____.
    A. are only permissible when the senior is terminally ill
    B. directly exchange a person’s life insurance policy for an LTC policy
    C. are sometimes used to fund payment for comprehensive LTC policies
    D. pay money to policyholders when their advanced age makes them uninsurable

27. An elderly homeowner with a reverse mortgage _____.
    A. has to sell his or her home immediately upon receipt of the loan
    B. will not be able to live in his or her home
    C. must pay monthly principal and interest to the lender
    D. receives money from a lender while continuing to live in his or her home

28. Premiums paid for a tax-qualified LTC policy _____.
    A. receive the same federal tax treatment as premiums paid for accident or health insurance contracts
    B. are not tax deductible
    C. will be refunded by the insurer
    D. are always lower than premiums for other LTC policies

29. Which law allows for the deductibility of some LTC insurance premiums and requires that tax-qualified policies meet specific requirements spelled out in NAIC model legislation?
    A. The Health Insurance Portability and Accountability Act
    B. The Estate Recovery Act
    C. The Deficit Reduction Act of 2005
    D. The Long Term Care Security Act

30. Partnership policies generally allow people to exempt more of their assets from _____ if they purchase a certain amount of LTC insurance.
    A. partnership ownership ratios
    B. deductibles
    C. non-forfeiture provisions
    D. Medicaid eligibility requirements

END OF EXAM

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1. (A) (B) (C) (D)	7. (A) (B) (C) (D)	13. (A) (B) (C) (D)	19. (A) (B) (C) (D)	25. (A) (B) (C) (D)
2. (A) (B) (C) (D)	8. (A) (B) (C) (D)	14. (A) (B) (C) (D)	20. (A) (B) (C) (D)	26. (A) (B) (C) (D)
3. (A) (B) (C) (D)	9. (A) (B) (C) (D)	15. (A) (B) (C) (D)	21. (A) (B) (C) (D)	27. (A) (B) (C) (D)
4. (A) (B) (C) (D)	10. (A) (B) (C) (D)	16. (A) (B) (C) (D)	22. (A) (B) (C) (D)	28. (A) (B) (C) (D)
5. (A) (B) (C) (D)	11. (A) (B) (C) (D)	17. (A) (B) (C) (D)	23. (A) (B) (C) (D)	29. (A) (B) (C) (D)
6. (A) (B) (C) (D)	12. (A) (B) (C) (D)	18. (A) (B) (C) (D)	24. (A) (B) (C) (D)	30. (A) (B) (C) (D)

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