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California Long Term Care 2013

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California Long Term Care Agent Training

Long term care insurance companies in California must establish marketing procedures to assure that any ***comparison of policies*** by its agents will be fair and accurate AND that ***excessive insurance is not sold or issued***. Insurers must also submit to the Insurance Commissioner a list of all agents or other insurance representatives authorized to sell individual long term care insurance policies updated every six months.

Further, insurers must verify that their agents complete the following special ***continuing education*** requirements before they solicit individual consumers for the sale of long term care insurance:

- For ***junior agents*** (less than four years in business), eight hours of California-specific long-term care annually.
- For ***senior agents*** (more than four years in business). Eight hours of California-specific long term care by the end of each renewal period.

These education requirements are ***part of, not in addition to*** the 24 CE credits an agent must complete every two years.

Example: Agent Bob's license renews in December. After he completes an approved 8-hour long term care training course, he need only 16 hours of other CE credits to fulfill his 24 hour bi-annual requirement.

Agents selling the ***California Partnership*** must complete a different 8-hour training course in addition to the conventional 8-hour long term care course cited above before soliciting clients. Partnership training, however, is ***optional***.

Agents over 70 years of age, with 30 years or more of continuous licensing, may be waived from CE requirements. However, if this same agent is receiving LTC commissions or continuing to solicit LTC insurance he must continue to take the 8-hour LTC training every renewal period. Similarly, "***out-of-state***", non-resident licensees MUST complete LTC training even though they may be exempt from normal CE requirements through state CE ***reciprocity***.

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Chapter 1
Long Term Care Basics

Introduction

With the aid of technology and today's advanced healthcare systems, more people are living to age 80, 90 or beyond. This reflects the truth behind the marketing phrase "60 is the new 40". Now, with on-going scientific programs beginning to offer hope of truly understanding the genetics of aging, we may soon see additional increases in life expectancy. Longer life expectancy increases a person's need to plan for long-term care.

What is long-term care? Essentially, it is the inability to care for oneself due to a chronic (long-term) medical condition. Every day more than 5,000 people in this country turn 65. More than 2.5 million are 85 or older. And the likelihood of chronic illness increases with age. The chance of a person currently age 65 being confined to a nursing home at some time in the future is now one in three. According to the U.S. Census Bureau, the over-85 population is the fastest growing segment of the U.S. population, and one out of four people in that age group today lives in a nursing home. Approximately 75 percent of nursing home residents are women. The programs that many believe cover chronic long-term care events are not necessarily designed to do so. Medicare and Medicare Supplements primarily pay for the costs associated with acute (as opposed to chronic) medical conditions. And, while Medi-Cal (Medicaid) does provide long-term care benefits for many senior citizens, they must first exhaust most of their income and assets to qualify. It is no secret that many seniors are paying a growing proportion of their income in out-of-pocket costs for health care and long-term care services at home due to limited or no insurance coverage. Every day people move into Medi-Cal/Medicaid facilities because they have run out of money from paying these out-of-pocket expenses for home health care or assisted living facility care.

The long-term care problem is made even more complex by the ever-rising cost of services. A study conducted by Genworth Financial and published in 2013 noted that the semi-private nursing facility cost of long-term care in the U.S. is $230 per day or $83,950 per year and the median cost for "hands-off" homemaker services is $18 per hour. Are Americans planning for the costs associated with long-term care? In 2010 Gerontologist Ken Dychtwald (www.agewave.com) conducted focus groups that discovered the following:

- *Uninsured medical expenses (including long-term care) are the top financial worry among men and women age 55 and older.*
- *People are over five times more worried about being a burden on their family than dying.*
- *Almost two-thirds of people will actually require some long-term care, such as home care, assisted living or nursing home care after they reach age 65, but only 35 percent of people believe they will need such care.*
- *People greatly underestimate the financial, social and lifestyle impact of caregiving responsibilities.*
- *When someone needs long-term care, a wide circle of primary caregivers, secondary caregivers, other family, friends and community members often provide the care and are impacted by the responsibilities.*

The answer is that consumers are concerned about long-term care issues and are looking for credible guidance from insurance agents, financial advisors and other sources.
Long-Term Care Insurance (LTCi) is a category of coverage designed to address these growing problems. Obviously, the ideal time to purchase long-term care insurance would be the day before you need it, but as we know, life doesn't work that way. A 2012 study by the Life Insurance Marketing Research Association (LIMRA) indicated that the number one reason people purchase long-term care insurance is for asset and income protection in retirement. Policyholders also obtain peace of mind, secure their independence and preserve their assets by having coverage.

The concepts of long-term care and long-term care insurance are presented in this outline in basic terms as we unfold a story that is important to consumers, insurance agents and financial advisors as well as employers. The reality is that long-term care has become one of the greatest health-care issues for older persons and their families and one of the most common catastrophic health-care expenses.

Defining Long Term Care

Clinically speaking, long-term care is the kind of help you need if you are unable to care for yourself because of a chronic illness or disability. Section 7702B of HIPAA 1996 defines a ***chronically ill*** individual as someone ***unable to perform*** at least two activities of daily living for a period of at least 90 days and/or someone who requires ***substantial supervision***, or ***continual supervision***, to protect themselves from threats to health and safety due to severe cognitive impairment.

California statute (10232.8) declares that a chronically ill insured will qualify for long term care benefits if he is impaired in two out of six activities of daily living and /or impaired by cognitive ability (tax qualified policies).

Where differences arise between California and federal policy requirements, the Commissioner may declare an emergency regulation to add applicable benefit eligibility.

Long term care services can range from help with daily activities of living, such as bathing, shopping or dressing, to skilled nursing care in a nursing home. Care can be provided by friends and family, local home care agencies, adult day care programs, nursing homes, and residential and retirement facilities.

This is a good time to clarify that the term ***long term care*** is a reference to a condition***. Long term care insurance***, on the other hand, is how people pay for their long term care services. Besides long term care insurance policies there are a host of alternative ways that people cover all or a portion of their long term care expenses, such as: Private pay (out-of-pocket, HMOs, reverse mortgages, viatical settlements, Medicare Supplement policies, Medicare, Medi-Cal. Keep in mind there is not one method of paying for long term care that is foolproof. Government programs, to the extent they may be available to your clients, may pay a portion. Private pay may be required to carry the balance or the entire amount if the client is Medi-Cal ineligible. More on this later.

As there are many ways to pay for long term care costs, there just as many long term care insurance policies. By definition, a traditional long-term care insurance policy is 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 acute care unit of a hospital. Agents should know that many policy restrictions and exclusions exist which may result in long term care policies paying only a portion of your client's long term care expenses. Likewise, policies may only pay these costs for a limited period of time.

Chronic Illness Evolution

From the discussion above it should become clear that there is an ***evolution*** for chronically ill patients, i.e., there is a need for ***different levels*** of health care at ***different times***.

For example, a chronically ill person may start out needing only "chore services" such as grocery delivery, lawn mowing, etc in the early stages. This might be progress to the need for home visitors (meals on wheels), periodic adult day care, then home health care. As the illness advances, there might be a need for rehabilitation programs to provide physical therapy leading to a more monitored environment in a retirement home and eventually skilled nursing care.

As you can see, the ***delivery*** of care and services to your long term care insureds is constantly changing . . . it's an ***evolution or continuum***. At times, an insured's long term care needs may be progressing (his condition or illness is getting worse). Likewise, his condition may rebound and the need for services goes back to a ***previous level*** or none at all.

Policy Evolution

Just as long term care services ***evolve***, so must the policies you sell. There are many providers and methods of receiving long term care services. The process of choosing a facility or provider is individual to the need and where he is at in the evolution of his illness. ***Policy evolution*** is the process of understanding the ***changing needs*** of clients in order to better advise them on new ***policies and benefits.*** The most important concept to remember is that ***acute care is given for a patient to get better.*** Once health care progress stops, it is termed ***chronic.***

The policies you provide can make a difference in the level of care policy holders receive. Hopefully, your advice leads to a policy that covers the benefits needed or replaces one that did not. Older policies, for example, may exclude home care coverage or require only skilled home health workers; even though many home care services can be more cost effectively provided by unskilled aides. New policies also demonstrate a willingness by insurers to expand policy benefits and definitions. Just a while ago, for example, adult day care coverage, was only available in connection with institutional care. Likewise, services like residential care facilities were not even addressed in older policies.

ACUTE VS CHRONIC CARE

Acute care is given to a patient to "get better", e.g., dressing bedsores, IVs, physical and speech therapy. Once progress stops, however, the care is termed ***chronic***. A colostomy drain, a catheter or oxygen needed for an emphysema patient are examples of chronic care.

Additional new policy benefit changes include benefits for cognitive disorders of many types, expanded nonforfeiture options, tax qualified deductions, tax free benefits, inflation protection and much more. The point is, agents should ***review old policies*** to uncover restrictive eligibility and gaps in benefits. Next, agents need to explain these options to policyholders to identify ***material improvement*** and why a policy should or should not be replaced or why a "first time" applicant should buy coverage and what kind he needs. For example, if a chronically ill client has no family support network to help with home care, he has ***less need*** for a comprehensive policy with a huge home care benefit. Why? Because the home care he would receive under most policies would need to be supplemented

by family or friends. He would be better off in a nursing facility or RCFE. Of course, you need to disclose all these facts and let your client make the decision.

Why Is Long Term Care Important

Long-term care insurance is important because of the likelihood of needing the types of services covered by the insurance and the cost of paying for those services. We frequently think about long-term care services being focused on older people like retirees or our parents. It is important to remember that about 40% of the individuals needing long-term care services are of working age. About one-third of stroke victims are under age 65.

The Society of Actuaries reported in 1995 that:

- · The odds of having a house fire with damages of $3,400 — one in 200
- · The odds of having a car accident with $3,000 in damages — one in 14
- · The odds at age 65 of spending 2.5 years in a nursing home — one in 3

Overall there is a likelihood that one half of the population will need long-term care services during their lifetime. And long-term care services are very expensive. Nationally the average cost of nursing home services runs between $45,000 and $50,000 per year. Long-term care services provided in the home costs about $26,000 per year. Most employees cannot afford that level of expense even for short periods. Many workers simply have no savings. Even among pre-retirees, most employees have less than $100,000 in savings. The limited functional ability of a family member has an impact on the family members that care for that loved one. This in turn affects the lifestyle of all family members and could jeopardize the family's financial security. Informal support systems of family and friends may not be available particularly in today's world where families are spread out and live great distances from each other. Additionally, a majority of caregivers are women and about 2/3 of them already work outside the home. Over half of the caregivers report missing at least one day of work and other attendance issues. One in five caregivers report leaving their jobs either temporarily or permanently.

Why Is Long Term Care A Problem

Long-term care for people with chronic illnesses and disabilities presents an urgent challenge as existing systems of care have come under great strain and are unable to fully meet growing demands. And, the problem is intensifying, due to a combination of demographic and epidemiological forces.

Changes in social structure provide a partial explanation of the increased need for long-term care solutions. Many families are having fewer children and as more young people migrate from rural to urban areas, and from poorer to richer countries, they may not be available to provide care. Similarly, as women, the traditional care-givers in society, are pulled into the labor force by economic necessity or personal desire, they may be unable to continue providing those services.

Furthermore, much of the demand for long-term care arises from aging populations, chronic health challenges, increasing dependency, the HIV/AIDS epidemic, dietary and lifestyle habits, increased road injuries, and the rise in diabetes, cardiovascular disease and stroke. There is a fundamental ethical obligation to provide care for all, particularly the weak and vulnerable, yet most societies are faced with resource limitations and difficult decisions about which of the competing needs are met. Governments have a crucial role as they must anticipate needs, ensure that resources are available and distribute them equitably and efficiently. Yet, strategies for providing long-term care have been low on government agendas everywhere and are

completely absent in some countries. Little has been done to address the current challenges, much less to prepare for the future.

Existing systems of allocating the burdens and benefits of caring for the chronically ill and disabled are often unfair and the inequity is likely to intensify. For example, caregiving tasks have fallen disproportionately on females who are not adequately compensated or protected. Removing a girl from school to care for an ailing relative may sentence her to a lifetime of poverty and unmet potential.

Risk Factors Associated With Long Term Care

Gender

Long term care services might be needed by almost *anyone*. An accident or sudden serious illness could be the trigger as well as a slow progressive condition like rheumatoid arthritis, Alzheimer's / Parkinsons or cardiovascular disease. Conditions are likely to befell any age and gender although women seem to need them more than men . . . *more likely* due to their longer life expectancy. In addition, women seem to have more chronic diseases that impair mobility such as arthritis and osteoporosis. Men have more *acute* health episodes that lead to an earlier and quicker death.

Long-term care services can assist those needing help with instrumental activities of daily living (IADLs), such as bathing, shopping or dressing, to skilled nursing care in a nursing home.

The process may start with a sudden illness such as a heart attack, stroke or accident where health services begin at the emergent level (hospital, doctor, etc). The patient's condition here might be described as **acute**, needing specific methods of treatment to "progress" the healing process. The result of the treatment can be a return to health or a transition to maintenance or lower levels of health that could turn to ***chronic*** care conditions needing varying levels of longer term care, e.g., skilled nursing, intermediate care and/or custodial care. Cognitive ability is also a consideration in the level or specialized care needed.

Age

Age is another risk factor. A large pool of elderly citizens increases the need for long term care services. In California there is a lower percentage of citizens age 85+ than the rest of the nation (perhaps due to the high cost of living), a lower frequency of older people with disabilities and a higher tendency for elderly to live with a companion or family. While these factors all generally contribute to a lower need for nursing facilities, it is also important to realize that the sheer numbers in California are significant. Regardless of the proportions, thousands more nursing beds and care personnel are needed in our state versus Arizona, for example, simply because the huge base of our population.

Further, the California Administration of Aging reports that while persons age 85+ constitute a comparatively low percentage of the total state population (about 1% compared with 2% nationwide) and their growth rate is also low -- expected to grow to 1.5% of the population by 2020 (California State Department of Finance) compared to 3% nationwide, the population age 64 to 84, however, is closer in line with national averages. Currently, this sector represents about 10 percent of the population and is expected to grow to 14 percent by 2020.

Also, it is a well known fact that people who are healthy enough to qualify for long term care insurance at age 60 or 65 can be expected to live even longer than the average life span. Since California elderly have characteristically ***fewer*** severe disabilities than the rest of the country we

can expect that more Californians will qualify for long term care insurance and more likely to live long enough to use it.

Marital / Domestic Partner Status / Medical History

Traditionally, a ***married couple*** can ***better weather a long term care event*** where at least one spouse is able to care for, monitor or manage the care of the effected spouse. Our society's high rate of divorce compounds the issue. And, while long term care insurance might be a partial or possible solution, premiums are affected by marital status, i.e., not everyone can qualify or afford the coverage.

While both California and Federal laws have expanded the reach of insurance benefits to domestic partners, legal issues remains. For example, since a California Domestic Partnership only effects State law, it is possible that older couples can live in a relationship sanctioned by their State government without adversely affecting any federal benefits earned by either Partner or the previous spouse of either Partner.

While the above State/Federal law distinction may protect the federal benefits belonging to each Partner, that same distinction may serve as a disadvantage should either of the Partners require Medi-Cal Long Term Care benefits.

Since the Partnership is not recognized under federal law, Domestic Partners are considered unmarried individuals and, therefore, subject to the asset transfer and limitations imposed on a single person. For example, while married persons may freely transfer assets between each other without subjecting those transfers to a Look Back Period or Penalty Period, with few exceptions, the transfer of Medi-Cal non-exempt assets between Partners will result in the imposition of a transfer penalty should either Partner require placement in a skilled nursing facility within thirty (30) months of the transfer.

As to assets limits, a married couple may protect specific limits of Medi-Cal non-exempt assets should one of the spouses be placed in a skilled nursing facility (Community Spouse Resource Allowance). In addition, the non-institutionalized spouse (Well Spouse) is entitled to retain a certain monthly income allowance (Minimum Monthly Maintenance Needs Allowance). Conversely, all of an institutionalized Partner's monthly income, with the exception of $35.00 for personal needs and the monthly cost of the ill Partner's Medicare supplementary insurance, is paid to the skilled nursing facility as the ill Partner's share of cost.

And finally, in a more traditional marriage, the Well Spouse can seek a Court ordered increase to his/her Community Spouse Resource Allowance where the fixed income available to that Well Spouse alone is less than his/her Minimum Monthly Maintenance Needs Allowance. No such increase is available to the non-institutionalized Partner.

Family Caregivers

As stated above, many families are having fewer children and as more young people migrate from rural to urban areas, and from poorer to richer countries, they may not be available to provide care. Similarly, as women, the traditional care-givers in society, are pulled into the labor force by economic necessity or personal desire, they may be unable to continue providing those services. The days when grandparents with failing health move-in with their kids are numbered. No one is home to help them.

Medical History

While other forms of health insurance are gravitating to a “guaranteed issue”, medical history underwriting remains as a risk factor for LTC insurance. A person’s medical history can effect the ability to obtain and afford long term care insurance

Financial Factors

Long-term care is very expensive. Contrary to what many people believe, Medicare coverage will not pay for most long-term care services needed. While some people may qualify for Medi-Cal, a major payer of long-term care services in California, most people won't. There are other federal public programs, such as the Older Americans Act, the Older Californians Act, and/or state funded programs that pay some long-term care services. But, like Medi-Cal they target those people with the most functional and financial need. Consequently, if your client is one of the 50% of people over the age of 65 who will need long-term care services – there's a very good chance they will have to pay for some or all of their long-term care services out of personal income and resources.

There are variations in long term care costs based on the type and amount of care needed, the provider and where one lives. Home health and home care services, provided in two-to-four-hour blocks of time referred to as "visits," are generally more expensive in the evening, or on weekends or holidays. The costs of services in some community programs, such as adult day service programs, are often provided at a per-day rate, but vary based on overhead and programming costs. Many care facilities charge extra for services provided beyond the basic room-and-board charge, although some may have "all inclusive" fees.

According to the Genworth 2013 Cost of Care Survey, average ***annual long term care expenses*** in California are substantial and rising:

- Homemaker Services -- $50,336 (5 days / week)
- Home Health Aide -- $52,510 (44 hours / week)
- Adult Day Care -- $20,020 (5 days / week)
- Assisted Living -- $44,520 (private 1 bed)
- Semi-Private Nursing Home -- $83,950
- Private Nursing Home -- $97,820

Long Term Care Services and Facilities

The LTC Continuum

Agents need to understand that long term care demands a ***range of services and facilities***. Care needs of the chronically ill can span from highly skilled personnel (nurses, physical therapists, nutritionists, etc) to a lower level of care such as an unskilled personal care attendant. Care can be at home or in a specialized facility like adult day care or a nursing home.

Likewise, long term care is in a ***constant flux*** as it responds to new terms, new legislation, coverage limitations, medical breakthroughs and other market-driven demands. Similarly, long term care policies, both old and new, must be placed in the context of continuum changes. adult day care, for example, is increasingly covered in today’s newer policies. Earlier policies restricted these benefit payments or failed to address them at all. Another example is policies that have evolved to cover home care. Without it, an insured would be limited to care in an institution.

Long Term Care Services

Long term care services are typically offered through three broad levels of care: skilled, intermediate or custodial.

Skilled Care: Skilled nursing care is care that can only be performed by, or under the supervision of licensed nursing personnel or physician. Skilled nursing facilities must provide twenty-four (24) hour nursing service and must require that the medical care of every resident/patient be provided under supervision of a physician.

Intermediate Care: Intermediate care is that type of care that is not as demanding as skilled care but requires more attention than custodial care. Because the patient's condition is not as demanding as a skilled care patient the twenty-four (24) hour nursing program is not required.

Because of their mental or physical conditions, patients in intermediate care facilities require care and services above room and board that can be provided through institutional facilities.

Custodial Care: An individual in need of custodial care typically would be in some need of help in personal needs such as dressing, bathing etc. Certainly, this type of care is no where close to the demanding needs required in a skilled care situation.

Now let's look at some detailed long term care services and facilities . . . and, as you move down the list, see how the ***continuum progresses*** into the next phase of services or facilities. Further, don't forget that the continuum can move back as the ill party may improve, needing less care or services than before. Finally, understand that a chronically ill person may arrive at some level of care and never progress or notch back:

Home Health Care: Home care includes a multitude of medical and personal services that can be provided at home. The word "home" is usually used to the context of meaning the private home of the person or even the home of a relative or friend. Typical Home Care services can include the following;

- **Homemaker -** A home-care agency staff member who provides meal planning and preparation (including assistance with special diets), routine housework, shopping, and assistance with personal care. This is considered to be non-medical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.

  Specific components of homemaker service include the following:

  - ✓ Teaching and/or performing of meal planning and preparation
  - ✓ Routine housekeeping skills/tasks
  - ✓ Shopping skills/tasks
  - ✓ Home maintenance and repairs
  - ✓ Assisting with self-administered medication which shall be limited to reminding the client to take the medicine, reading instructions for utilization, uncapping medication containers and providing the proper liquid and utensil with which to take medications.
  - ✓ Assisting with following a written special diet plan and reinforcement of diet maintenance
  - ✓ Observing client's functioning and reporting to the appropriate supervisory personnel
  - ✓ Performing and/or assisting with personal care tasks (e.g., shaving, shampooing, combing, bathing, cleaning teeth or dentures and preparation of appropriate supplies, transferring client, and assisting client with range of motion.
  - ✓ Escorting the client to medical facilities, errands, shopping and individual business

- **Health Care** - These are medically-related services prescribed by a physician including nursing services, physical, respiratory, or speech therapy, and performance or personal care and medication administration.
- **Personal Care** - assistance with personal needs such as hygiene, dressing, bathing etc. This can be performed by a Personal Assistant who would be directed by you or your representative to assist with household tasks and personal care as listed above. The person hired must meet specific requirements of the insurance companies.
- **Hospice Services -** Hospice provides care and support for terminally ill people and their families. Can be provided in a facility setting or at home.
- **Respite Services –** Insurers can provide home care or institutional care for limited periods of time to give the caregiver a rest.
- **Adult Day Care -** Direct care and supervision of individuals in a community-based setting. Services include transportation to and from the adult care center, assistance with activities of daily living, meals and snacks, health and medication monitoring, and an activity program. These programs can be useful for working couples needing others to care for an elderly parent who requires some form of supervision. Adult day care can also respond to a need for planned therapy or learning activities and better nutrition. Adult care ***emphasizes*** both achievement and a continued effort to retain and enhance independence. For the elderly, adult day care enables them to live at home and to retain community contacts
- **Nutritional needs** - meal planning, cooking and delivery
- **Special needs** - transportation, telephone and companions.
- **Emergency Home Response System -** Communication devices which signal a network of emergency responders. The system must provide 24-hour a day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an emergency arise. An Electronic Home Response Center is part of a network of emergency responders.
- **Remodeling -** Modification of your home to enable you to be less dependent on direct assistance from others. Examples include, installation of ramps, grab bars, or widening doorways for wheelchair access.
- **Assist Equipment -** Equipment with a useful life of at least one year, designed to increase independent functioning (e.g. wheelchair).
- **Other Approved Services -** Partnership Policies also provide alternate services deemed essential to prevent institutional care and offered by licensed or approved providers. These “other” services must be approved in advance by the Department of Public Aid and the insurance company.

Public Programs

Agents and their customers need to understand that long term care is NOT generally provided the government. The following are LTC services extended to people who qualify,usually in low income categories:

Local Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

Clients eligible for the program must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff make this certification determination based upon Medi-Cal criteria for placement.

In-Home Supportive Services (IHSS) Program will help pay for services provided so that eligible recipients can remain safely in their own home. To be eligible, people must be over 65 years of age, or disabled, or blind. Disabled children are also potentially eligible for IHSS. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.

The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Program for All–Inclusive Care for the Elderly (PACE) is a federally and state funded program that works towards helping the elderly live independently in the community. The goal is to keep them out of long term care for as long as possible. PACE coordinates all–inclusive medical and social services that meet the particular needs of eligible seniors who have remained in the community, but would otherwise need to be in long term care. PACE provides in–home care services in addition to transportation to adult day health care centers where participants can receive medical care, rehabilitative therapies, and social services.

Facilities That Provide Care

Formal Care

Chore services: Volunteers buy groceries, mow lawns, vacuum, run errands, etc.
Home visitors: Meals-on-Wheels, story reading, companionship, etc.
Senior centers: Social activities, dances, bus tours, etc.
Adult day care: ***(Social, health-focused or cognitive oriented)*** Daytime activities, arts and crafts, entertainment. Mental stimulation, stretching, discussion groups, local outings, therapy, games, etc.
Home health care: In-home services by nurses, physical therapists and dieticians, etc.
Rehabilitation programs: Provide extensive physical therapy, occupational therapy and speech therapy.
Respite care: Individuals provide relief to aid primary caregivers.
Continuing care communities (CCRC) and centers: Designed to meet residents' changing needs from retirement housing through skilled care.
Residential care facilities for the elderly (RCFEs) – Sometimes called ***"assisted living"***, RCFEs provide personal care and safe housing for people who may need supervision for medication and assistance with daily living but who do not require 24-hour nursing care.
Nursing facilities / skilled nursing: Provide intensive nursing care around the clock.
Subacute care: Provide post-acute or heavy skilled care that is expected to be of shorter duration than usual skilled care.
Acute care: Surgical or hospital with lengths of stays limited by diagnosis-related insurance coverage.

Alternative Living Arrangements

Retirement Homes Living Arrangement: Seniors or the chronically ill are able to manage their home and personal needs on their own. Unlike CCRC's above, the living arrangement is entirely separate from nursing homes or assisted living.
Life Care Communities: By California law, a "life care" community must provide guaranteed health care coverage for life, a guarantee the resident would not lose their residence or benefits if their resources were exhausted and a nursing facility must be located within the community.
Family Care: Usually at the person's own home or in a family member's home.
Fraternal, Religious and Union Organizations: Many of these groups provide services, facilities or insurance to cover long term care illness.

Information on Services & Locating Long Term Care Facilities

Services

There are as many types of facilities providing long term care as there are services in the continuum. Let's look closer at what these facilities do and how to find them:

Hospital Based Nursing Facilities: These services are also known as extended care facilities and are actually departments located within hospitals. They provide the highest levels of medical and nursing care, including 24 hour monitoring and intensive rehabilitative therapies. They are intended to follow acute hospital care due to serious illness, injury or surgery.

One of the major differences between the hospital and nursing home facilities is that the hospital facilities are not meant to be a permanent residence but rather for a short term until the patient can be sent home or maintained elsewhere. It should be obvious that hospital based care will be very expensive as compared to other types of long-term services available.

Skilled Nursing Facilities: Non-hospital based skilled nursing facilities provide a relatively high level of nursing and other medical care, as well as a personal care and assistance. These type patients are typically in need of close monitoring due to illnesses or impairments.

Licensed nursing is available around the clock with at least one supervising registered nurse on duty at all times. Additionally, most other prescribed medical services can also be provided, including rehabilitative services. Depending on the seriousness of the illness, a stay in a skilled nursing facility can be for a short-term or even extended to a long-term stay.

Intermediate Care Facilities: These facilities provide less nursing and other medical care than the skilled nursing facilities. These facilities are geared for long-term residents with chronic illnesses or impairments but whose conditions are as acute as those who would stay in the skilled nursing facilities.

Staffs are geared toward personal care and assistance with rehabilitative services optionally available. Typically, these types of facilities will not cost as much as the skilled facility and therefore the number of intermediate care facilities available will be limited.

Intermediate care facilities may also provide a combination of both skilled and intermediate services. However, because of the flexibility and diversification of services, the more serious patients may not receive the same degree of care that a dedicated skilled facility may provide. Additionally, the high cost of skilled medical care may be passed on to those who are not in need of those services.

Assisted Living Facilities : Assisted living centers are a form of intermediate care facility that should not be confused with skilled nursing care. Assisted living can take up a special wing of a building or they can be "mom and pop" operations as small as six beds in a private home (Residential Care Facilities for the Elderly – RCFE).

The ***difference between an assisted living facility and a nursing home*** lies in the ***degree of assistance*** needed by the patient. Nursing home residents typically need help with four activities of daily living while assisted living residents need help with only two ADLs. Assisted living provides a place for people who are not typically bed-bound but can't stay at home anymore because they need help.

Newer long term care policies provide assisted living benefits as a ***percentage*** of the nursing home benefit (usually half) although some offer equal benefits. Policyholders generally qualify for assisted living coverage where they are unable to perform two or more activities of daily living. In some cases, cognitive impairment may trigger coverage.

Assisted living is considered an alternative to nursing homes care and one of the fastest growing segments among long term care providers.

Alternative Care Facilities: Senior citizens needing daily living assistance are always looking for alternatives from having to enter a nursing home. Two of these alternatives include the Life Care Communities (LCC) and the Continuing Care Retirement Communities (CCRC).

Many communities require individuals to carry a Medicare-supplement policy in addition to Parts A and B of Medicare. This requirement, often written into the contract, ensures that the Retirement Communities do not have to pay for acute illnesses.

Some Communities also require that individuals carry long-term care insurance. Since these facilities aren't generally funded in advance, the policies help pay for resident's care. Some facilities that require long-term care policies want residents to buy the policies they have preselected. Others may require the purchase of a long-term care policy but don't specify the specific policy that they would prefer.

Life Care Community (LCC): A Life Care Community, sometimes referred to as a Continuing Care Community, is a living accommodation where one can expect to live an active, independent life for many years. Many are run or sponsored by ***fraternal, religious or union organizations***. Later, should additional care be necessary, it is available on the same premises at two different levels: independent living and assisted living.

The third level is considered to be skilled nursing and requires 24-hour care with a registered nurse present. At this level, the resident is under the care of his/her own doctor.

Finding Long Term Care Facilities

Sources for ***finding*** long term care facilities include the following:

The California Department of Aging: The CDA offers counseling services to all parties interested in locating long term care providers. Known as ***Health Insurance Counseling and Advocacy Program or HICAP***, they help seniors and others review life insurance policies, file medical claims, advise on long term care services and counsel on other consumer health concerns. A complete list of HICAP offices can be found at www.aging.ca.gov . . . click HICAP Number.

Residential Care Facilities for the Elderly: The California Department of Social Services licenses Residential Care Facilities for the Elderly, as these are not medical facilities. Go to h*ttp://ccld.ca.gov/docs/search/search.asp* to locate a Residential Care Facility in your area. The Department of Social Services also has regional offices throughout the State to help answer questions you may have about a facility. Log on to ***www.dss.cahwnet.gov****, then choose "Find a Facility"* to get the addresses and phone numbers of the regional offices

The Eldercare Locator 1-800-677-1116: The Eldercare Locator is a way to find community assistance for seniors. The locator is a nationwide, directory assistance service designed to help older persons and care givers locate local support resources for aging Americans. The Eldercare locator is a public service of the Administration on Aging, U.S. Department of Health and Human Services and is administered by the National Association of Area Agencies on Aging and the National Association of State Units on Aging. Log on to ***www.dhcs.ca.gov*** *then choose Eldercare Locator*

Nursing Facility Locator: To locate a nursing home in California and find a report of any findings on the home, go to *http://www.medicare.gov/nhcompare*

County Profiles: The County Profiles tell you the number of nursing facilities available in that county, the total number of licensed beds, the average occupancy rate and the Average Daily Private Pay Rate for nursing facility care in that county. Log on to ***www.dhcs.ca.gov*** *then choose County Profile*s.

How Services Are Provided and Funded

Home and Community Care. Long-term care, often associated with institutional care, is provided in many different settings. But, most long-term care is actually provided at home – either in the home of the person receiving care or at a family member's home. It's estimated that individuals currently turning 65 may need 3 years of long-term care in their lifetime, with almost 2 years of that care provided at home. The majority of that care that provided at home . . . some or all without pay. There is also an increasing amount of long-term care available in the community through programs such as adult day service centers, transportation services, and home care agencies that often supplement care at home or provide respite for family caregivers.

For people who cannot stay at home, but who do not need the level of care provided in a nursing home, there are a variety of residential care settings, such as assisted living, board and care homes, and Continuing Care Retirement Communities (CCRCs). Nursing homes provide long-term care to people who need more extensive care, particularly those whose needs include nursing care or 24-hour supervision in addition to their personal care needs.

Informal Care. A caregiver is a ***family member, partner, friend, or neighbor*** who helps care for an elderly individual or person with a disability who lives at home. In 2004, there were more than 44 million caregivers age 18 or older in the United States - about 21% of the adult population – providing care for an adult family member or friend. Approximately 60% of caregivers are women. Thirteen percent (13%) of caregivers caring for older adults are themselves aged 65 or over. The typical caregiver is a 46-year-old woman who is married and employed, and is caring for her widowed mother who does not live with her. [1]

Caregivers provide a vast array of emotional, financial, nursing, social, homemaking, and other services on a daily or intermittent basis. A 2006 study of caregivers found that on average caregivers spend 21 hours a week giving care. Half of them have intensive caregiving responsibilities, performing at least one activity of daily living, such as bathing and feeding, for their care recipients. Twenty-six percent (26%) perform three or more of these activities. Eighty

[1] Department of Health and Human Services, *Clearinghouse for Long Term Information Website 8/10*

percent (80%) of caregivers perform activities like fixing meals, doing housework, and providing transportation to medical appointments. [2]

Community Based Care. Community-based services describe a range of personal, support, and health services provided in communities to help people stay at home and live as independently as possible. ***Examples are shown below.*** Most people who receive long-term care at home generally require additional help either from family or friends to supplement services from paid providers. This is because so much of the care needed is personal care: help with activities such as bathing and dressing, help managing medications, or supervision for someone with a condition such as Alzheimer's disease.

Private LTC Insurance. Due to the popularity in home health and community care, legislation has surfaced regulating long term care policies. Section 10232.9, for example, states that ***every long-term care policy or certificate that purports to provide benefits of home care or community-based services, shall provide at least the following:***

(1) Home health care.
(2) Adult day care.
(3) Personal care.
(4) Homemaker services.
(5) Hospice services.
(6) Respite care.

Whereas many of these services were only options to policyholders of the past they are now mandated. Of course this is an upgrade for insureds and additional costs to carriers. Further, community-based services and facilities also need to respond by providing more services and brick and mortar facilities to accommodate these requirements.

Additional aspects of 10232.9 detail that home care benefits in California long term care policies shall not be limited or excluded by any of the following:

- Requiring a need for care in a nursing home if home care services are not provided.
- Requiring that skilled nursing or therapeutic services be used before or with unskilled services.
- Requiring the existence of an acute condition.
- Limiting benefits to services provided by Medicare-certified providers or agencies.
- Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.
- Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.
- Requiring "medical necessity" or similar standard as a criteria for benefits.

This opens many new doors to home and community-based services and facilities for the long term care insured that did not exist a few years ago.

Section 10232.9 goes on to provide that where a ***long term care policy covers both institutional and home care benefits***, the ***home care benefit*** shall be at least ***50 percent of the maximum benefit payment*** for institutional care, and in no event shall home care benefits be paid at a rate less than fifty dollars ($50) per day. (Insurance products approved for residents

[2] Department of Health & Human Services, *Clearinghouse for Long Term Care Information Website 8/10*

in continuing care retirement communities are exempt from this provision.) Time limits for benefits granted for institutional coverage in a long term care policy must also be matched for home care benefits.

The thrust of provisions such as these focus on the importance that home care plays in the long term care continuum. While not yet on an equal footing with institutional care, the cost of home care is at least partially covered under policies providing home care benefits.

Section 10232.92 also upgrades and improves an insured's chances of receiving care. Residential care facilities, for example, must now receive a benefit amount payable for care at no less than 70 percent of the benefit amount payable for institutional confinement. In addition, all expenses incurred by the insured while confined in a residential care facility, for long-term care services that are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual as authorized by Public Law 104-191 and regulations adopted pursuant thereto, shall be covered and payable, up to but not to exceed the maximum daily residential care facility benefit of the policy or certificate.

While this legislation still does not place residential care at par with institutional care it closes the gap and opens many more long term care options to insureds than those that existed just a few years ago. And, with added competition, costs are likely to be lower than when fewer facilities and service options existed.

A Word On The Agents Duty and Long Term Care Services

The financing and/or paying for long term care services is a major discussion we will address later in this course. Suffice to say, the costs can be very high and besides long term care insurance there are many ways to cover the costs or portions of the costs of long term care. It is also important to point out that there is not one method of paying for long term care that is foolproof. Government programs may pay only a portion or none at all. Private pay may be required to carry the balance or the entire amount, especially if the person is Medi-Cal ineligible.

Further, agents should know and make their clients aware that the purchase of a long term care policy will not necessarily ensure that someone will avoid Medi-Cal or other public assistance when they need long term care.

As an ethical agent it is your job and duty to point out the risks of needing and paying for long term care. The State of California wants you to know, however, that ***all presentations must be fairly presented and not overstated.*** Refer to the next section on Financing Long Term Care to better understand this concept.

As a California Agent it is important that you know that newer LTC policies cannot ***require*** the use of ***licensed provider*** unless the State also requires a license for that provider. SOME OF THE LISTED PROVIDERS ABOVE DO NOT REQUIRE LICENSING IN CALIFORNIA.

Finally, in any decision to place a chronically ill individual in a nursing home facility it is important that consumers be aware of their rights. Every facility should post a notice on how to make a complaint, if necessary, and a list of patient rights and privileges generally referred to as a **Nursing Home Bill of Rights**. A sample is included in the appendix for your review.

Chapter 2
Financing Long Term Care

Some Basics

In this section we will analyze ways that the chronically ill pay for long term care services. We have already pointed out that costs for long term care are high and there is no single method that pays for everything. In fact, it is likely that your clients will find that their care is financed from multiple sources, including long term care insurance.

First, we need to dispel some widespread beliefs surrounding who pays for what in the long term care continuum. Please look at this chart provided by the U.S. Department of Health and Human Services. We have replaced references to Medicaid with the California version Medi-Cal.

Long-Term Care Service	Medicare	Private Medigap Insurance	Medi-Cal	You Pay on Your Own or use LTC Insurance
Nursing Home Care	Pays in full for days 0-20 if you are in a Skilled Nursing Facility following a recent hospital stay. If your need for skilled care continues, may pay for the difference between the totals daily cost and your co-payment of $137.50/day for days 21-100. After day 100 does not pay.	May cover the $137.50/day co-payment if your nursing home stay meets all other Medicare requirements.	May pay for care in a Medi-Cal certified nursing home if you meet functional and financial eligibility criteria.	If you need only personal or supervisory care in a nursing home and/or have not had a prior hospital stay, or if you choose a nursing home that does not participate in Medicaid or is not Medicare-certified.
Assisted Living Facility (and similar facility options)	Does not pay	Does not pay	May pay care-related costs, but not room and board	You pay on your own except as noted under Medicaid if eligible.
Continuing Care Retirement Community	Does not pay	Does not pay	Does not pay	You pay on your own
Adult Day Services	Not covered	Not Covered	Varies by financial and functional eligibility required	You pay on your own [except as noted under Medicaid if eligible.]
Home Health Care	Limited to reasonable, necessary part-time or intermittent skilled nursing care and home health aide services, and some therapies that are ordered by your doctor and provided by Medicare-certified home health agency. Does not pay for on-going personal care or custodial care needs only (help with activities of daily living).	Not covered	Option to limit some services, such as therapy	You pay on your own for personal or custodial care, except as noted under Medi-Cal, if you are eligible.

It is clear from this chart that Medicare and Medigap does little to finance long term care costs. If one is eligible for Medi-Cal, more services can be provided but some feel it is substandard care. For many this leaves the majority of costs to be self-financed or covered by a long term care insurance policy.

Let's break down these individual care providers and potential sources of funding.

Private Pay / Savings

As you will see throughout this course, it is imperative that we in the LTC industry start educating clients that in the not-to-distant future, quality care is the responsibility of the individual. Some of this care can be financed through LTC insurance (discussed below), but a portion may also be the responsibility of each client in the form of private pay -- supporting LTC costs through private investments and savings.

In fact, integrated somewhere in American values is the concept that people should take primary responsibility for their own lives and their personal expenses. We are encouraged to earn our own way. Health care provisions can be seen as a personal investment, planned and funded by the individual. Unfortunately, this is not a subject people like to discuss, much less set aside a percentage of their paycheck to finance.

That is why it is the job of agents in the U.S. to explain the need for private pay and LTC insurance. For example, it might surprise a lot of clients to learn that despite all the talk about Medicare and Medi-Cal, most long-term care is paid privately (approximately 49%). This means that most patients pay for long-term care out of their own pockets, or their ***family pays***, whether the care is skilled, intermediate or custodial. With government cutbacks can anyone expect this to improve?

The massive amount of care provided by family members and other unpaid caregivers adds another dimension to the social costs of long-term care. More than 70% of those receiving long-term care must rely exclusively on unpaid caregivers. Can baby boomers and other rely on their children for the same contribution of time and effort?

Home Equity

Another form of possible income is through home equity in which you can withdraw the equity in your home, in the form of a loan or reverse mortgage, and use the money for living expenses or long term care.

Many seniors in this country work diligently to make sure that when they retire they own their home "free and clear". If medical expenses start piling up, many can find themselves in a situation where they are ***house -rich*** but ***cash poor***. An equity loan or reverse mortgage is an excellent way for these older homeowners to convert home equity into needed cash without immediately selling the home.

In the typical reverse mortgage transaction, a lender agrees to pay the homeowner a specified payment each month. The balance owed the lender grows as more monies are disbursed to the homeowner. The total accumulated balance is considered a loan against the homeowner's equity but no repayment is required until the borrower dies, moves or sells the home. If there are two spouses who own the house, there is no repayment due until the last surviving borrower dies or sells or moves from the home.

Most lenders who participate in reverse mortgage plans require the homeowner to be 62 years of age or older. Homes must be single family (not condominiums unless they are FHA-approved). There are no income qualifications and little, if any, credit requirements because the owner is not going to make any payments. The maximum loan amount varies per locality, from $67,500 in low-cost rural areas to $151,725 in costlier housing markets. The amount also varies on the client's age. Payments are based on actuarial tables. In addition to the full loan

amount, the borrower is liable for fees, points, closing costs, insurance premiums, plus all interest. Interest and closing rates are generally higher than those in conventional mortgages. Liability to homeowners is limited to the value of his home, i.e., they can't be made to pay from other assets. Some reverse mortgage financing programs are FHA-insured, however, many lenders require no insurance -- they are simply banking on the owner's large "pot of equity" to secure the deal.

The proceeds from a reverse mortgage can be used for any purpose, including long term care expenses and they are tax free to the homeowner.

So popular is this concept that even government-insured plans are surfacing. Here are some popular options:

FHA-Insured Reverse Mortgage (RM)

This plan offers several payment options. You may receive monthly loan advances for a fixed term or for as long as you live in the home, a line of credit, or monthly loan advances plus a line of credit. This RM is not due as long as you live in your home. With the line of credit option, you may draw amounts as you need them over time. Closing costs, a mortgage insurance premium and sometimes a monthly servicing fee is required. Interest is charged at an adjustable rate on your loan balance; any interest rate changes do not affect the monthly payment, but rather how quickly the loan balance grows over time.

The FHA-insured RM permits changes in payment options at little cost. This plan also protects you by guaranteeing that loan advances will continue to be made to you if a lender defaults. However, FHA-insured RMs may provide smaller loan advances than lender-insured plans. Also, FHA loan costs may be greater than uninsured plans.

Life Settlements

The ability to convert life insurance into cash for living and long term expenses is a form of "living benefits" used by many seniors and others with chronic illness.

In recent years, insurers have been offering long term care-specific riders as accelerated death benefits. Despite this improvement, these policies ***should not be sold as traditional long term care insurance.*** A long-term care rider will pay some of the policy's death benefit while an individual is still alive. For example, suppose a person has $300,000 worth of life insurance coverage. Assume he spends three years in a nursing home. Since he has a long-term care rider on that life insurance policy, $75,000 is paid out for nursing home costs ($3,000 per month for 25 months) while he is still alive. When the insured dies, the beneficiaries will receive $225,000 instead of $300,000. When he taps into the long-term care living benefits, he is using the cash value that would ordinarily belong to the beneficiaries.

Long-term care riders often pay ***living benefits*** when a serious illness occurs, even when no nursing home care is needed. For example, victims of strokes, heart attacks, cancer, coronary artery surgery, and renal failure can collect benefits while they are still living. Sometimes the policy holder can receive as much as 25 percent of the policy's face value up front, rather than in regular monthly payments.

Older riders may have limits. They may not cover nursing home stays outside the United States or long-term care resulting from alcoholism, drug addiction, or attempted suicides. The long-term care riders usually cover nursing home care only after a stay in a hospital or in a skilled

nursing home where medical treatment is dispensed. Most nursing home residents enter the homes directly, not after a stay in a hospital or skilled nursing homes.

The money available for nursing home benefits on a long-term care rider is normally two percent of insurance coverage per month. By this rule, a $100,000 policy would pay $2,000 per month. However, if the policy is over $150,000, the policy holder may get less than two percent. For example, suppose the policy holder has a $300,000 life insurance policy with a long-term care rider, and he is confined to a nursing home. This insured may get two percent of the first $150,000 ($3,000) plus one-half percent of the next $150,000 ($750) for a total of $3,750 per month.

Also, some policies place a ***limit*** on the monthly payment amount. Some policies permit the policy holder to collect 100 percent of the amount of the life insurance, while others cap it at 50 percent. Most polices require that the policy holder pay at least for the first 60 days of nursing home care before a long-term care rider kicks in.

With some riders, the policyholder will have to make ***out-of-pocket*** payments for at least 180 days before he can collect. Some long-term care riders will not pay until the policyholder has been paying the extra premium for at least three years. For example, if an individual buys a long-term care rider in 1997, he may not be able to collect before 2000, 2002, or some other date.

Older long-term care riders will pay for skilled care or intermediate care nursing home stays and some riders ***do not pay*** for custodial care. Others will pay only after a specified number of days in a hospital or a specified number of weeks in a skilled care or an intermediate care home. While receiving benefits from a long-term care rider, the policy holder is not obligated to keep paying premiums if the rider has a waiver of premium feature.

Viatical Settlements. A viatical settlement is a transaction whereby a non-related party purchases all beneficial interest in a life insurance policy insuring the life of a terminally ill person. Since many long term care patients are terminal, they may consider selling the proceeds of their life insurance policy before they die to use the funds for current, more pressing medical needs and expenses.

The theory behind these transactions may sound gruesome but can be beneficial for both parties. Think of it, by the time a terminally ill person considers “selling” his or her life insurance policy, they are typically on their “last leg”, financially speaking. The income realized from the sale of the life insurance policy can be ***very welcome***.

The mechanics of the transaction are fairly simple. A third party “broker” or viatical company pays the terminally ill person a percentage of the death benefit and becomes the owner and beneficiary of the policy. The terminally ill person receives a lump sum of money to use ***now***. When he dies, the proceeds of the policy go to the viatical company. Viatical companies are usually funded through investors and buy all kinds of policies, term, whole life, universal life, group life, etc. The policy must have been in force for at least two years and not be subject to a contestability period. In some cases the viatical company even continues paying the premium on the policy to keep it going. Also, viatical companies are known to work with a combination of ***accelerated death benefits AND viatical settlements*** to net an even greater sum of cash for the seller of the policy.

More and more, people diagnosed with other terminal illnesses are turning to viatical settlements to meet their financial needs -- ***including long term care***. The list includes terminal sufferers with cancer, “Lou Gehrig’s Disease, cardiovascular illness and more. As a matter of fact, the statistics point to a larger market for viatical settlement from terminally ill

patients with cancer who, in 1995, represented 78 percent of all hospice care admissions versus AIDS at only 4 percent. The industry is expecting more cases from non-AIDS related illnesses as more people learn about the product.

A real boost to viatical settlements should also come as a result of HIPAA (The Health Insurance Portability and Accountability Act) of 1996 which allows people diagnosed with a terminal illness to sell their life insurance policies to viatical settlement companies for a ***tax free lump sum payment***. This tax free provision will apply ONLY to people whose life expectancy is less than 24 months and the purchasing company must be licensed by the state in which the viator (seller) resides.

Policies of all sizes are viaticated and twenty-one states have adopted all or a portion of the regulations for viatical settlements set forth by the National Association of Insurance Commissioners. And the Viatical Association of America has established minimum standards of consumer protection for its viatical company members.

Other Insurance Products With Long Term Care Benefits

Stand Alone Long Term Care Policies

While purchasing a stand alone long term care policy seems to be a simple and effective solution, there are some inherent risks: They can be expensive, they acquire no cash value, the premiums may increase, and the underwriting can be time-consuming.

For pure long term care protection, however, a stand alone policy is hard to beat. On the other hand, if people drop this protection because premiums increase they will have no protection. Further risk of termination can occur where people pay LTC premiums for years and years, then drop it because they “don’t use their long term care protection”.

For these reasons, alternatives to stand alone policies have been developed.

Annuity Contracts.

For years, the insurance industry has designed annuity contracts that appeal to the liquidity needs of seniors and other market groups. Most new generation annuity policies, for example, offer ***free withdrawals*** that allow the owner to withdraw 10 percent or 15 percent of the account value every year. These withdrawals can be used for any purpose including medical costs and long term care.

More significant are the ***nursing home and terminal illness waivers*** found in many competitive annuity products. Now the contract owner can withdraw . . . ***penalty free . . .***large portions of the account value (usually up to 50 percent) without penalty or surrender charges so long as the proceeds are used for nursing care or terminal illness expenses.

Drawbacks to both long term care riders and annuity coverage should be noted: Benefits paid may be less than the standard long term care policy, particularly in areas such as home health care and assisted living. Similarly, the duration of payments will most certainly be limited. And, without inflation protection, the proceeds may do little to cover actual LTC costs. “Pot of money” approaches will most likely be exhausted in a matter of years or sooner and few, if any, can be expected to provide lifetime benefits. Then again, such long term benefit durations in stand alone long term care insurance, while available, are very costly leading to few takers anyway.

Accelerated Death Benefits

Life policies and annuities that provides accelerated death benefits to pay medical expenses first came on the scene in 1988. Since then, they have been very popular. More companies are modifying existing policies to add actual long term care riders. Typically, the basic premium cost will be increased by 5-to-15 percent to pay for the rider, although some riders can increase the cost of a basic policy by as much as 33 percent.

The ***problems*** with funding long term care coverage through an old generation accelerated death benefit policy are obvious: Benefits may be slower than a stand alone policy, benefit triggers can be tricky and there is typically no inflation protection other than by expensive inflation riders. Furthermore, the death benefits that could have gone to an insured's estate are usually "eaten-up" in long term care costs thus defeating the purpose of buying a life insurance policy. However, this is changing. See our section on Long Term Care Combo Plans.

It is significant to note that the tax treatment of accelerated death benefits has changed as a result of HIPAA (Health insurance Portability and Accountability Act) and the Pension Protection Act of 2006. Both provide for ***tax free treatment of accelerated death benefits for terminal and chronically ill people paid directly by insurance companies***. This should serve as another reason for the seriously ill to take a look at accelerated provisions in their life policies for current "living benefits", including long term care riders where permitted. Caution must be advised, however, in how one defines terminal or chronic illness to the satisfaction of the Internal Revenue Service. A recent private letter ruling indicated the definition shall comply with HIPAA.

Other Catastrophic Benefits

A new breed of ***linked benefit*** products combine catastrophic long term care with traditional products like an annuity or life insurance. **Long Term Care Insurance Linked to an Annuity**

An example of these combination long term care health insurance policies links long term care benefits to a single premium deferred annuity. This product begins as an annuity with either a lump sum deposit or structured deposits made over time. If no care is needed, the annuity gains interest functioning like any other fixed annuity. But if the owner/annuitant needs care in a nursing home or elsewhere, a formula will be used to determine the amount of the monthly benefit available to the client. Taking the example used earlier, a healthy 65 year old woman who deposited $150,000 into this account would have the advantages of tax-deferred, safe growth in the annuity and approximately $4,700 a month of long term care benefits for 36 months. At an additional cost, a benefit rider added to this policy would provide the $4,700 monthly benefit for her lifetime. On these types of policies, the additional benefit rider is usually a wise purchase in order to obtain maximum guarantees.

Another linked benefit product is the long term care annuity. This product also functions exactly like a fixed annuity, but has a long term care multiplier built into the policy. There is no premium rider attached to this medically underwritten annuity policy. Instead, a portion of the internal return in the contract is used to pay for the long term care benefit. Long term care coverage is calculated based on the amount of coverage selected when the policy is purchased. The insurance company offers a payout of 200% or 300% of the aggregate policy value over two or three years after the annuity account value is depleted. For example, a policyholder with a $100,000 annuity who had selected and aggregate benefit limit of 300% and a two year benefit factor would have an additional $200,000 available for long term care expenses after the initial $100,000 policy value was depleted. The policy owner would spend down the $100,000 annuity

value over a two year period and then receive the additional $200,000 over a four year period or longer. In this example the contract pays $50,000 a year for a minimum of six years, but care will last longer if less benefit is needed. Again, if long term care is never needed the annuity value would be paid out lump sum to any named beneficiary.

Medi-Cal vs. Medicare

Because the terms are so similar, most people and many insurance agents confuse the two. The Medicare program covers ***medical expenses*** as opposed to ***custodial care***. Medicare is ***not*** a financially need-based program, and, therefore, it pays for medical treatment regardless of the recipient's financial status. By comparison, Medi-Cal (the California version of Medicaid) ***is needs based***. It provides benefits only to those who demonstrate financial need. Furthermore, since California is a "share of cost" state, a person who applies to Medi-Cal cannot have more than a limited amount of cash or other available assets. And, any costs paid on behalf of a recipient can be recovered from his estate (see Medi-Cal recovery).

Medicare is a federal health care program funded by federal tax dollars. Because it is related to the Social Security Program, eligibility is based on a person's work history or relationship with another individual with a work history (i.e., spouse or dependent child). Medicare was designed to pay for physician and hospital care for people who are elderly or disabled. As described in "***Taking Care of Tomorrow, A Consumer's Guide to Long Term Care***", produced by the California Department of Aging:

"Most long term care is furnished in nursing homes to people which chronic, long-term illnesses or disabilities. The care they receive is personal care, often called custodial care. Medicare does not pay for custodial care. Medicare pays less than 10% of all nursing home costs. To qualify for the Medicare nursing home benefit, you must spend three full days in acute care hospital within 30 days of your admission to a nursing home. You must also need skilled nursing care seven days a week, and/or rehabilitation services at least five days a week. Medicare will not pay for your stay if you need skilled nursing or rehabilitation therapy only once a week. The longest nursing home stay that Medicare will pay for completely is 20 days. After the first 20 days, if you still require skilled care, Medicare will pay only a part of the nursing home bill. You will have to pay a copayment for each day of the next 80 days if Medicare continues to pay for your stay.

Will Medicare Pay if I Need Care in My Home? "Taking Care of Tomorrow" answers: "Yes, but only if you meet certain requirements of the Medicare program …… You must be homebound and require skilled nursing or rehabilitation services. The services you receive must be from a home health care agency that participates in Medicare. You may also receive some personal care services along with the skilled services.

However, Medicare does not pay for general household services such as laundry, shopping or other home care services that are primarily needed to assist people in meeting their personal care needs….."

Medi-Cal, as originally intended, was created to help the "medically needy", aged, blind and disabled citizens who lacked access to the health care system. Unfortunately, the system has inadvertently fostered generation after generation of poverty level families who use the system to pay for their health care. Seniors may also end up on Medi-Cal after spending many productive years paying taxes and contributing to society. Combine this dependence expanding elderly population and you understand why the system has . . . **and will** . . . have trouble supporting long-term care.

Medi-Cal, is funded by both federal and state tax dollars and provides health care coverage for approximately 6 million eligible beneficiaries. Medi-Cal is designed to provide services for people with low income and few assets. The program provides health care services to people on public assistance and to others who cannot afford to pay for their health care. Medi-Cal pays for hospital, medical, prescription drug, and "medically necessary" nursing home care. California does not consider a person's impairment in their ability to perform Activities of Daily Living in determining eligibility for Medi-Cal's nursing home benefit.

Medicare Facts

Although Medicare does not usually pay for nursing home costs, the federal Medicare Catastrophic Coverage Act (MECCA), enacted in 1988, adds to the confusion, since it allows Medicare to pay for a limited amount of nursing home costs that previously were, for the most part, paid by Medi-Cal for patients who qualified for welfare benefits, since such long-term care costs were not deemed to be medically necessary.

Medicare only pays for "**Skilled Care in a Nursing Home"** or **"Intermittent Care in a Nursing Home or at Home"**. Medicare does NOT pay for intermediate or custodial care, such as that required for Alzheimer's patients. The following table will help put this into perspective:

BENEFIT	MEDICARE PAYS	YOU PAY
First 20 days	100% of Approved Amount	NOTHING
Next 80 Days	All but -$137.50 / Day	$137.50 / Day
Beyond 100 days	NOTHING	ALL COSTS

Source: Medicare.org

As mentioned, Medicare pays for skilled care only. Medicare will pay the full cost to stay in a Nursing Home Facility for only 20 days. It will pay a part of the cost for the next 80 days, but only if you are receiving a "skilled" level of care. Medicare pays absolutely NOTHING after 100 days. Medicare does NOT cover intermediate care, except for intermittent skilled services received, or custodial care.

Medicare

Medicare came into existence in 1965 and it was billed as a medical "savior" for older Americans. In some respects it was and is a "safety net" allowing millions of Americans access to the finest health care system in the World. Today, Medicare offers very little by way of LTC services since its primary mission is to provide "acute care" needs – in hospitals and sometimes in nursing homes. Following is the breakdown by Part and Part B coverage.

MEDICARE PART A (See www.AEupdate for benefit amount updates)

While far from serving as long term care insurance, Medicare Part A covers some costs related to hospital stays and is available for people who are 65 years old and over. When all program requirements are met, Medicare part A will help pay the costs for medically necessary inpatient services customarily supplied in a hospital or skilled nursing facility and for hospice care for the terminally ill. Medicare Part A also pays the full cost of medically necessary home health care and 80 percent of approved costs for durable medical equipment supplied under the home health benefit. Medicare Part A covers only those services that are considered medically necessary and only those charges that are considered reasonable.

Part A Benefits

All persons age 65 and over who are entitled to monthly Social Security cash benefits or monthly cash benefits under Railroad Retirement Benefits are eligible for Medicare Part A benefits free of charge. Others may be eligible for Medicare if they pay a monthly premium. Persons age 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working does not affect the amount of future Social Security benefits.

Enrollees in Part A are automatically offered the option of enrolling in Part B. However, they do not have to accept Part B if they do not want the coverage. Part A is financed through the Social Security (FICA) tax paid by workers and employers. The Health Care Financing Administration enters into agreements with state agencies and with intermediaries to administer the Hospital Insurance Plan. State agencies survey institutions to determine whether they meet the conditions for participation as a hospital, skilled nursing facility, home health agency, or hospice. They also help the institutions meet the conditions for participation.

An individual does not have to pay a monthly premium for Medicare Part A if he or a spouse is entitled to benefits under either the Social Security or Railroad Retirement systems, if he has worked a sufficient period of time in government employment to be insured, or if he is under age 65 and has met the disability program's requirements. Those who do not meet the above coverage requirement may voluntarily enroll in Medicare for a monthly premium determined by the number of quarters (less than 40) that they paid into Social Security or Railroad Retirement.

A dependent or survivor of a person entitled to hospital insurance benefits, or a dependent of a person under age 65 who is entitled to retirement or disability benefits, is also eligible for hospital insurance benefits. Additionally, a dependent or survivor is eligible for hospital insurance benefits if that person is entitled to a spouse's or widow's Social Security benefit.

A Social Security disability beneficiary is covered under Medicare after entitlement to disability benefits for 24 months or more. Those covered include disabled workers at any age, disabled widows and widowers age 50 or over, and beneficiaries age 18 or older who receive benefits because of disability beginning before age 22.

Hospital Benefits

Hospital benefits entitle an individual to 90 days of in hospital care for each benefit period. A benefit period begins when the insured enters the hospital and ends after he has been out of the hospital (or skilled nursing facility) for at least 60 continuous days. There is a deductible for each benefit period. In addition, the individual must pay a coinsurance amount for days 61 through 90. After exhausting 90 days of coverage, Medicare will pay for an additional 60 days of care in that person's lifetime. However, the insured may have to pay a coinsurance amount during these final 60 days of care.

MEDICARE PART B (See www.AEupdate for benefit amount updates)

Medicare Part B changes annually. However, it basically covers most reasonable and necessary medical services with little benefit in the long term care areas. An individual can receive this coverage once he turns 65, but he must pay a monthly premium. If he waits to enroll in Part B until after age 65, the monthly premium may be higher, since Medicare imposes a 10 percent premium penalty for every year that enrollment is delayed. However, if an individual is working and is covered under his employer's group health plan, he may delay enrolling without a penalty until seven months after retirement. This enrollment period is a

seven-month period beginning on the first day of the third month before the month he attains age 65.

If a person decides not to enroll in the initial enrollment period, he may enroll during a special enrollment period beginning with the first day of the first month in which he is no longer enrolled in a group health plan by reason of employment, and the enrollment period ends months later.

Medicare sets approved charges for all of the medical services it covers. Medicare does not cover many common health expenses such as prescription drugs, routine checkups, vision and hearing care, custodial care, and dental care. It also does not cover experimental procedures. Medicare does cover biannual mammograms, tri-annual pap smears, or flu vaccines.

Under Medicare Part B, an individual must pay an annual deductible. Once the deductible has been met, Medicare generally will pay 80 percent of its approved charge for medical care. The following doctors' fees and services are covered by this portion of Medicare:

- Doctors' services are covered wherever furnished in the United States. This includes the cost of house calls, office visits, and doctors' services in a hospital or other institution. It includes the fees of physicians, surgeons, pathologists, radiologists, anesthesiologists, and osteopaths.
- Services of clinical psychologists are covered if they would otherwise be covered when furnished by a physician.
- Services by chiropractors with respect to treatment of subluxation of the spine by means of manual manipulation are covered.
- Fees of podiatrists are covered, including fees for the treatment of plantar warts, but not for routine foot care. The cost of treatment of debridement of mycotic toenails is not included if performed more frequently than once every 60 days. Exceptions are authorized if medical necessity is documented by the billing physician.
- The cost of routine physicals, most vaccine shots, examinations for eyeglasses and hearing aids is not covered.
- The cost of diagnosis and treatment of eye and ear ailments is covered.
- Plastic surgery for purely cosmetic reasons is excluded. However, plastic surgery for repair of an accidental injury, an impaired limb, or a malformed part of the body is covered.
- Charges imposed by an immediate relative (for example, a doctor who is a son or daughter or brother or sister of the patient) are not covered.
- Radiological or pathological services furnished by a physician to a hospital inpatient are covered.
- Immuno-suppressive drugs used in the first year of transplantation are covered.

Accepting Assignment

Some health care providers take assignment which means that they agree to accept Medicare's approved charge as payment in full. Medicare pays 80 percent of the approved charge, and the individual pays the remaining 20 percent. Local Medicare carriers have a directory which lists all doctors and suppliers in the area who take assignment. If an individual wants to limit the amount he pays for medical expenses, he can obtain a copy of this directory and use it when choosing a health care provider.

Even when doctors do not take assignment, federal law limits the amount that they may charge Medicare patients. This limit is 15 percent above Medicare's approved charge. Some states have stricter limits with respect to what doctors can charge Medicare patients.

Payment of Claims

A Patient's Request for Medicare Payment form is used for submitting a supplementary medical insurance claim. This form must be submitted to the Medicare carrier in order for supplementary medical insurance to pay for covered services of doctors and suppliers. All Social Security offices and Medicare carriers and most doctors' offices have copies of this form.

If a doctor or supplier participates in Medicare or uses the assignment method of payment, he submits the claim. If the doctor of supplier does not accept assignment, the patient submits the claim, using the Patient's Request for Medicare Payment form. It doesn't matter whether all bills are from one doctor or supplier or from a number of different doctors or suppliers. A patient can send in the bills either before or after he pays them.

The itemized bill must show the following:

- The place where the patient received the services
- A description of the services
- The charge for each service
- The doctor or supplier who provided the services
- The patient's name and health insurance claim number

If the bill does not contain all of this information, payment may be delayed. It is also helpful if the nature of the patient's illness, that is, the diagnosis, is shown on the bill. A patient submitting a claim for the rental or purchase of durable medial equipment should include the bill from the supplier and the doctor's prescription. The prescription must show the equipment needed, the medical reason for the need, and estimate how long the equipment will be medically necessary.

Before any supplementary medical insurance payment can be made, a person's record must show that he has met a $75 deductible. Once a person has met the deductible, he should send in future bills for covered services as soon as he gets them so that Medicare payment can be made promptly. If all medical bills for the year amount to less than $75, supplementary medical insurance will not pay any part of that person's bills for the year.

If the person filing a claim dies and payments are due, special rules apply for services covered under the supplementary medical insurance plan. Hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency, or hospice that provided covered services. If the bill was paid by the patient or with funds from the patient's estate, payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person. If the bill has not been paid and the doctor or supplier does not accept assignment, the supplementary medical insurance payment can be made to the person who has the legal obligation to pay the bill for the deceased patient. This person can claim the supplementary medical insurance payment either before or after paying the bill.

The time limit for submitting a supplementary medical insurance plan claim is 15 months. For example, for services received between October 1, 2008 and September 30, 2009, a claim must be submitted by December 31, 2010.

If a person disagrees with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare, he has the right to ask for a review of the decision. The notice from Medicare advising a person of the payment decision also tells him about his right of appeal and how to request it.

If a person needs more information about his right to appeal, he should contact his local Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization (PRO) in his state. Peer Review Organizations assign committees to conduct reviews involving Medicare and its decisions.

A supplementary medical insurance claim may be appealed by the patient, the doctor, or the supplier who submits the claim. Medicare will notify the claimant of the decision made on the claim. If the person disputes the decision, he can ask the Medicare carrier for a review of the claim. If the claim is still disputed and if the amount in dispute is $100 or more, a hearing can be requested. Appeals can eventually be appealed to a federal court.

Medicare and Long Term Care

Medicare is inextricably connected to long-term care by virtue of the fact that changes in the Medicare system of payments has lead to a boom in long-term care services. In essence, Medicare has promoted a system that gives hospitals an incentive to move patients out quickly, sometimes without regard to the patient's actual condition or need for continuing care. The Mayo Clinic coined this practice as the ***quicker and sicker*** release of patients.

Because hospitals release patients quicker and sicker, there has been a 40% increase in nursing home admissions since the start of the PPS and DRG payment system described below. The bigger problem is that when patients are released from the hospital to the nursing home, only 2% meet the criteria for payment of their nursing home stay from Medicare. It should be obvious to agents that this information is essential to the health care planning of their clients and the pending need for long-term care coverage.

Medicare's Prospective Payment System & DRGs

Under Medicare's ***Prospective Payment System***, first effective in 1983, most Medicare hospital payments are based on the *patient's diagnosis at the time of admission to the hospital*. The costs incurred after admissions are not relevant.

An incoming hospital patient is assigned to a ***diagnosis-related group (DRG)*** . The hospital's payment from Medicare is the flat amount that Medicare establishes for the DRG. DRGs are based upon a system which starts with all of the possible diagnoses listed in the International Classification of Diseases, then classified into 23 major diagnostic categories, and finally divided into 477 distinct groups.

If the patient stays in the hospital for 8 days but the relevant DRG says that 4 days is the standard stay for the patient's disease, then Medicare pays for only 4 days. On the other hand, if the hospital treats and releases in 2 days, the hospital still gets paid for 4 days.

Of course, hospitals maintain that they care for a patient as long as it is medically necessary to do so, regardless of the Medicare DRG. But the DRG system clearly gives hospitals an incentive to curtail care in the following ways:

1) Early discharge of patients
2) Refusal to admit Medicare patients who's treatment and stay will probably exceed the average

Medicare does attempt to monitor quality care and access by entering into contracts with peer review organizations (PROs) in each state. These groups investigate and review hospital

admission and length of stay practices. Patients who are denied admission have an option to appeal.

In-Home Supportive Services

California's In-Home Supportive Services (IHSS) program is administered by each county Departments of Social Services under guidelines established by the state. IHSS provides assistance to low income, eligible aged, blind and disabled persons who are unable to remain in their homes safely without assistance. Most people are eligible for IHSS when they meet eligibility criteria for the Supplemental Security Income / State Supplementary Program (SSI/SSP) for the aged, blind and disabled.

The services available through IHSS are domestic services such as heavy cleaning, meal preparation and clean-up, laundry services and reasonable shopping.

What are other eligibility criteria for IHSS?

- You must be a citizen of the U.S. or a qualified alien. You must also be a California Resident.
- You must live at home (acute care hospital, long term care facilities and licensed community care facilities are not considered “at home”).
- Personal property may not exceed $2,000 for an individual or $3,000 for a couple.
- Depending on the amount of your income, you may be required to pay for a portion of your IHSS benefits (share of cost).

How does the IHSS program work?

- A county social worker will interview you at your home to determine your eligibility and need for IHSS. Based on your ability to safely perform certain tasks for yourself, the social worker will assess the types of services you need and the amount of time the county will authorize for each of these services.
- If you are approved for IHSS, you must hire someone to perform the authorized services
- If your county has contracted IHSS providers, you may choose to have services provided by the contractor
- The current IHSS hourly rate set by State law is $8 per hour.

Medicare Supplement Insurance

There are many gaps in coverage left by Medicare such as limited benefit periods, deductibles, coinsurance and exclusions that can be filled with a private Medicare supplement policy . . . sometimes called ***Medigap Coverage.*** Unfortunately, like Medicare this conventional insurance restricts coverage to skilled care . . . and not chronic conditions.

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

There are now ***11 standard Medigap plans***: A, B, C, D, F, F with a high deductible, G, K, L, M and N. Plan A consists of the core benefits alone; plans B through N contain additional benefits such as coverage of at-home help and physician charges in excess of Medicare’s approved amounts; and plans K, L, M and N provide fewer benefits at lower premiums than Medigap

plans A through J. Insurers may offer some or all of these Medigap plans; but they are not allowed to vary the benefit configurations within each plan.

Aggressive Medigap plans extend coverage to "at-home recovery" (short term assistance with activities of daily living) and skilled care may provide for items like IV's, bedsore care and physical therapy. But once health progress stops, the condition is termed ***chronic*** and no longer covered. That is why someone like an Alzheimer's patient is considered under these plans to need little or no skilled care. He is not covered by Medicare or a supplement plan yet cognitive impairment may limit his abilities to perform simple activities such as bathing or eating. Patients like this move through the evolution process . . . from acute to chronic conditions leading to the need for nursing home care or advanced home health assistance. The Health Care Administration estimates that Medicare and private insurance like Medicare supplement plans provide only 12 percent of the nation's total nursing home care expenses.

A Medigap policy is different from a ***Medicare Advantage Plan***. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements Original Medicare benefits.

Senior Hmo's

In lieu of Medicare and/or a Medicare supplement policy, a popular choice is the managed care plans which are often called ***HMO's or Coordinated Care Plans.*** Most of these plans collect a fixed monthly payment from the government, regardless of the patient's health, and must promise to cover all patient needs that would have been paid under Medicare. To contain costs, many of these groups contract with specific health care providers and clinics to offer Medicare services. In some cases, manage care groups provide a bit more than Medicare or supplement plans as an incentive to switch. Unlimited prescriptions drugs and some respite care are a couple of examples that have been used to attract Medicare enrollees. Currently, about 15 percent of the people eligible for Medicare choose managed care plans. Congress is happy about this because the government's monthly commitment is fixed and these private concerns are far better at cost containment than Medicare.

The concept of senior managed care is being tested in some our country on a grand scale. The primary advantage to this type of system is that it is a prepaid health care plan that ***promotes*** wellness and preventative medicine.

The predicted effects of managed care tend to offset the advantages of a more traditional comprehensive health care program. Under a traditional managed care program, doctors are salaried, and their earnings are not affected by quantity of care. Therefore, there is no incentive to over treat patients. As a result, waste and unneeded services are minimized. The purpose of managed care is to promote cost effectiveness of medical services.

It must be emphasized that while senior HMO's offer a few more frills than Medicare, they ***do not*** cover long term care. Services such as nursing homes and home health care are excluded for chronic conditions.

Taking No Action

Though the subject of this course is long term care insurance, one of its major drawbacks is whether an individual, such as a retiree, can afford the cost. For a portion of retirees, the answer is no. The average annual per capita income for someone 65 or over is about $20,000. If a 65 year-old with average income could pay about $2,000 each year for a good long-term care policy with inflation protection 10 percent of his/her annual income would be exhausted. Add other expenses and you can see that it may be quite difficult for the elderly to handle these

kind of premiums. Again, this is where agents must counsel clients on the need for "some" benefits or perhaps **taking no action at all**. Why? Perhaps your client already has ***large assets, is not eligible for LTC, or has an uninsurable preexisting condition.***

As good as LTC coverage seems, it is extremely important for you to know and point out to your clients that ***the purchase of long term care insurance does not ensure that someone will avoid ALL long term care costs***. A person who owns a policy could still end up on an ***assistance program*** like Medi-Cal. How does this happen? Like other forms of insurance, people buy less than they need, or, they refuse a valuable option like inflation protection leading to coverage short falls. There is also the possibility that their insurer waivers their specific condition or simply goes out of business.

Taking no action may also be an inevitable conclusion when clients you meet have ***no medical eligibility and/or a preexisting (uninsurable) health condition***. Lending them hope that they can be helped can do substantial damage where continued rejections may inflict severe disappointment leading to the potential for emotional distress. Please be considerate of your senior clients -- their medical conditions often leave them with the sensation that they have no control over their lives. Adding additional trauma can only add to these problems.

Informal Care By Family or Friends

According to the AARP, ***family caregivers*** are considered to be the backbone of the long-term care system in the United States. They provide about 80 percent of the care for people who need help with daily activities, such as bathing and dressing, taking medications, and paying bills. This form of care is generally unpaid ("informal" caregiving) compared to caregiving services from paid workers ("formal" caregiving). One study (Arno et al., 1999) estimated the value of family caregiving at $196 billion in 1997, assuming that the average annual number of hours of informal caregiving was replaced with paid services.

The 1997 National Alliance for Caregiving/AARP national survey reported that two in 10 working caregivers turned down chances to work on special projects; almost as many avoided work-related travel. Forty percent of the survey respondents said that caregiving affected their ability to advance in their jobs.

In October 2000, Congress enacted the National Family Caregiver Support Program (NFCSP) under the Older Americans Act. This program provides support services for family members caring for persons with disabilities and grandparents caring for grandchildren. Program components include education and training, counseling, support groups, and respite care. Congress appropriated $125 million for FY 2001 and $141.5 million for FY 2002.

Until passage of the NFCSP, state general revenues provided the bulk of public funding for family caregiving. Other sources of state revenue for caregiver services have included casino funds (for respite care in New Jersey), lottery money, and tobacco settlement funds. States can also cover respite care under Medicaid Home and Community-Based Waiver programs.

Examples of comprehensive statewide family caregiver programs include:

- *California's Caregiver Resource Centers*
- *Pennsylvania's Family Caregiver Support Program*
-

Twenty-two states help family caregivers with their financial burdens by providing ***tax credits*** or deductions. State tax credit programs build on the federal tax credit, which reduces the amount of income taxes a family owes. If payment is made by an employed caregiver to a third party for

expenses incurred for the care of a dependent person, the federal dependent-care tax credit can be claimed.

What is the future of informal family caregiving? Well, considering we will enjoy even longer life spans and the trend away from government help for long term care, the odds for the demand for formal and informal in-home and nursing home services will increase substantially. Just how much family members can continue doing remains to be seen.

Is family caregiving important in the selling of long term care insurance? You bet. The degree family support, or lack thereof, a client has can make the difference in the type of policy you suggest.

Take, for example, a client who has absolutely no family support network to help with home care. He might have less of a need for a comprehensive policy with a huge home care benefit, opting instead for strong nursing home coverage. Likewise, a client who has willing children but they have children of their own and busy careers is not likely to see his family as frequent caregivers. Contrast these policyowners with a couple that is in good health with a strong likelihood that one or the other spouse will be healthy enough to assist at home and a good volunteer family support system may possible since their children and close relatives live locally. A strong home care option that allows for benefits to be paid where the caregiver is a family member or close friend may be a good suggestion.

Medi-Cal

(See www.AEupdate for benefit amount updates)

(See Attachment I for additional information on Medi-Cal)

While Medicare is the single largest payer of health care costs for the elderly, it often provides little in the way of benefits for long-term health care needs.

As a government program, Medi-Cal includes the providing of long-term nursing home care for those who qualify. Medi-Cal, therefore, can be considered both a companion and competitor of private long-term health care policies. Unlike, Medicare, Medi-Cal is jointly funded and administered by the state and the federal government. Because each state administers the Medicaid program and is free to tailor its Medicaid rules within federal guidelines, the Medicaid program varies considerably from state to state.

Medicare, with its limited coverage, is not a solution for long-term care. It can afford some adjunct assistance in paying for initial admissions, and should not be overlooked as a source in the event that a current private pay resident enters a hospital and later re-enters the nursing facility, with needs that may fall within the health care guidelines.

Curiously, current federal laws seem to encourage skilled nursing facilities to refuse to submit Medicare claims. Consequently, the patient, his or her family, and their professional advisors should not be shy about pursuing at the very least the initial stages of an appeal.

More on Medi-Cal

Medi-Cal pays for hospital, medical, prescription drug and “medically necessary” nursing home care. California does not consider a person’s impairment in their ability to perform Activities of Daily Living in determining eligibility for Medi-Cal’s nursing home benefit.

The Medi-Cal system was originally intended to be a “safety net”. It was established to assist families in crisis and help the medically needy who lacked access to medical care. Above all, it was deigned as a ***short-term solution*** for health care. Use of the system, however, has been far different than was intended. The program now has the stigma of a social welfare program providing current, on-going and long-term health care for families and seniors alike. Combined with our rapidly aging population and the high costs associated with long-term care, it is easy to see why there is great concern.

Unlike Medicare, Medi-Cal is a ***needs based*** program. Medi-Cal provides benefits only to those who demonstrate a financial need. This means that a patient cannot have more than a limited amount of cash or other available assets, i.e. California is a ***Share the Cost*** state. Of course, there are exemptions and methods for these families to restructure their assets to qualify for Medi-Cal benefits. This process is called ***spendown***. It is a complicated area, but essential to the understanding of Medi-Cal and long term care.

Here are some frequently asked Medi-Cal questions:

Will Medi-Cal pay if I need Long Term Care Services in My Home? Medi-Cal provides choreworker and personal care services (assistance with activities of daily living and personal safety) at home through the Personal Care Services Program (PCSP). The counties through their In-Home Supportive Services program administrator PCSP based on guidelines issued by the State. Timely access to these services varies widely from county to county.

What are the Eligibility Requirements for Medi-Cal? Determining eligibility for Medi-Cal is the responsibility of the county Departments of Social Services. The county eligibility worker will look at how much the applicant and each member of the family has in monthly income (wages, dividends), property (real and personal), and assets (savings and CD accounts, investments). The home the applicant lives in, its furnishings, personal items, a limited amount of jewelry, and one eligible vehicle are not counted as assets and are considered “exempt” for determining eligibility. Eligibility rules are different for single individuals than for married couples.

ALERT: WHILE NURSING HOME RESIDENTS DO NOT HAVE TO SELL THEIR HOME IN ORDER TO QUALIFY FOR MEDI-CAL THERE IS A HOME EQUITY LIMIT OF $750,000, I.E., AN APPLICANT WITH MORE THAN $750,000 HOME EQUITY WILL BE DISQUALIFED FROM MEDI-CAL. HOME VALUES AE DETERMINED BY THE LESSER OF THE TAX ASSESSEMENT VALUE OR BY APPRAISAL. (Welfare and Institutions Code 14006.15(c)).

What is Eligibility For Married Couples? The Minimum Monthly Maintenance Income Allowance (MMMNA) is the amount of community income ($2,898 per month) the ‘community spouse” (the well-spouse) is entitled to receive. The well-spouse at home may keep all of the income received in his or her name, regardless of the amount. If the amount is below the MMMNA, the institutionalized spouse may allocate income to bring the at-home spouse’s income up to the MMMNA limit. If one spouse will enter long term care and the other will remain at home, together they may keep a total of $115,920 (2013) in liquid assets (not including home and other exempt assets).

Example: Bob enters into a nursing home paid for by Medi-Cal and has monthly income from Social Security. His wife, Joan receives $800 a month from Social Security. Joan is under the MMMNA limit. Joe can now allocate a portion of his income to Joan to bring her to the MMMNA limit and deduct it from his share of costs.

Note: Income and asset limits for Medi-Cal eligibility are subject to change each year. See www.AEupdate for benefit amount changes.

Basic Services Offered By Medi-Cal

Federal law and regulations specify a list of basic services that must be included in any state Medicaid program. Those services include:

- Inpatient hospital services
- Outpatient hospital services, including ambulance services offered and included in the state's Medicaid plan.
- Physician services furnished in the physician's office, patient's home, hospital, skilled nursing facility, or elsewhere. Also, medical and surgical services furnished by a dentist where state law permits either physicians or dentists to perform such services.
- Laboratory and x-ray services
- Skilled nursing facility services for individuals 21 and over. Coverage does not include services in an institution for mental diseases or tuberculosis, but does include early and periodic screening, diagnosis, and treatment of individuals under age 21 for physical and mental defect.
- Home health care for persons eligible for skilled nursing facility services.
- Family planning services and supplies.
- Rural health clinic services, including ambulance services offered and included in the state's Medicaid plan.
- Federally qualified health center services.
- Services of certified pediatric or family nurse practitioners.
- Early and periodic screening diagnostic and treatment services for children under 21.

Medi-Cal and Long Term Care

Both MediCal and Medicaid have become public assistance programs . . . welfare . . . that combined pay for almost two-thirds of all nursing home patient days in the United States. Some states are spending more money on Medicaid than on education prompting national debate on how to finance long-term care. The program has a dismal reputation for access, quality, reimbursement, discrimination and institutional bias. Nevertheless, citizens, private attorneys and even public entities such as state Long-Term Care Partnerships encourage middle class people to virtually impoverish themselves in order to gain access. This process is referred to as ***Medicaid or Medi-Cal Planning***.

The government wants to stop the practice of transferring assets and other abuses of the Medi-Cal system. That is why legislation created tax incentives for citizens to buy their own, private long-term care insurance. Additionally, rules have been established that make it a crime to transfer assets to avoid paying for long-term care expenses.

On the industry side of the scales, nursing homes that accept Medi-Cal, are now required to notify new residents who pay with private funds at entry that they might have to move if they eventually run out of money and need to rely on Medi-Cal. Up to now, nursing homes took private payers, and kept them when they could no longer pay, shifting them to Medi-Cal. They felt it was "bad public relations" to kick these patients out. Nursing home giant Vencor tried this a couple years ago and suffered a huge scandal, together with falling share values.

The new law may furnish nursing homes with yet another incentive to leave the Medicaid/ Medi-Cal program and another argument convincing prospects for long-term care that if they want quality care, they must insure it on their own.

Medi-Cal and Its Impact on California Long Term Care

Medi-Cal, California's Medicaid Program, is funded by both federal and state tax dollars and provides health care coverage for approximately six million eligible beneficiaries in the state. ***Medi-Cal eligibility*** is based on being in ***financial need*** and being able to pay for health care services. Since there is no other payment source for custodial long term care service, the Medi-Cal program has become the largest payor for these services when people cannot afford to pay. With the significant costs associated with receiving long term care services, many Californians who were otherwise middle-income find it necessary to apply for Medi-Cal.

It is unfortunate, but many individuals in the state view the Medi-Cal program a program for the "poor". As is with many programs that were developed with "good intentions" to assist citizens during a time of need, the Medi-Cal Program has developed the stigma of being an extension of the social welfare system. This in unfortunate and not entirely true.

The program was established to help those in need, those who were experiencing financial difficulty (the program has thousands of hard-working beneficiaries) and for the aged, blind and disabled citizens that had no other way to access health care benefits. These individuals and especially the aged population are those at risk for needing long term care services, primarily nursing home care, and are generally in the "Medically Needy" category.

The Medi-Cal program pays for almost 60 percent of all such services in the State. Twenty-five percent of people going into a nursing home become impoverished and will need to apply for Medi-Cal to pay for the cost of their care.

What may surprise most people (agents take note) is that the impoverished person we are speaking about is kindly Mrs. Jones who lived next door or Mr. Smith on the corner. Your automatic response would be, "no way!. Mr. Smith worked for the school district for 42 years! He isn't poor or impoverished.". You even know that Mr. Smith gets $1500 per month in retirement and was proud of a small savings and some investment he had. It just does not sound right, does it? But you also know they had to put Mr. Smith in a nursing home over a year ago. You have never thought much about how he has been paying for it. You know now, because of this training, that Medicare and health insurance pays nothing toward custodial care. Sadly, Mr. Smith did not know it either.

Well, Mr. Smith is paying for it out of his retirement, savings and investments. The nursing home runs $3,600 per month. With $2,100 per month being paid in a co-pay, it is not going to last long. What will happen to Mr. Smith when he does not have the extra money to supplement his retirement to pay for the nursing home? Another scenario that could have landed Mr. Smith in this frustrating situation is one where he purchased a $50 a day without inflation protection, long term care insurance policy 10 years ago. At that time the cost of care was around $65-70 a day. Mr. Smith thought he could manage the other $15-20 a day and still have money left at the end of the month for personal items. The cost today is $120 a day. Mr. Smith has to co-pay $70 a day or $2,100 per month. Remember, Mr. Smith only gets $1,500 per month. Mr. Smith will have to spend all his assets and "impoverish" himself. When this happens to Mr. Smith, he falls into the category of "medically needy". Who would have thought this possible?

You have no idea how often this situation happens. It can play out in a variety of ways but it happens more than we would like to see and to people we never would have expected. Good planning can keep it from happening and that is part of what you are here to learn.

Except for the very wealthy, those who did not know to plan, did not choose to plan or purchased inadequate long term care coverage, have to rely on the Medi-Cal program to pay for

their long term care. This is done by the applicant or their legal representative contacting their local county Department of Social Services. Eligibility for Medi-Cal is not automatic. Though each case is individual, there are some basic requirements that are important to know:

- The county will look at how much the applicant and each member of their family has in monthly income (wages, dividends), property (real and personal), and assets (money market and CD accounts, investments, jewelry).
- If the monthly income is below the limit set by Medi-Cal, they most likely will qualify for Medi-Cal. If they have more income than the limit for the month, the applicant will be denied Medi-Cal coverage for that month or the applicant will be required to provide a "share-of-cost" toward any treatment received during that month.
- The home they live (own) in, furnishings, personal items, and one vehicle are not counted as assets and are considered "exempt" for eligibility purposes only.
- **THERE ARE SPECIAL INCOME AND ASSET RULES WHEN ONE SPOUSE REQUIRES NURSING HOME SERVICES**.
- If one spouse (husband or wife) needs to go into a nursing home or is already residing in a nursing home, and the remaining spouse is still living at home, the spouse at home may keep $109.560 (2010 figures) in assets (not including home and other exempt assets) while the spouse in the facility can keep $2,000.
- The spouse remaining at home is allowed a minimum income of $2,730 per month (2010), while the institutionalized spouse is allowed just $35 per month for personal needs.
- When one spouse is in a nursing home and the remaining spouse also has income, each spouse's income is considered separately. This allows the healthy spouse to keep their own income. *Problems can occur when the bulk of the household income is being received by the institutionalized spouse. The name on the check (e.g., income, IRA, retirement) is the spouse credited with the income. If the check is made out in both names, the income is considered 50/50 for each of them.*
- Income and eligibility requirement may change. Limits on income and exempt assets are adjusted annually.
- Understand, if an individual has property (e.g., house, car, etc) and/or assets, that were exempt during the eligibility process the property or assets are protected during estate recovery. Upon their death, the State Department of Health Services, Medi-Cal Recovery Unit can place a lien and/or claim against the entire estate of the deceased for the expenses incurred by the Medi-Cal program to recover those costs paid by the state. If the individual was married, a lien would not be placed until the remaining spouse dies or sells the property.
- If single, a claim would be made directly against the estate of the deceased.
- This last but extremely important issue relates to applicants transferring assets to qualify for Medi-Cal service. The Health Insurance Portability and Accountability Act of 1996 established criminal penalties for whoever knowingly and willfully assists in disposing of assets in order for an individual to become eligible for Medi-Cal services. This demonstrates how committed the government is on issue of Med-Cal transfers. Lack of an amendment in the 1996 Health Care Act eased these rules so "granny won't go to jail". However, the Balanced Budget Bill, signed by President Clinton on 8/5/97, still targets advisors. Thus, any financial planner, agent, lawyer, etc involved in illegal Medi-Cal planning transfers can risk jail time. Citizens involved in the scam will NOT go to jail, but could face extended periods of ineligibility for their improper transfers. Current law also states that a "statement, representation, concealment, failure or conversion by such a person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony, and upon conviction thereof, fined not more than $25,000 or imprisoned for not more than 5 years." As you can see, this is a very serious issue, so be sure you listen very carefully when discussing income and assets with your applicants.

The Medi-Cal program has many rules and regulations and is very complex. It is best that you do not try to describe the ***whole*** program to an applicant but to at least familiarize yourself with the basic information so you can explain the risk involved based on the applicant's financial status. Also, make certain that you keep current on the property/asset and income allowances. You can get these updated figures each December for the following year from the local county Department of Social Services or the Departments of Health Services Eligibility Branch in Sacramento or go our special website www.AEupdate.com. Should an applicant have any additional questions, refer them to their local county Department of Social Services.

ALSO IMPORTANT: AGENTS NEED TO BE AWARE THAT THE PURCHASE OF A LONG TERM CARE POLICY WILL NOT NECESSARILY ENSURE THAT SOMEONE WILL AVOID MEDI-CAL WHEN THEY NEED LONG TERM CARE.

(Note: For agents planning to become California Partnership certified, you will receive more detailed training on Medi-Cal eligibility, recovery and asset protection at the time you attend the special 8-hour class to receive certification to sell Partnership policies.)

Medi-Cal Estate Recovery

Federal law requires each state to recover the costs of nursing facility and other medical services from the estates of Medi-Cal recipients. This means the state of California is federally mandated to recover from Medi-Cal recipients who receive services at the age of 55 or older, or in a nursing home, in order to help pay Medi-Cal covered expenses for the increasing number of individuals needing medical care.

Example: Mr. Roberts, a widower, left his only property, a house valued at $175,000, to his son. At the time of his death, Medical had provided $24,000 for his nursing home care. In addition to this claim, there was a total of $10,000 in funeral bills and costs for probating his estate. Mr. Roberts' son received $141,000 ($175,000 - $24,000 - $10,000 = $141,000) after all the claims were paid.

Recoveries from a deceased recipient's estate will include all medical expenses paid by Medi-Cal These expenses include:

- Health insurance premiums (including Medicare),
- Nursing home services,
- Home and community based services,
- Hospital services,
- Prescription drug services, and
- All other Medicaid covered services.

Food stamps, emergency assistance and cash grants are not Medicaid costs, and will not be recovered under this process

How do clients know when Medi-Cal intends to try to recover from their estate? Medi-Cal should provide notice that the Estate Recovery Program exists when they first apply for Medi-Cal. When Medi-Cal is actually trying to get recovery, it must notify the legally authorized representative of your estate. If there is no representative, they must try to notify known family members or heirs.

Before 1993, Medi-Cal could only recover from your estate if it discovered that you had owned assets during the period in which you received benefits and that those assets would have made

you ineligible for Medicaid. In 1993. Recovery powers were greatly expanded for people who receive Medicaid after October 1, 1993 and who die after that date.

Medi-Cal can now try to recover after a client's death in these additional situations:

- If the client is 55 years old or older when they receive Medi-Cal; or
- If the client received Medi-Cal under a provision that disregards certain assets because they have purchased a long-term care insurance policy, e.g., The California Partnership for Long-Term Care.

Frequently Asked Medi-Cal Recovery Questions

What portions of your client's estate are protected from recovery by Medi-Cal?

If they own a joint tenancy in real estate with someone else, that real estate cannot be recovered by Medi-Cal. If they have sold or transferred property to someone without keeping any interest in that property for themselves, that property is also protected for recovery purposes.

NOTE: If clients transfer any property for less than its fair market value, they could have trouble getting Medi-Cal for nursing home or other long term care for three years after transferring the property.

If clients own any personal property , such as a car or a bank account, in joint tenancy with someone other than their spouse, a blind or disabled child, or a child under 21, Medi-Cal may try to recover against that property. It is not clear whether DHS can recover personal property held in joint tenancy.

Can Medi-Cal recover from a spouse's estate? No.

What are the so-called "lookback" provisions? OBRA '93 established a 30 month "look-back". Assets given away within 30 months of applying for Medi-Cal are assumed to be transferred to avoid payment of medical expenses. The Deficit Reduction Act of 2005 increased the lookback to 5 years. The look-back is also 60 months for transfers of income or principal to an irrevocable trust. The penalty for either is a period of ineligibility equal to the amount of the "illegal" transfer.

NOTE: AS OF THE PUBLISHING OF THIS COURSE, CALIFORNIA HAS DRAFTED LEGISLATION TO MODIFY THE ABOVE 30 MONTH LOOKBACK RULES TO COMPLY WITH THE DEFICIT REDUCTION ACT OF 2005. AN ASSET NOT QUALIFIED UNDER THE LOOK-BACK PERIOD WILL BE CONSIDERED IN DETERMINING ELIGIBILITY (Welfare and Institutions Code 14015(c)).

ALERT: IF A PERIOD OF INELIGIBILITY DUE TO LOOKBACK PROVISIONS ENDANGERS A MEDI-CAL RECIPIENTS LIFE OR HEALTH A "HARDSHIP" EXEMPTION HEARING CAN BE GRANTED (Welfare and Institutions Code 14015.1 and 14015.2)

What is the treatment of property transfers made during the Medi-Cal "lookback" period? If the transfer in means an outright gift or sale at less than "fair market value", Medi-Cal will calculate the period of ineligibility for nursing facility level of care.. It will be the number of months resulting when the 'net fair market value" of the transferred is divided by the monthly average private nursing facility costs (ADPPR). In 2010, the average cost used to calculate the period length is $5,698 per month.

Are "exempt assets" protected against Medi-Cal Estate Recovery? No, even the home, if it has not been previously transferred, is part of the estate against which Medi-Cal has the right to recover the cost of Medi-Cal benefits received after the recipient is age 55. Such recovery will not occur until after the death of the community spouse and/or there are no more dependents.

Are there any other protections?
Yes. If a client dies leaving a "dependent," Medi-Cal will not file a claim against their estate. A dependent is a surviving spouse, a child under the age of 21, or a child who is blind or permanently or totally disabled. If clients leave an estate that will be probated , any claim for recovery from their estate must be filed within four months after death . If, at the end of that four-month period, a surviving spouse or disabled child is still living, or if there is still a child under 21, Medi-Cal will not try to recover from the probated estate. If an estate will not be probated , Medi-Cal will not try to recover from it if, two years after death , the surviving spouse or disabled child are still living, or if there is still a child under 21.

A client's estate can also be protected if MediCal's actions will create an "undue hardship" on someone who survives him or her. Medi-Cal will look at the following circumstances to decide whether undue hardship exists for the survivor:

- Whether the property was the primary residence of the person claiming undue hardship;
- Whether that person used personal resources to maintain the property, pay taxes, etc.;
- Whether that person lived on the property and provided significant care so that you could remain at home for a longer period of time;
- Whether that person had entered into a contract with you in which the residence was held as security or in which the residence was supposed to be transferred to that person for value already received by you;
- Whether you had promised that the residence would belong to that person after your death and the person had relied on that promise and would be harmed if the promise were not met;
- Whether that person is a resident and co-owner of the property; or
- Whether the property produces income necessary for that person's support.

Medi-Cal Liens

Liens against the real property of a recipient may be filed when the Department of Social Services determines that the recipient cannot reasonably be expected to return home. The purpose of the lien is to recover any payments made by the State of California on behalf of the Medi-Cal recipient. A lien does not change property ownership. However, it does represent a debt that must be satisfied when the property is sold, transferred, or the recipient dies.

Written notice will be provided ninety (90) days prior to filing a lien. Medi-Cal recipients or their personal representatives will have an opportunity to present any objections during a hearing process.

Automatic statutory liens are also imposed against judgments, awards and settlements in lawsuits when the state has provided medical assistance to a recipient for which a third party is responsible.

Medi-Cal Conclusions

The U.S still lacks a universal system for medical and long term care and Medicaid and Medi-Cal is NOT it! Medicaid programs pauperizes families who must use it, and encourage the non-poor to try methods (some now considered a crime) to transfer assets to qualify.

Medicare was created as a public welfare program for the indigent funded by Federal, state and local governments. Some of the benefits go to families and dependent children but a huge and growing portion is for the aged, blind and disabled. One private study indicates that over 25 percent of Medicaid funds were for nursing home costs alone.

The problem is obvious. A huge portion of our senior population has been caught "off-guard". Their longevity combined with escalating costs of long term care has created a need to try and capture the benefits of Medi-Cal. If they don't, a reasonable stay in a nursing home could impoverish their entire estate. It is a small wonder, then, why these people have turned in record numbers to lawyers and financial advisers to find Medi-Cal ***loopholes*** -- ways to divest themselves of income and assets in order to qualify for Medi-Cal.

Privately funded long term care insurance is seen as a substitute for some form of national long term health plan. But it may come too late for anyone who has accumulated a modest nest egg. They may not be able to afford the premiums and they can't go it alone. Finding a way to qualify under Medi-Cal is, for them, a viable option.

As discussed, Medicaid programs can vary from state to state. Therefore, the insurance professional, when marketing long-term care insurance in more than one state, must become familiar with the Medicaid programs in each of those states

It is recommended that any Medicaid or Medi-Cal plan should be reviewed at least every two years to see if it is the best plan in light of current state law. Make sure you are aware of the planning options available and seek the necessary advice in carrying out the "best plan for you". This will be well worth the time and expense and it can be thought of as a part of the cost of "health care insurance".

A Word of Caution

The Medi-Cal system is basically a form of welfare. The rules can and do change frequently. Consequently, advising persons about Medi-Cal carries with it a certain amount of risk. "Grandfathering" of an existing situation under which one may qualify for Medi-Cal when the rules change is uncertain. When consulting with a client on Medi-Cal, the professional is urged to disclose to the client the risks, and to continually keep abreast of changes in the law. Because the Medi-Cal program varies and constantly changes, the information contained within this chapter is intended to be illustrative in nature. Extreme caution should be exercised; the advisor is warned not to rely on these materials as a sole source of authority

Medi-Cal Spendown & Asset Transfers

To be eligible for Medi-Cal, a person can only have a certain amount of assets or "resources". In essence, the system is designed to "impoverish" an individual before benefits can be allowed. It is no wonder, then, why people have turned, in record numbers, to lawyers and financial advisors to find ***loopholes*** -- ways to divest themselves of income and assets in order to qualify. This process is know as the ***spendown***. In fact, an entire industry has grown around strategies for spendown called ***Medi-Cal Planning***.

Before we get to specific spendown rules, let's look at basic eligibility tests – the starting point for anyone considering Medi-Cal assistance:

Medi-Cal Eligibility – A Basic need

The begin with, an individual wishing to apply to Medi-Call must be in need of care. He or she must be 65 or older, disabled in some way – blind, physically disabled, mentally disabled, etc. The disabled person may also be less than age 65 and qualify if they meet other income / asset eligibility categories.

NOTE: DHCS FORM 7077 IS USED TO DETERMINE MEDI-CAL ELIGIBILITY. IT EXPLAINSEXEMPT RECOURSES, PROTECTIONS AGAINST SPOUSAL IMPOVERISHMENT AND CIRCUMSTANCES WHERE AN INTEREST IN A HOME MAY BE TRANSFERRED WITHOUT AFFECTING MEDI-CAL ELIGIBILITY.

Medi-Cal Eligibility – Income

In addition to asset criteria, there are guidelines for income. Generally speaking, for a person to be eligible for Medi-Cal he must spend all his income -- Social Security, pensions, interest, dividends, and so on -- on nursing home care before Medi-Cal helps.

The income restrictions are severe. Income is "capped" at about $2.739 per month (2010), even if all assets are "spent down" and even if this income doesn't cover the cost of the nursing home. Married couples are treated differently. Once a spouse is in a nursing home, each spouse's income is considered separately. This allows the healthy or "at home" spouse to keep their own income. Problems occur when a bulk of the income is still being received by the spouse in the nursing home.

In determining which spouse is entitled to the income, the Medi-Cal uses the ***name on the check rule***.

Example: Frank and Eleanor are married and receive income from several sources. Eleanor's Alzheimers condition was being handled by Frank at home with help from family members and incidental private care services paid for by Frank. As her illness worsened, Frank could no longer provide the level of care needed and Eleanor was admitted to a nursing home. Frank applied to Medi-Cal where his income was analyzed as follows:

Income paid to Frank from his company pension plan was considered **his** *income and not part of the Medi-Cal formula, i.e., the "name on the check" is Frank's so this income remains with Frank.*

Dividend and interest income on Frank and Eleanor's small stock fund and a small CD is paid to BOTH and there is no division or share indicated. This income is considered belonging one half to each. So, 50% of this income will not be available to Frank since the "name on the check" is BOTH Frank and Eleanor

Eleanor also receives a check every month from a trust set up by her parents. Since the name on the check is her's, alone this income will be used to pay nursing care costs before Medi-Cal pays.

Still more can be kept, in certain areas, if a hardship will result. Additional expenses such as housing payments, taxes and utilities may increase the monthly allowance.

All of these guidelines and limits are a clear reminder that ***Medicaid and Medi-Cal benefit programs are designed for low income individuals***

The Spendown

As we discussed above, the process by which medical and nursing home care reduces a person's assets is known as a ***spendown***. In the case of Medicaid / Medi-Cal, some have referred to it as the "path to poverty". In essence, a person can't get assistance from Medicaid until virtually all assets are depleted. Certain assets are considered ***noncountable*** or exempt. They include:

- a house used as a primary residence.
- a car for transportation to work or medical services
- a wedding ring
- a cemetery plot
- household furniture
- cash surrender value of life insurance under $1,500
- real property if it is essential for support (land to grow food) or it produces income for one's daily activities.

Assets that are ***countable*** vary from state to state. California lets the recipient keep about $2,000 in liquid assets. The general rule is, if the principal of the item can be accessed (even if it cost a penalty to get), it counts as an asset for Medi-Cal purposes. Here is a short list of what counts:

- cash, CD's and money market accounts
- stocks, bonds, mutual funds
- treasury notes and treasury bills
- vacation homes and second vehicles
- cash value life insurance and deferred annuities
- revocable living trusts

Certain other items are exempt because of their protection under federal law. These items include;

- Food stamp coupons
- US Department of Agriculture donated foods
- Supplemental food assistance programs
- Benefits received under the Nutrition Program for the Elderly
- Payments received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Tax exempt portions of payments made under the Alaska Native Claims Settlement Act
- Receipts distributed to certain Indian tribunal members
- Certain student loan funds
- Supplement security income payments received by recipients who do not reside in certain group care facilities
- Certain state provided assistance to senior citizens for property tax relief or other needs
- Payments made to veterans from the Agent Orange Settlement Fund
- Certain payments made by the US Government to citizens of Japanese ancestry who were interned during World War II
- Assets which are unavailable to the person.

Finally, an asset disregard of $3,000 in cash or other assets.

Medicaid rules do not also require the immediate impoverishment of a spouse. But, the limits of what can be kept may mean a lower quality of life than what he or she is accustomed to living.

In addition to exempt assets mentioned above, the amount a spouse can keep varies from state to state. The maximum in California is $109,560 (2010). The amount that can be kept is determined by adding ALL available assets of BOTH husband and wife. If one-half of the total does not exceed the amounts above, the spouse can keep them. The rest must be sold and used to pay any medical bills before Medi-Cal will participate.

Giving Away Assets & Income

Transferring assets or income in order to qualify for Medicaid is a topic of much discussion. There are five obstacles that your clients must consider before considering this strategy.

It's complicated. The process of divesting may require an irrevocable trust and legal property transfers. To stay within the law and avoid financial penalties will unquestionably require the services of an elder attorney. The costs and paper maze will sidetrack most. Transfers may also have serious negative income tax consequences.

It requires advance planning. OBRA '93 established a 30 month "look-back". Assets given away within three years of applying for Medicaid are assumed to be transferred to avoid payment of medical expenses. The Deficit Reduction Act of 2005 increased the lookback to ***5 years***. The look-back is also 60 months for transfers of income or principal to an irrevocable trust. The penalty for either is a period of ineligibility equal to the amount of the "illegal" transfer. NOTE: AS OF THE PUBLISHING OF THIS COURSE, CALIFORNIA HAS DRAFTED LEGISLATION TO MODIFY THE ABOVE 30 MONTH LOOKBACK RULES TO COMPLY WITH DEFICIT REDUCTION ACT OF 2005.

Example*: In anticipation of filing for Medi-Cal assistance, Dick transferred $50,000 to his son in October 2009. In May of 2010, Dick entered a nursing home and entered his formal application to Medi-Call in July of the same year. Since an uncompensated transfer (gift) occurred 9 months prior to Dick's application for Medi-Cal, he will be subject to a period of ineligibility (because it is within the 30 month look-back period). The period of disqualification is $50,000 divided by $5,698, the average private pay rate (This rate changes each year). Dick will be ineligible for 8.77 months. However, in California, the penalty period does not include partial months so Dick will be ineligible for 9 months.*

It can be a criminal offense. HIPAA, effective January 1,1997, has made it a misdemeanor punishable by a fine of $10,000 or one year imprisonment, or both to " . . . ***knowingly and willfully dispose of assets (including any transfer in trust) in order for an individual to become eligible for medical assistance (Medicaid)."*** Since no amendment was created, this law eased substantially for seniors, i.e., "grandma will not go to jail". However, it is a still a felony for a service provider or professional, such as an insurance agent, to help someone transfer assets. The fine is $25,000 or five years in prison or both.

It is only cancelled out. In the end, Medicaid recipients who temporarily avoid spending their own assets or income must still pay it back because OBRA '93 requires ***estate recovery***. Every state is required to pursue the estate of a deceased Medicaid recipient to recover any assets not subject to probate. They have a right to lien property and seek recovery from assets in which the recipient had any interest at the time of death. Even a life estate in a former house that was transferred to a child years ago could be attached.

There is loss of control and choice. When all assets are out of the individual's control he is finally eligible for Medicaid, but at what cost? If he recovers, there is little to come back to enjoy.

Further, as a Medicaid patient there are few choices as to doctors, facility location and upgrades. Some facilities do not accept Medicaid and ones that do may not be located near family and friends. Also, there is a remote chance that rates paid by Medicaid . . . typically lower than private pay . . . result in fewer service upgrades, furnishings, etc. The thrust of all these efforts is clear and chilling: Congress wants middle class citizens to buy long term care insurance and stay away from Medicaid.

Medi-Cal Trusts

It is important for insurance professionals to understand that clients are no longer able to shelter nonexempt income and property within trusts as a way of establishing Medi-Cal eligibility. Rules on these trusts and annuities were filed January 1998 as Director Letters #95-75 and #96-68 (now Section 50489 of Title 22). These regulations impact all trusts established on or after 8/11/93 containing the income, property or property rights of an individual or individual's spouse. Now, if an individual or spouse creates a trust, Medi-Cal counts as currently available anything contained within that trust (if not normally exempt; such as a home) regardless of when or whether distributions can be made and ***regardless of any special use limitations.*** This means that no matter how remote the possibility of a distribution may be, it will be currently counted for purposes of establishing eligibility for Medi-Cal. In addition, anything that cannot be released under any circumstances is subject to a "transfer-of-property penalty" which means that an individual may be ineligible for nursing facility care for the number of months that the property could have paid for their care at the average private pay rate.

There is one exception: trusts established for a disabled individual by someone other than him where there is specific language contained in the trust requiring repayment t DHS for the cost of medical assistance upon the death or earlier termination of the trust.

Annuities And Medicaid / Medi-Cal

Using annuities to protect assets from the nursing home expense has become very popular. Two recent books on the subject, The Medicaid Planning Handbook by Alexander A. Bove, Jr. and Avoiding the Medicaid Trap by Armond Buddish, specifically discuss the use of annuities to avoid Medicaid seizure. In fact, two insurance companies have designed deferred annuity products with features that are implemented at the appropriate time to get around Medicaid rules.

ALERT: SB483 (2008) now requires any recipient of Medi-Cal benefits to disclose any interest he or his spouse has in an annuity as a condition of eligibility. This bill also requires that the state be named a remainder beneficiary of certain annuities. Failure to do so may require that the annuity be treated as a transfer of assets for purposes of determining eligibility. Of course, certain hardship cases may be heard. (Welfare and Institutions Code 14006.15, 41 and 9.6).

In addition, there are many potential disasters with using annuities to shield assets. Following are some parameters to remember:

- Many states' rules for Medicaid differ greatly. It is important to learn as much as possible about your own state's specific rules.
- The annuity must be annuitized prior to applying for Medicaid. Many consumers who own deferred annuities will not remember that they must annuitize the policy prior to applying for Medicaid. Once the Medicaid applicant reveals that their annuity is a deferred annuity, then

it's too late. Medicaid (Social Services) will order the policy owner to either cash in the annuity for spend-down or simply disqualify the applicant for having assets that exceed the qualifying amount.

- If you purchase an annuity for the purpose of protecting your money from nursing home spend down, there is no guarantee that Medicaid will not simply change their qualification rules in order to disqualify such Medicaid applicants. The government is an expert at changing the rules.
- Under the Kennedy Kassebaum and OBRA '93 Act, an annuity must have life expectancy payout rates that are in accord with the latest social security mortality tables. Many insurance companies' payout rates are not compliance.
- Some annuities will not allow you to annuitize the first year. Therefore, if your situation should require annuitization during the first year, you would simply be out of luck! (There are other annuities that will not allow annuitization for 5-15 years.)
- If a deferred annuity is purchased to shield assets against Medicaid, the purchaser will often make a spouse the annuitant, so that in the event of nursing home confinement, the deferred annuity can be annuitized with income going to the spouse. However, if the annuitant predeceases the annuity owner, the death benefit is triggered. In some cases, a surrender charge is charged upon the death of the annuitant. In addition, the owner of the annuity will receive notice from the IRS for the taxable gain, not a pleasant experience. Finally, since the spouse is usually the primary beneficiary, the proceeds will be made payable to the contingent beneficiary. This is most likely the children and not the owner of the policy. This scenario could cause exercise of your E&O.
- Many purchasers do not understand how Medicaid actually works and therefore are not qualified to engage in this type of planning.
- OBRA 93 established and mandated a 60-month look back for deferred annuities. Many State Medicaid offices use this provision to initiate or trigger the ineligibility penalty period, creating an array of problems that may ultimately be attributable to ownership of a deferred annuity.
- Using an annuitized annuity to shield assets loses its glitter when it comes to single individuals, since the annuitized income cannot be directed to another individual as with married couples and the income stops should the income recipient die.
- What happens when the annuitant simply dies? You cannot attempt to qualify for medicaid by annuitizing your policy with the intention of passing excessive monies to your heirs. Under the Estate Recovery rules passed by OBRA 93, any income that continues to heirs after your death could be subject to recovery by Medicaid.
- It is worth considering that if you annuitize based on your life expectancy, the interest rate provided by the company may be quite low!
- If the annuity owner has to enter a nursing home because he has become incapacitated or mentally incompetent, who can make the decision to either gift the annuity policy or simply annuitize it? No one can, unless there is a durable power of attorney which grants such power. Even having a durable power of attorney is no guarantee, since many documents do not contain the requisite language for gifting or annuitizing such a policy.
- You cannot use a section 1035 exchange to avoid some of the problems mentioned above (see, for example, items 4), 5), and 6) because this procedure requires that the owner and annuitant in the successor contract remain the same.

In short, the advice to anyone considering the purchase of an annuity to shield their assets from Medicaid is: Let the buyer beware!

Consider this example. Bill wants to reside in a nursing home that costs $3,500 per month. In order to pass Medi-Cal qualification tests, he uses a significant portion of his assets to purchase an immediate fixed annuity that pays $1,200 per month for life. Bill's only other income, from

Social Security, is $950, making the monthly income total $2,150. However, in order to qualify for Medicaid, his monthly income must be less than the federal limit of $2,050

According to the Medi-Cal eligibility rules, Bill now has too much money coming in. In the process of "ridding" himself of much of his assets, he has established a guaranteed income that is too high and that he has no way of reducing. Even worse, this amount of income very likely won't be sufficient to cover the cost of his current medical expenses. In short, not only has Bill failed to qualify for Medicaid coverage, he has also locked himself into a situation in which his current income is not enough to meet the medical expenses that he alone is obligated to pay.

More Problems with Medi-Cal

Once someone qualifies as a Medi-Cal nursing home resident, the worries don't end. All of a sudden, the Medi-Cal resident, loses his or her ability to choosing a nursing home.

Not all nursing homes accept Medi-Cal residents. Many facilities are for private pay residents only. One school of thought provides the rationale: If Medi-Cal doesn't reimburse for the full cost of care (in California it doesn't), then private pay residents subsidize Medi-Cal residents. A private pay facility can provide care at a lower cost because the residents there are not subsidizing the expense of providing care to other residents.

Not all nursing homes have room for a Medi-Cal resident. Most facilities allocate a certain number of beds for Medi-Cal, and private pay residents. In theory, a nursing home administrator may want a private pay bed to remain empty while a waiting list exists for Medi-Cal residents.

If a Medi-Cal bed is not available at the time someone needs one, there will be a search for a Medi-Cal available bed. One could open up down the block from someone's favorite facility or it may be on the other side of town or even in the next county. People may have to wait at home or the hospital until a Medi-Cal bed becomes available.

Let's assume everything works out as the attorney said it would—money is hidden, Medi-Cal is paying the bills, and the resident is in a great facility. What happens when this person must enter a hospital to recover from a heart attack, stroke, or broken hip? Medi-Cal will pay the nursing home to hold the bed for only a week or two. After that time, the recovering Medi-Cal patient, who left the facility of choice, again starts looking for a facility. A Medi-Cal resident will find it harder to get into the better facilities than a private pay resident.

Once someone else pays the bills, the nursing home resident is at the mercy of the payer. Thus, it is not always desirable when Medi-Cal pays the bills and, as we discussed at the very beginning f this course, anyone interested in the quality of LTC system should not rely on the welfare support system alone.

Referral to HICAP

In California, the Department of Aging offers counseling services to all parties interested in locating long term care providers. Known as Health Insurance Counseling and Advocacy Program or HICAP, they help seniors and others review life insurance policies, file medical claims, advise on long term care services and counsel on other consumer health concerns. They also provide follow-up to ensure that these services were received. A complete list of HICAP offices is provided at on the Department of Aging Website -- www.aging.state.ca.us

As an agent, you are responsible to know the name, address and telephone number (not older than six months) of the local HICAP program in the area in which you are selling. Be sure to visit the Department of Aging website to fulfill this requirement.

Chapter 3
Long Term Care Insurance Legislation

See Attachment II – Tax Treatment of LTCI Expenses

Federal Legislation

Health Insurance Portability and Accountability Act of 1996 (HIPAA) . . . sometimes referred to as Kassebaum-Kennedy, contained a change in tax law for long term care insurance contracts that meet federal standards. In general HIPAA created a framework by which costs incurred for chronic illness would be treated as medical expenses under IRC Sec 213(d). ***Qualified long term care insurance premiums are deductible to the extent they exceed 10% of an individual's adjusted gross income.***

90-Day Certification for Activities of Daily Living

Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it could have had the unintended consequence of allowing taxpayers to deduct expenses associated with short-term disabilities due to the broad nature of the definition of a qualified *long-term care service*.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days.

The federal standard also ***defined chronic illness*** by specifying the ***level of disability*** required before benefits can be paid under a qualified contract to qualify for tax advantages. Specifically, the ***federal law restricts*** the payment of benefits to an inability to perform 2 out of 6 ADLs and a ***HIPAA Certification*** that services will be needed for a likelihood ***90 days (NOTE: THIS IS NOT AN ELIMINATION PERIOD)***. HIPAA also defined a chronically ill individual as one with severe cognitive impairment requiring ***substantial supervision or continual supervision*** to protect his health and safety. The legislation also left the door open for a third definition that has yet to be determined.

California required companies to pay benefits when a person was impaired in 2 out of 7 ADLs and did not allow the application of a 90-day requirement. Read more on the restrictions and what these terms mean below.

There were other conflicts in regards to cognitive impairment, the severity of both the ADL and cognitive impairment triggers, and the type of assistance that could be provided under a tax-qualified contract. Some companies had been paying for home care when a person needed services, regardless of whether the 2 out of 7 ADLs or cognitive impairment trigger had been met. These payments and other benefit triggers or standards such as ***medical necessity*** for benefit eligibility are not permitted in a ***tax qualified*** contract.

Because the federal benefit triggers ***conflicted*** with California requirements for benefit eligibility, qualified contract were not available in California until 1997. Enacted legislation allows the sale of these tax qualified contracts using the federal standards for claims payment, but requires the concurrent offering of contracts that meet the more liberal benefit payment standards required in state law. Contracts that were sold under state law before January 1, 1997 are automatically granted the status of a qualified contract. These older contracts enjoy all of the tax benefits of a qualified contract, regardless of the construction, benefits, or standards in those older contracts.

What The Long Term Care Legislation Means

The advent of HIPAA has created a new evaluation procedure for agents to make: tax-qualified or non-tax qualified contracts. With the advent of California's SB 870 legislation, the lines between the two policy types is harder to distinguish.

The first order of comparison is the ***tax issue*** itself. Agents need to help a client determine whether the tax breaks associated with a tax qualified policy are meaningful to the client. Clients who itemize on their tax return have a potential need for tax deductions; those that don't itemize have little need for them. Remember also that the tax status of your client may change dramatically as he moves from full employment to retirement

The next order of analysis is ***benefits***. Prior to SB 870 Guidelines from the IRS have also been helpful in establishing tax qualified status based on many ***safe-harbor*** definitions of terms like "substantial assistance", "hands-on assistance", "standby assistance", "severe cognitive impairment" and "substantial supervision". When insured individuals comply with these guidelines, certain payments received on account of a chronically ill individual from a qualified In addition, certain expenditures incurred for qualified LTC services required by a chronically ill individual are deductible as medical care expenses. As well, ***qualified LTC insurance premiums are deductible*** to the extent they ***exceed 10%*** of an individual's adjusted gross income.

In general, tax qualified plans are, for the meantime, considered ***more restrictive*** than non-tax qualified policies. The basis for this evaluation is the requirement that two out of six activities of daily living must be failed to qualify for a tax-qualified plan while many non-tax plans allow two out of seven. Further, a ***licensed health care provider*** must certify chronic illness under tax qualified plans and ***medical necessity*** is not considered a trigger for benefits while it is quite common in non-tax plans, although not many are sold today.

NOTE: THE MEDICAL NECESSITY CERTIFICATION BY A LICENSED HEALTH CARE PROVIDER MUST BE RECERTIFIED EVERY 12 MONTHS.

MEDICAL NECESSITY

Medical necessity means that a doctor or another source of independent judgement has certified that an insured's medical condition ***will deteriorate*** if he does not receive nursing home or home care. Medical necessity was a good thing for consumers but it is prohibited in tax qualified plans . . . the most common policy sold.

Per the IRS, a ***licensed health care practitioner*** means a physician, registered nurse, licensed social worker, or other individual who may be defined by the Department of the Treasury. The practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification.

The best example of how these restrictions may effect a policyholder was presented by Consumer Reports (10/97). Their discussions with one insurer uncovered an alarming result.

The company estimated that under the tax-qualified triggers currently in place, 40 percent of its paid claims or home care would NOT have been paid; 20 percent would NOT have been paid for nursing home claims.

IRS Notice ***97-31*** provides very specific guidance relating to ***qualified*** long term care ***services*** and ***qualified*** long term care insurance ***contracts*** under sections 213, 7702B and 4980C of the Internal Revenue Code. Let's look at a few definitions that would be minimum requirements to establish ***tax qualified status*** for an LTC contract:

Substantial assistance means hands-on assistance or standby assistance
Hands-on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL.
Standby assistance means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL
Substantial supervision means ***continual supervision*** by another person that is necessary to protect a severely cognitively impaired individual from threats to his or her health or safety.
HIPAA allows up to a $2,500 deduction for premiums used to buy tax-qualified long term care insurance. However, since less than 30 percent of all taxpayers itemize (very few of them seniors), this deduction may not be a significant incentive to buy tax-qualified plans. Even among those who do itemize, the expense is deductible only to the extent it exceeds 7.5 percent of the policyholders adjusted gross income. One industry source believes that only 5 percent of the population would consider the tax benefits of these plans viable.

It is important that all agents make careful evaluation in replacing policies issued prior to 1/1/97 with newer policies. These older policies have been ***grandfathered*** and receive the same tax treatment as the new tax-qualified contracts. In any decision to replace one of these older policies, the loss of these tax considerations must be considered. Making major revisions to the policy to upgrade benefits or purchase options is considered a violation that will also jeopardize tax benefit status. However, policy upgrades that are already built-in to the policy, such as a non-forfeiture provision, are not considered a material change and would retain all tax benefits. Some older policies also have ***easier benefit triggers*** that clients may not want to replace.

California LTC and Senior Legislation

The selling of long term care in California has changed dramatically in the past 15 years. Some of the Nation's most aggressive long term care consumer protection regulations and agent due care rules are now law in our State. Compliance with these rules is mandatory and the sanctions for violating them severe.

The California Insurance Code has adopted many NAIC standards in 1988 and 1990. However, the most significant legislation shaping long term care insurance sales today stems from the following bills:

SB 1943

Senate Bill 1943, authored by State Senator Henry Mello, was approved and signed by Governor Wilson on September 28, 1992. Its provisions went into effect on January 1, 1993. This law made major changes in both the definition of long term care insurance and in the design and sale of those products. Specifically, it added a number of consumer provisions, did away with many of the gatekeepers that had plagued older policies, and liberalized the triggers for benefits. It also regulated agent compensation and imposed heavy fines for improper sales practices and inappropriate replacement of existing policies.

SB 1943 changed, replaced, or deleted a number of sections of ***Chapter 2.6*** of the Insurance Code. The changes were reflected in the 1993 edition of the code.

Long term care regulation did not change again until 1997 when insurers tried to introduce "tax-qualified" long term care policies authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Certain consumer groups, ***Consumers for Quality*** and the ***Congress of California Seniors*** successfully sued the insurance department to block their sale and rescind approval of any existing policies. These groups felt that insurers were trying to capitalize on a conflict between state and federal law. Specifically, federal legislation under HIPAA permits long term care policies to qualify for a tax deduction, but required a higher disability threshold before benefits are paid. The ability to walk, for instance, was eliminated as a trigger of benefit. SB 1943, however, directly outlawed policies with such a high disability levels. Existing California law prevailed.

In April 1997, the California Senate held a joint hearing of the Senate Health and Human Services Subcommittee on Aging and Long Term Care in which all parties, including the California Department of Insurance, the insurance industry, and senior and consumer groups pledged to work together to develop consensus legislation. The following three bills reflect the result of these efforts.

SB 527

Senator Rosenthal introduced SB 527 on February 24, 1997 and signed by Governor Wilson on October 5, 1997. The bill requires insurers, who provide long term care intended to qualify for favorable tax treatment under federal law, to also offer coverage that conforms to current state eligibility requirements, i.e., non-tax qualified policies. The bill also covers long term care riders to life insurance policies but exempts group long term care contracts issued prior to January 1, 1997 because they are "grandfathered" as federally qualified contracts under Section 7702B(f)(2) of the Internal Revenue Code. Group policies that cease to be treated as federal qualified long term care insurance contracts, for whatever reason, must be amended to conform with all provisions of SB 527. Content of the bill was felt to be so important that it was passed as an urgent statute, i.e., ***effective immediately.***

This bill required insurers to provide a specified notice (TQ vs NTQ) at the time of solicitation, and a specified notice in the application form.

SB 1052

This bill was passed concurrently with SB 527 and AB 1483 discussed below. SB 1052 creates or amends ***twenty three*** long term care insurance codes covering thirty different issues such as policy construction, agent disclosures, required handouts, suitability standards, waivers, reporting requirements on agent activities, options to increase / decrease coverage, annual notifications, reinstatement provisions and more! This is a huge piece of legislation that also addresses tax qualified policies under HIPAA.

Supporters of SB 1052 believe the bill provides consumers with information they need to choose between tax favored and non-tax favored long term care policies. Under the bill, insurers are required to offer both types of policy. However, "sunset provisions" of the law suggest that this requirement end in two years with the Department of Insurance reporting back on whether it should be extended.

The SB 1052 rules were broad and complex leading to new mandatory California Continuing Ed requirements that must be met by all long term care agents on or before July 1, 1998.

Again, due to the perceived need to preserve protections for the long term care insurance purchasers as soon as possible, this bill was passed on October 5, 1997 and was ***effective immediately*.**

AB 1483

Introduced by Assembly member Gallegos on February 28, 1997 and passed *effective immediately* on October 5, 1997. Highlights of this statute can be found on the following pages. This bill requires that every policy that is intended to be a qualified long term care insurance contract as provided by federal law, i.e., a "tax qualified policy", to be identified as such with a specific disclosure statement, including riders to life insurance policies. Similarly, the bill requires that any policy that is NOT intended to be a qualified long term care insurance contract as provided by federal law be identified. This bill also sets forth eligibility criteria for policies and certificates (activities of daily living) intended to be "tax qualified" and "non-tax qualified".

SB 1537

This legislation concerns IRS decisions on the taxability of long-term care policies. If the IRS issues a decision, declaring that the benefits paid under long-term care insurance policies or certificates, that are not intended to be federally qualified, are either taxable or nontaxable as income, insurers offering both forms of policies must offer a holder of either form of policy a one-time opportunity to exchange the policy from one form into the other form. The bill provides for the emergency regulations to require insurers to allow exchanges to be made on a guaranteed issuance basis, but to allow insurers to lower or increase the premium, with the new premium based on the age of the policyholder at the time the holder was issued the previous policy, as specified. The bill also provides for the exchange to be made by rider to a policy at the discretion of the department, and provide that policies may not be exchanged if the holder is receiving benefits under the policy (he is under claim) or would immediately be eligible for benefits as a result of an exchange (adverse selection).. The bill also requires insurers to take certain actions to notify holders of these policies and certificates of the availability of the exchange option.

SB 870

Signed September 7, 1999, this bill was designed to "clean-up" certain disclosure issues and reflect the market's interest in residential care and home health care coverage. The disclosure portions of the bill expanded cognitive eligibility by no longer limiting mental illness triggers to Alzheimer's and organic disorders. Now, clinically diagnosed conditions of "related mental disease" are also covered. Nonforfeiture benefits are more permissive as well as benefits that may be added when an insurer adds a new product policy to his line. Inflation protection was reinforced with a special caveat that available benefits may accrue without any maximum specified indemnity amount. A new checklist is added to the application to assure that agents provide full disclosure and residential care coverage is boosted to *70 percent* of institutional benefits.

SB 475

This legislation, adopted in 1999, requires the Insurance Commissioner to annually prepare a consumer rate guide for long term care consumers. Insurers, under this bill, are also required to provide specified data on long term care policies.

SB 898

Senate Bill 898 is a rate stabilization bill, which creates more stringent standards for long-term care insurance premium pricing and regulation. The premium rates for policies issued after January 1, 2003 (or, in some cases July 1, 2003) are subject to actuarial review by the Department and rate increases on these policies will be subject to additional review and justification requirements. Clients who purchase a policy which uses pre-SB 898 rates, must be offered the SB 898 rates/policy within 12 months of the availability of the new, SB 898 policy, but they may also have to go through the underwriting process again.

SB 455

Effective January 1, 2002, provision 10232.65 of the Insurance Code is restored requiring a limit of one month on the amount of premium that may be collected by a long term care issuer with an application prior to the time the policy is delivered.

SB 1613

Approved in 2002, this bill requires the evidence of continuing education to be filed with and approved by the Commissioner for nonresident licensees. And, specifies that an insurer is not prohibited from filing new group forms and individual forms with the commissioner after 1/1/03.

SB 620

Enacted September 27, 2003, this legislation has more to do with abusive marketing disability, life and annuity policies to seniors than long term care issues. Advertisements directed to produce leads from any person over age 65, for example, must disclose that an agent may contact that person if that is the fact. There is also emphasis on the illegality of marketing materials that deceive or mislead the prospect as to the agent or company's true status, character or capacity. For example, it would be illegal under this legislation to use initials or logos similar to the Social Security Administration (SSA), that might induce someone into thinking that your company was somehow associated with the SSA. It would also be in violation to make a senior believe that he would lose some right, privilege or benefit if he fails to respond to your ad. There are also limits on advertising "seminars", "classes" or "informational meetings" when the true intent is to present an insurance product. Want to visit a senior's home? Under this legislation you must now deliver a notice to him in writing no less than 24 hours prior to any initial meeting. For pre-existing insurance relationship a notice must still be delivered prior to the meeting. And, at any time a senior request you to leave, you must do so immediately! Again, these rules specifically excluded long term care sales, however, if you plan to cross-sell other products at the same time you present long term care, you have some additional duties to follow.

SB483

Approved 2008, this bill requires a recipient of Medi-Cal benefits to disclose any interest he or his spouse has in an annuity as a condition of eligibility for medical assistance for home or facility care. The state of also entitled to become a remainder beneficiary of certain annuities. If a Medi-Cal recipient refuses to allow this beneficiary arrangement, the annuity can be treated as an asset for purposes of determining Medi-Cal eligibility. Of course, there is a provision that any penalty related to eligibility can be appealed on the basis it create an extreme hardship.

AB 2150

Many senior-oriented financial designations have surfaced over the years. Agent earn some of them with little training and time. Certain financial abuses of seniors has occurred on the strength of these designations so the commissioner, under this bill, must now approve any such designations based on their experience and education requirements.

Tax Treatment of Long Term Care Insurance

IRS Notice 97-31 – TAX QUALIFIED LTCI

The IRS has created "safe harbor" guidelines outlined in 97-31 to help determine is an individual is chronically ill. Policies with insuring clauses matching these guidelines are considered Tax Qualified. Benefits of a tax-qualified policy include:

- Tax free reimbursement benefits
- Exemptions of per diem and cash (indemnity) benefits determined annually ($280 per day exemption from income taxes in 2009). Additional amounts if justified by actual expenses fro chronic illness.
- Premium tax deductions and//or reimbursements for individuals, health savings accounts, self-employed and employer LTC costs (see Premium Deductibility below).

A major requirement of 97-31 is certification from a licensed health care practitioner that the ill person meets the defined criteria by inability to perform certain activities of daily living or is chronically ill based on severe cognitive impairment. Below you will find a sample certification. If a certification is not obtained, a taxpayer would not be allowed to deduct the expenses as qualified long term care expenses.

SAMPLE CERTIFICATION OF CHRONICALLY ILL INDIVIDUAL

The undersigned certifies that he or she is a licensed health care practitioner as defined in IRC §7702B(c)(4) (that is a physician (as defined in §1861(r) of the Social Security Act), a registered professional nurse, or a licensed social worker).

The undersigned certifies that _____ is a chronically ill individual because he or she meets one of the following two tests:

Activities of Daily Living Test. He or she is unable to perform at least two of activities of daily living (ADLs), eating, toileting, transferring, bathing, dressing, and continence, without substantial assistance from another individual and has or will be unable to perform such ADLs without such assistance for a period of at least 90 days due to a loss of functional capacity. I understand that (1) "Substantial assistance" means hands-on assistance and standby assistance; (2) "Hands-on assistance" means the physical assistance of another person without which the individual would be unable to perform the ADL; (3) "Standby assistance" means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual's throat if the individual chokes while eating).

Cognitive Impairment Test. He or she requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment. I understand that (1) "Severe cognitive impairment" means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning, and that (2) "Substantial supervision" means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

This sample certification is based on IRC §7702B, Notice 97-31, 1997-1 C.B. 417, the Conference Committee Report on the Health Insurance Portability and Accountability Act, P.L. 104-191, and the General Explanation (Bluebook) of Tax Legislation Enacted in the 104th Congress (1996).

Consumer Protection

HIPAA requires tax qualified policies to include many of the consumer protection provisions mandated by the ***NAIC*** (National Association of Insurance Commissioners) LTCI Model Act and Model Regulation. A few include that a tax qualified policy MUST:

- Be either guaranteed renewable or noncancellable
- Include a third-party notification of lapse provision
- Offer an inflation protection, and
- Offer as non-forfeiture option

Reporting of Tax Qualified Long Term Care Benefits.

HIPAA established a reporting mechanism for benefits received under *all* long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an ***IRS 1099 LTC Form*** issued by the carrier. Benefits reported on the 1099 must also be reported on ***IRS Form 8853***. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does not need to determine the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional mystery to the taxation of non-qualified benefits conundrum because it provides a vehicle for these benefits to be taxed. Despite continuing confusion neither the Department of the Treasury nor Congress seems anxious to clarify this matter.

Reporting of Accelerated Benefit Distributions

Many terminally ill or chronically ill individuals use ***accelerated death benefits*** from their life insurance policies to cover medical expenses while still living, including long term care. Prior to HIPAA, these distributions were includible in gross income. HIPAA, however, created a tax benefit that allows tax-free accelerated benefits from life insurance policies as long as the individual receiving them is considered to be chronically ill, as defined in IRC 7702B or IRC 101 (g)(1):

Under these regulations, a person is considered chronically ill if he or she has been certified in the past 12 months by a licensed health care provider as:

1) Being unable to perform (without ***substantial assistance*** from another individual) at least ***two activities of daily living*** (eating, toileting, transferring, bathing, dressing, continence) for ***at least 90 days*** due to a loss of functional capacity, or
2) Requiring substantial supervision to protect an individual from threats to health and safety due to ***severe cognitive impairment***.

Grandfathered Status – Pre-1997 Policies

Policies issued ***prior to 1/1/97*** are considered tax qualified unless material modification to the policy has been made. Interestingly, most of these policies feature triggers that make it easier for policyholders to qualify for benefits than do new tax qualified policies. Then again, some of the new policy features may not be present in these older versions, and, if any material modification" is made to upgrade older contracts, their tax qualified status could be lost. Treasury guidelines allow changes in these policies so long as they have been "built-in", e.g., a nonforfeiture rider or inflation protection option.

MATERIAL CHANGE

In the eyes of the law, a material change in a policy is considered issuance of an entirely new contract, thus voiding Pre-1997 TQ status under federal "grandfather" rules. ***Examples*** of changes that could trigger this include any altering on the timing of benefits, premiums or nonforfeiture rights; a substitution of the insured or a change in the eligibility for membership in a group contract; or exchanging a Pre-97 policy for a new one. Simply exercising an option or right existing in a Pre-1997 contract is NOT material.

As a precaution against losing favorable tax status the California insurance code now requires that if a policy or certificate holder requests a ***material modification*** to his insurance contract, and the policy or certificate was issued prior to 12/31/96, the policyholder shall receive ***written notice*** that the contract changes requested may constitute a material modification that jeopardizes the federal tax status of the contract and to seek appropriate tax advice.

For policies issued ***after 1/1/97*** there is no automatic favorable tax status granted unless the policy is exchanged for a new policy designed specifically to comply with both federal and new California insurance laws.

Long Term Care Premium Deductibility

Individuals

Tax-qualified LTCi premiums are considered a medical expense. For an individual who itemizes tax deductions, medical expenses are deductible to the extent that they exceed 10% of the individual's Adjusted Gross Income (AGI). The amount of the LTCi premium treated as a medical expense is limited to the eligible LTCi premiums, as defined by Internal Revenue Code 213(d), based on the age of the insured individual. That portion of the LTCi premium that exceeds the eligible LTCi premium is not included as a medical expense.

Individual taxpayers can treat premiums paid for tax-qualified long-term care insurance for themselves, their spouse or any tax dependents (such as parents) as a personal medical expense.

The yearly maximum deductible amount for each individual depends on the insured's attained age at the close of the taxable year (see below for 2010 limits). These deductible maximums are indexed and increase each year for inflation.

2012 Federal Tax Deductible Limits

Taxpayer's Age At End of Tax Year	Deductible Limit
40 or less	$ 360
More than 40 but not more than 50	$ 680
More than 50 but not more than 60	$1,360
More than 60 but not more than 70	$3,640
More than 70	$4,550

Source: *IRS Revenue Procedure*

Example: A husband and wife ages 55 and 49 purchase policies. The Eligible amount that the husband can include toward reaching the 10% of the Adjusted Gross Income (AGI) threshold is $1,360. The wife (age 49) can apply $680. Note: In two years, when the wife will fall into the 51-to-61 threshold, the higher amounts for both will apply. And, these amounts are increased annually.

Planning Tip: Some LTC insurers offer "shared care" policies where two people share one pool of benefits. This may be used to maximize the eligible tax deductibility when there is a difference in ages between the spouses.

Tax Savings Tip: Long-term care insurance premiums may be paid from a Health Savings Account (HSA) up to the limits shown above.

Taxability of Benefits Received: Generally, benefits received from a tax-qualified LTCi policy that was purchased by an individual are non-taxable and therefore excluded from Adjusted Gross Income. Benefits paid under an ***indemnity policy*** are not taxed unless they exceed the higher of the cost of qualified long-term care or $360-per-day (the 2012 limit).

Self-Employed

A self-employed individual can deduct 100% of his/her out-of-pocket long-term care insurance premiums, up to the Eligible Premium amounts listed above [IRC 162(l)]. The portion of LTCi premiums that exceeds the Eligible Premium amount is not deductible as a medical expense. The deductible amount includes eligible premiums paid for spouses and dependents [IRC 162(l)]. It is not necessary to meet a 10% AGI threshold in order to take this deduction.

However, a self-employed individual may not deduct LTCi premiums during any calendar month in which he/she or his/her spouse is eligible to participate in a subsidized LTCi plan (where the employer pays all or part of the premiums for LTCi).

Partnership ² Limited Liability Company (LLC) ² Subchapter S Corporation

Partners in a partnership, members of an LLC that is taxed as a partnership, and shareholders/employees of Subchapter S Corporations who own more than 2% of the Corporation, are taxed as self-employed individuals. The partnership, LLC or Subchapter S Corporation pays the premium.

The partner, member or shareholder/employee includes the LTCi premium in his/her Adjusted Gross Income, but may deduct up to 100% of the age-based Eligible Premium, as listed in Table 1. It is not necessary to meet a 10% AGI threshold.

If the sole shareholder/employee purchases LTCi in his/her own name instead of that of the S Corporation, the S Corporation is not treated as a partnership and the shareholder is not treated as a partner. As such, the shareholder is not treated as self-employed and is only eligible to include his/her eligible LTCi premiums in his/her itemized deductions, which are subject to the 10% AGI threshold.

Planning Tip: *In a sole proprietor or a partnership situation, the owner/partner who has a spouse who is a true employee can deduct the actual (full) premium for that spouse's policy. If that spouse's policy had a shared benefit rider, that would be included in the deductible premium amount (actual total premium is deductible).*

Subchapter C Corporation

When a business purchases a tax-qualified LTCi policy on behalf of any of its employees, or their spouses and dependents, the corporation is entitled to take a 100% deduction as a business expense on the total premium paid. The deduction is not limited to the aged-based Eligible Premiums.

The purchase of a tax-qualified LTCi policy is not subject to any non-discrimination rules, thus allowing an employer to be selective in the classification of employees it elects to cover.

Planning Tip: *Premium payments generally will be tax deductible when the class is based on such factors as the officers of the corporation and length of service (e.g. company pays for all those who are Senior Vice President or higher and have been with the company for 12 or more years). Tax rulings have stipulated that the class cannot, however, be based on stock ownership.*

Tax Savings Tip: The use of Ten-Pay or Accelerated Premium plans provide higher tax deductions for the Corporation and enable the long-term care insurance premium to be fully paid-up by the time the owner retires (no ongoing premiums) or sells.

Selling Tip: *Fiscal Year-End Planning for profitable companies with a retained earnings issue. The fiscal (tax) year for C-Corps generally don't end on December 31st (as they do for 'pass through' entities and individuals). At the beginning of the fourth quarter of their Fiscal Year, profitable companies start looking for tax deductions. Recommend long-term care insurance as an executive benefit … benefits are far more valued than new office furniture.*

The premium paid by the business is excluded (not reported) from the employee's Adjusted Gross Income even if the premium exceeds the Eligible Premium amount listed in Table 1.

Employer-Pay Contributory Arrangement on Behalf of an Employee

If an employer pays all or a portion of the tax-qualified LTCi premiums on behalf of an employee, the amount paid is deductible by the employer as a business expense. The deduction is not limited by the age-based limits. The entire employer contribution would also be excluded from the employee's AGI.

If the employer only pays a portion of the premium, the employee is able to apply the balance that he/she pays towards his/her medical expenses, up to the Eligible Premium amount, and would then be entitles to a deduction for medical expenses that exceed 10% of AGI.

Gift Tax Exclusion

In addition to the annual Gift Tax Exclusion of $13,000 per donee, a donor has the ability to pay for the medical expenses of the donee [IRC Sec. 2503(e)]. If those medical expenses are tax-qualified LTCi premiums, the exclusion is subject to the age-based limits for Eligible Premium listed in Table 1. An individual (donor) can purchase LTCi policies for family members (donees) and still maintain the annual Gift Tax Exclusion when selecting a Ten-Pay or Accelerated Payment Option.

Return of Premium

The refund is included in the beneficiary's gross income and is taxable, to the extent it was either excluded from the owner's income or deducted by the owner. It must be included as income in the year it is received.

Health Savings Account (HSA)

Tax-qualified LTCi premiums can be reimbursed through an HSA, tax-free up to the Eligible Premium amounts listed in Table 1, even if the HSA is offered through an employer-provided cafeteria plan.

Health Reimbursement Account (HRA)

Reimbursements for insurance covering medical care expenses, as defined in IRC Sec. 213(d), which includes qualified long-term care services and qualified long-term care insurance premiums are allowable under an HRA. Although employers pay for HRAs, an HRA cannot be provided by salary reduction or IRC Sec. 125 plans. As such, the LTCi premiums cannot be paid on a pre-tax basis through an HRA.

Cafeteria Plan

Tax-qualified LTCi premiums cannot be purchased with pre-tax dollars under an employer-provided cafeteria plan. However, LTCi premiums may be paid through an HSA that is offered under an employer-provided cafeteria plan.

Flexible Spending Account (FSA)

Tax-qualified LTCi premiums cannot be reimbursed under an FSA.

Pension Protection Act of 2006

As a result of the Pension Protection Act of 2006 that went into ***effect on Jan. 1, 2010***, policyholders with specially designed annuities have the ability to take cash value withdrawals for qualifying long-term care expenses, ***free of income taxes***, regardless of the cost basis. Benefit payments from LTC insurance riders and cash value withdrawals to pay for LTC insurance premiums also are not taxable.

As long as an individual meets the ***HIPAA definition of chronic illness***, the Act, ***affirms HIPAA*** rules allowing LTC insurance benefits, paid out of these plans (even if a portion of those serves to reduce account values in the underlying annuity), to be paid as tax-free LTC insurance benefits. ***Immediate annuities and single premium deferred annuities*** may contain these same qualified chronic illness benefits. Prior to HIPAA there was no mechanism that allowed for gains in annuity contracts to be paid out on a tax-free basis.

In addition, the law also allows for ***1035 exchanges*** into annuity/LTC combination plans from an annuity without riders or LTC benefits. Specifically, Section 1035 of the Code was amended to allow for tax-free exchanges of life insurance contracts, annuity contracts, endowment contracts and qualified LTC contracts for qualified LTC contracts. In addition, the Act clarifies that life insurance and annuity contracts containing long-term care features will be eligible for tax-free exchange treatment.

Regarding internal ***cash value growth***, the Act provides for new rules regarding the use of a combined contract's overall cash value to fund the long-term care portion of the contract. Charges that are assessed against the life or annuity contract's cash value that fund a long-term care rider are excluded from gross income. Under prior law, these were treated as taxable distributions. In short, the Act allows LTC insurance to be paid from the cash value of life insurance and annuities on a before tax basis. Payment made in this manner will, however, reduce the investment in the contract. In addition, any such payment will not be deductible under Code Section 213. These limitations do not change the fact that the new rules will allow a significant tax advantaged method of paying for LTC.

Benefit Triggers: TQ vs. NTQ

In the benefits section of the policy the insured will find the terms as to what will have to happen before benefits start to flow. This is often referred to as the ***benefit trigger*** and is further defined in the policy as to what conditions must be met for the policy to pay benefits.

California legislation (SB 870) established eligibility thresholds for long term care policies. Residential care facility coverage, for example, can be no more restrictive than home care benefit eligibility. Also, every LTC policy that covers care in a nursing facility must grant coverage for an insured who experiences impairment in two ADLs **or** impairment in cognitive ability.

All California long term care policies require standards in mental and physical condition. Many policies also require that additional ***conditions*** be met before an insured can receive a benefit payment. These conditions are events that must occur, or documents that must be submitted, ***after*** the insured meets the benefit triggers and ***before*** benefits will be paid.

The most common benefit triggers for long term care insurance are:

1) ***Impairment in "Activities of Daily Living"***
2) ***Impairment in Cognitive Ability***

There are some distinct differences in how these triggers are administered between TQ and NTQ policies.

Let's look at some ***examples*** that clearly establish benefit eligibility under California TQ policies:

*Paul is 85 and requires more assistance on a daily basis. Moving him from a bed to a chair now requires constant **"hands-on" assistance** lifting help versus a few months ago when it was only*

*necessary to have a caregiver "standby" in case he slipped or fell in the move. Annie is in the late stages of Parkinsons and having difficulty eating. Being ready to remove food from her throat if she chokes is considered **"standby assistance**". Both forms of assistance could trigger benefits in TQ and NTQ policies. However, in the case of TQ,, a licensed health care practitioner must certify the need for this assistance for 90 days or more.*

*The need to stand by or near an exit door to prevent 74 year old Mark from wandering off is called considered **substantial supervision**. Whether it meets Federal TQ guidelines depends on whether Mark's wandering could be considered a threat to his health and safety. (It probably is). Most NTQ policies, on the other hand, would consider this a trigger under loss of reasoning or orientation.*

The definition of the following activities is currently prescribed by federal law. Further, if the federal government expands these triggers, the Department of Insurance can issue emergency regulations.

Eating which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intraveneously.

Bathing which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

Continence shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain a control of bowel or bladder function, the ability to perform associated personal hygiene (including the care of catheter or colostomy bag).

Dressing shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Toileting shall mean getting to and from the toilet, getting on or off the toilet and performing personal hygiene.

Transferring shall mean the ability to move into or out of bed, a chair or wheelchair. Transferring may also mean the ability to walk or move around inside or outside the home, regardless of the use of cane, crutches or braces.

Non-Tax Qualified Policies

In every long term care policy or certificate that is NOT intended to be federally qualified the insured must qualify for benefits if either of the following criteria are satisfied:

1) Impairment in ***two of seven*** activities of daily living .
2) Impairment of cognitive ability.

The contract or policy may provide for lesser, but not greater eligibility criteria.

Activities of daily living include eating, bathing, dressing, ambulating, transferring, toileting, and incontinence. "Impairment" means that the insured needs human assistance, or needs continual and substantial supervision.

These ADLs are further defined below:

Eating shall mean reaching for, picking up, and grasping a utensil and cup; getting food or a utensil, and bringing food, utensil and cup to mouth; manipulating food on a plate; and cleaning face and hands as necessary following meals.

Bathing shall mean cleaning the body using a tub, shower or sponge bath, including getting to the basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing and drying.

Dressing shall mean putting on, taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments and artificial limbs and splints.

Toileting shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping clean the body after toileting, and using and emptying a bedpan and urinal.

Transferring shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

Continence shall mean the ability to control bowel and bladder as well as colostomy or catheter receptacles, and apply diapers and disposable barrier pads.

Ambulating shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches or braces.

"Impairment of cognitive ability" means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or other.

The California Commissioner has the right to approve different definitions of activities of daily living if they would result in more policy or certificate holders qualifying for long term care benefits or if federal legislation changes.

The full impact of the assistance and supervision requirements of tax qualified policies has yet to be sorted out. The most obvious difference lies in easier qualification under non-tax qualified contracts where loss of 2 out of 7 ADLs will trigger coverage. Tax qualified plans exclude ambulating, but may accept the inability to move about as a trigger under transferring. Second, the added step of a licensed health practitioner in tax qualified plans adds one more chore to the process of qualifying that is not a requirement under non-tax plans. Probably the most difficult, however, is the substantial supervision requirement to determine cognitive impairment. Here, a safety issue must be considered. Under non-tax policies, cognitive coverage is often times triggered by a simple lack of thinking, reasoning or orientation: an easier qualification than the tax qualified version. California's SB 870 legislation addresses the mental health issue by mandating that mental illness is no longer limited to Alzheimer's and organic disorders. Rather, eligibility can now occur through "related mental disorders". An obvious goal of this legislation is to bring the eligibility factors between tax and non-tax qualified products closer in sync.

California LTCI Premium Deductibility

California offers tax incentives to encourage the purchase of LTCI. The. maximum amount deductible based on sliding scale, increases each year to account for inflation. Residents who need LTC services for at least 180 days can qualify for a $500 tax credit as long as their

adjusted gross income does not exceed $100,000.

For information on the deductibility of long term care premiums and benefits and more HIPAA-related tax issues, refer to Attachment II at the end of this book.

The ERISA Exception

Among other reasons, the Employee Retirement Income Security Act (ERISA) was created to keep high-income professionals and business owners from providing themselves extraordinary retirement and medical reimbursement benefit plans (including long term care) while rank-and-file employees are limited to only limited benefit options.

In general, a benefit NOT considered to be a "qualified benefit", would not be subject to ERISA non-discrimination rules. Qualified benefits, on the other hand, are ordinarily fully subject to ERISA non-discrimination rules.

However, long term care insurance is uniquely allowed to be funded with income tax deductible dollars and still enjoy a tax-free benefit. Further, by special exemption, long term care insurance is NOT subject to ERISA non-discrimination rules and can be funded by the employer for designated key employees only.

New Trends

As they develop, agents must observe new legislation and the affect on long term care.

Patient Protection and Affordable Care Act (PPACA)

While portions of this major health care reform act are still being discovered, here is what we know as of the writing of this course:

Signed into law on March 30, 2010), the Act is the product of the health care reform agenda of the Obama administration.

The law includes a large number of health-related provisions, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research. The costs of these provisions are offset by a variety of taxes, fees, and cost-saving measures, such as new Medicare taxes for high-income brackets, taxes on indoor tanning, cuts to the Medicare Advantage program in favor of traditional Medicare, and fees on medical devices and pharmaceutical companies; there is also a tax penalty for citizens who do not obtain health insurance (unless they are exempt due to low income or other reasons).

The affect this legislation will have on long term care is unknown. One can speculate, however, that the shift of major federal funding from senior-oriented healthcare in the form of major cuts to Medicare and Medicare-advantage, to an expansion Medicaid programs targeting substantially younger individuals will not help improve long term care for seniors since fewer services in primary care can lead to the development of chronic illness.

Proponents, however, point to specific portions of the bill that address long term care . . . the ***CLASS ACT***. The act "creates a ***national insurance trust*** that people can ***voluntarily*** participate in. It's a ***publicly sponsored*** insurance plan, to make it as low-cost as possible. You pay a monthly premium. If you become disabled and need assistance with activities of daily living at any age, you can qualify for a daily cash benefit on the order of about $50 to $75 a day, depending on your level of disability. The legislation does not set specific benefits. The Secretary of Health and Human Services will develop the details

The law does not create a new entitlement program because the law requires that the program be self-supported by premiums. The law states that "No taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan... the term ‘taxpayer funds’ means any Federal funds from a source other than premiums.... and any associated interest earnings"

Chapter 4
Long Term Care Insurance

This section will provide you a solid background in long term care policy construction and benefits. Agents need to know that many legislative safeguards have guided some of the features and benefits you will read about. The reason: The potential for abuse among seniors. With long term care, the problem is magnified since the nature of a chronic illness is so devastating to the insured and his family and support group. That is why long term care insurers are mandated to provide clear, expanded explanations of their benefits. Agents are also part of the equation in abiding by marketing disclosures beyond what is seen in the standard life/health arena.

Types of Policies

Long term care insurance comes in many "flavors" . . . and the menu is expanding as carriers become more creative and competitive. Let's explore the options by benefits, type and provisions.

Benefit Types

There are three traditional benefit policy styles:

- Home Care ONLY
- Nursing Home & Residential Care Facility ONLY (Institutional Care)
- Comprehensive

Home Care ONLY policies only cover care in the home or community setting, but NOT in assisted living facility or nursing home. These policies may include benefits for home health, adult day care, hospice, respite care, personal care, hospice, respite care and homemaker services. Providers vary from private companies to hospice services for the terminally ill.

Some older policies caused many problems for policyholders where clear definitions were not specified. Here is one such example:

Karen. bought a long-term care insurance policy in 1990 that only pays for care at home and has no other benefits. She did however have the foresight to purchase an 8 percent compounded inflation protection benefit, a very rare benefit to be offered or purchased in 1990 which illustrates the seriousness with which she attempted to plan for her future care. Despite Karen's prudent planning her claim for benefits has been denied. Now 84 years old, Karen has dementia and is living in a state licensed assisted living home in California that is also licensed to provide specialized services to residents with dementia. Karen is getting the same personal care services she could receive if she were living in her single family home, but in this home she has round the clock supervision, specialized activities for people with dementia, and socialization with other people who have the same condition. This assisted living home is not licensed to provide skilled nursing care nor is it a skilled nursing facility.

Still, the company refuses to pay her home care benefits arguing that this assisted living home meets the definition in the policy of a licensed skilled nursing facility and is therefore excluded as a place of care, and that the personal care services described in the policy which Karen is getting are not being provided by a licensed home health agency as required by the policy but

instead are provided by the staff of the assisted living home. However, nowhere in the policy is a person's home defined, nor is there a definition of where policy benefits will be paid.

Nursing Home & Residential Care Facility ONLY policies only cover care in a nursing home or a place licensed as a Residential Care Facility for the Elderly (RCFE) that provides assisted living care. The benefits of these policies include the cost of all LTC services you receive in the facility . . . not just charge for room and board . . . up to the policy's maximum daily benefit amount.

Comprehensive long term care policies cover care in a nursing home, assisted living facility, home care and community care (such as adult day care) under the same rules as the two policy types above. At least ***50%*** of the benefit payment for institutional care (nursing homes, etc), must be available for home care services. Policies cannot restrict services to only ***licensed or skilled vendors*** if the same services can be provided by ***unskilled workers*** (other than where a license to administer services is required by state law).

Stand Alone LTC Products

Stand-alone policies represent the bulk of plans sold to date. They are usually purchased with monthly, quarterly, semiannual or annual premiums which are paid for the life of the insured. While stand alone LTCI provides the most comprehensive benefits, the marketplace is changing. LTCI consumers market has complained vigorously about the cost and "use it or lose it" aspects of stand alone policies. Sure, they are assured tax qualified status, with tax-free benefits and deductible premiums, and benefits are generally more generous. But, for the market to survive an alternative is needed.

Products With Long Term Care Riders

These types of products are gaining. Some carriers are reporting as much as 30% of their total sales in products with LTC riders. A variety of choices exist:

Life Insurance Riders: LTC insurance is as an "either/or" feature in life insurance. When the insured dies, a death benefit results. If the insured needs long-term care before death, stipulated benefits are paid instead of life insurance. If all benefits are paid before death, the policy expires. Any benefits not used result in a reduced pay-out at death. These policies can be purchased with periodic premiums for the life of the insured or with a single premium of $50,000 or more. These policies offer the advantage that the insured is guaranteed a benefit since everyone eventually dies. A disadvantage is that many people who purchase LTC insurance don't need life insurance, but because the policy needs to cover the mortality risk of death as well as the morbidity risk of LTC, premiums are much higher than an equivalent stand-alone LTC policy. Another disadvantage is that underwriting standards for life insurance are more strict than standards for LTC insurance. Many who qualify for LTC insurance would be denied coverage for life insurance.

Annuity Riders: Typically, this usually requires a lump sum of $50,000 or more. Part of annuity earnings pay for the morbidity risk of the LTC insurance. Thus an annuity that would normally yield 6% might only yield 4% when combined with LTC insurance. One advantage of this arrangement is that LTC premiums are paid with tax deferred earnings but since they are expensed inside the policy, premiums become tax free. Another advantage is the perception that no money is lost to an LTC policy that may never be used. In fact the lump sum even grows larger. A major disadvantage is that the money is tied up. Removing money will kill the LTC coverage, yet few people have $50,000 lying around that they're willing to tie up and never use. In most cases it's better to fund a stand-alone LTC policy with earnings from a separate

investment account. This leaves the account unencumbered. Pending federal legislation will also make investment income used for LTC insurance premiums tax free.

Disability Insurance: The most common misconception is that long-term care insurance is strictly for seniors and disability insurance is for everyone else. Essentially, disability insurance is a product that protects your ability to earn an income — arguably your most valuable asset. If you were to become disabled due to sickness or injury — meaning that you couldn't perform the duties of your occupation — then the insurance company would pay you a percentage of your income (approximately 50%-70%) tax-free until you are no longer disabled or for a certain time period. LTC insurance is a product that also protects you from major financial loss due to sickness or injury. LTC insurance does not replace income; it pays towards the cost of receiving care.

Critical Illness Insurance: Critical illness insurance provides a lump sum benefit when a critical illness occurs. It is based on the premise that an expensive critical illness, even when covered by good, comprehensive health insurance, can financially disable you or a loved one. Whereas long-term care insurance is designed for the mature audience and long-term disability insurance is designed for the actively working audience, critical illness insurance is designed for younger members and their dependents. It has nothing to do with an inability to perform activities of daily living or the activities of one's occupation. It is not related to the expenses of long-term care or occupational income. In fact, the benefit has no direct relationship at all to the expenses of the qualifying illness. It pays a scheduled lump sum at the first diagnosis of a variety of expensive health conditions that often occur, such as a heart attack, cancer or stroke.

Accelerated Benefits: Accelerated Death Benefits are a popular feature of many modern life policies. Accelerated death pays part of the death benefit for terminal illness or doctor-certified, terminal, long-term care confinement while the insured is alive. Since very little long-term care could be certified as terminal, this policy feature might be considered "bare bones" long-term care coverage.

Other Products: As carriers and consumers demand, the industry will respond with new products and approaches.

Hybrid / Combo Long Term Care Policies

First generation hybrid / combo plans have been around for as long as 15 years. These early generation products typically linked long term care coverage, in the form of a rider, to life or annuity contracts. The problem? They provided fewer LTC benefits and their tax deductibility was questionable. In addition, some insurers underestimated benefit payouts leading to financial problems and even takeovers.

Early indications are that many consumers are intrigued by the concept of an insurance vehicle that can provide protection against the risk of long-term care, and also provide cash values even in the event that no long-term care services are ever needed. This overcomes one of the major concerns of consumers regarding standalone LTCI, the fear of a "use-it-or-lose-it" proposition.

LTC Combo Plans and the Pension Protection Act of 2006

The provisions of the Pension Protection Act (PPA) of 2006 provide new incentives for LTC combo products to thrive. PPA permits ***tax-free distribution of life insurance or annuity cash value to pay for long-term care*** (both beginning in 2010). In other words, policyholders can withdraw money from the base policy to fund long term care without having to worry about taking a tax hit. What used to happen was when the long term care portion of the policy

collected money from the base policy, which was considered a taxable distribution from the policy

Let's break these tax advantages down a bit further:

Approval of LTC riders on annuity contracts. Formerly, these riders were specifically allowed for life insurance policies but not annuities. Now it's clear that LTC riders can be added to annuities without losing the tax deferral of annuities or some tax-free insurance benefits of most LTC insurance policies.

Tax-free access to cash values for LTC coverage. Previously, when insurance or annuity cash values were tapped to pay for LTC coverage, the consumer owed tax on the money moved from one side of the combo product to the other, as if a distribution from the insurance policy or the annuity had occurred. Now such internal transactions won't generate income tax.

LTC insurance eligibility for tax-deferred exchanges. Life insurance policies, annuities and LTC insurance policies can be exchanged for LTC policies under the like-kind exchange rules of Section 1035 of the tax code. Life insurance policies and annuities with LTC coverage are included. Until 2010, Section 1035 didn't extend to LTC insurance.

As might be expected, some strings are attached, and the language can be confusing. Only "qualified" or "tax-qualified" LTC insurance will get the benefits described above. That's generally not a problem because 99% of all LTC insurance sold now contains the product features needed to be tax qualified, according to LIMRA.

However, these new tax breaks are not extended for any "qualified" annuities-those purchased and held within a retirement plan such as a 401(k) or an IRA. Thus, the new tax benefits for combo annuities apply only to those with tax-qualified LTC benefits that are held outside of a qualified retirement plan.

To illustrate how the tax savings work, consider this example: An individual purchases a five percent fixed annuity with a LTC insurance rider. After one year of ownership the annuity is worth $105,000, consisting of the $100,000 initial investment and $5,000 of accrued interest. The annuity owner withdraws from the annuity $5,000 to help pay for some qualifying LTC expenses. According to PPA, the $5,000 withdrawal comes first out of the "basis". While the annuity contract was initially purchased for $100,000, in the event that owner would sell the contract or withdraw funds from the contract to pay for something other than LTC expenses, the annuity's cost basis remains at $100,000. Also, if the contract is sold or surrendered for more than $100,000, the annuity owner will have to recognize for tax purposes: (1) the excess of the sales price over the cost basis (in this example, the $100,000 original cost); and (2) the amount withdrawn from the annuity to pay LTC expenses will be recognized for tax purposes as ordinary income; in this example, the $5,000 withdrawal will also be recognized as ordinary income. In other words, the both the sales proceeds exceeding the $100,000 cost basis and the $5,000 will be included as income in the year that the contract is sold or surrendered.

Other Hybrid / Combo Plan Types

New generation combo plans are getting very creative:

- Policies may offer a Return of Premium option (you could say a Money Back guarantee) that allows for a full refund of your premium at any time.

- Some companies offer recurring premium policies which may be more attractive to middle-aged buyers. The base policy you buy is permanent life insurance (as opposed to term life) and the long-term care benefit protection is provided through an optional rider.
- Others offer single-premium policies that can be attractive to older consumers with invested assets they have set aside to "self-insure" their health and long-term care needs in their retirement years.
- Some policies will provide multiples of long-term care benefit options. So, say you purchase $200,000 of life insurance; you could have access to $400,000 to pay for qualifying long-term care costs. Any portion of your death benefit not used for long-term care will go to your beneficiaries as a death benefit.

Like all life insurance policies these policies pay a death benefit to your beneficiaries. What makes them special, however, is your ability to use as much of your death benefit as you need to pay for qualifying long-term care costs.

The benefit payout structure under many combo plans is typically defined as an accelerated benefit, whereby LTCI benefit payments are made from the annuity account value while waiving surrender charges. This can also be combined with some form of ***tail benefit*** payable after account values are depleted. The benefit is paid monthly and is usually expressed as a percent of the annuity account value at the time of initial claim. For example, 1/24 of the lifetime LTC benefit limit may be payable for 24 or more months from the account value, with a 12-, 24-, or 48-month extension of benefit "tail" as selected by the client. This creates the opportunity to convert what would have been partially taxable account values from the annuity into tax-free payouts that range from 150% to 300% of the account value as LTCI benefits.

There are several alternative structures, all of which combine accelerated benefits and independent benefits, but under different configurations. Certain segments of the market will find these new designs even more interesting than the tail design described above. There are also various ways to provide protection against the risk of LTC ***cost inflation***. Those designs that tie LTC benefit amounts to account values inherently provide a form of inflation protection, in that account value growth would naturally occur within the annuity.

*Consider a 60-year-old annuity purchaser depositing $100,000 ($100K), who at age 80 needs 24 months of accelerated LTC benefits and another 24 months of tail benefits. Assuming an annuity purchase **without** the LTC rider, she cashes out $219K (4% annual growth) and pays $36K of taxes on gain (assuming a 30% tax rate), with a net of $183K after tax. In contrast, with an **LTC rider attached** that pays out up to 200% of account value, with a cost of 65 basis points per year assessed against the account value, the annuity grows to $193K, so the contract pays out $386K tax-free. Note that this ignores potential tax benefits of itemized deductions for unreimbursed LTC medical expenses, which might dampen some of the differentials above for many insureds.*

Next, consider a second scenario, where the same client eventually needs six years of care after the purchase of a more expensive 24 month accelerated benefit plus 48-month extension of benefit tail, effectively creating a total potential benefit of three times the account value. With the LTC rider featuring a cost of 90 basis points per year, the annuity funded with $100K grows to $184K, so the contract pays out $552K tax-free, versus the $183K without the rider.

These examples highlight the combination of tax benefits and insurance benefits that can leverage accumulation values within annuities. Admittedly, not all consumers will actually utilize long-term care services. But the risk of long-term care utilization is sufficiently high (50% or

more at ages 65 and above), and the cost versus potential benefits sufficiently compelling, that we expect producers and companies will appreciate the power of these combination plans.

Some Self Insurance

Whether the long term care benefit is being funded by a life insurance or annuity product, there is a level of self insurance involved in both options. For annuity combinations, the first layer of coverage typically comes from the payout of the account value — in other words, from money that belongs to the policyholder. In life combinations, the face amount pays for long term care benefits, with a portion of those payouts also coming from the cash value.

The upshot of paying for long term care costs in this manner is that it dramatically reduces the cost of coverage when compared with a standalone long term care insurance policy. For example, while the average premium on a standalone policy may run $2,200 per year for consumers in their early 60s, a long term care rider on an annuity could cost less than $1,000 per year.

Suitability

Some combo sales are funded on a single-premium basis, as opposed to the annual premium setup of a standalone policy. The bottom line is the purchaser of these contracts needs to have funds available to secure the coverage. The average premium, for example, is in the $80,000 to $100,000 range to provide meaningful coverage, whereas the standalone long term care buyer doesn't need $100,000 of liquid assets to move into a protection vehicle . . . they simply pay the annual premium year after year for 30 years or more."

From a benefit payout perspective, producers should also be aware that combo policies may be best for short-term claim situations. In other words, if a policyholder's claim goes on for more than five years, they may have been better off with a traditional long term care insurance policy with lifetime benefits. . . unless they have the funds to self-insure the remainder of the bill and are comfortable with the idea of "high-deductible" coverage. Of course, this also boils down to "who has the better crystal ball".

Additional Hurdles

To date, there are several key obstacles to the success of LTC combos. Simplifying the underwriting process to protect the company, yet not burden the producer, is one challenge. Agent training and licensing issues need to be addressed to enable the sales process. Sufficient compensation needs to be provided to motivate producers to market these products

Solutions are on the way. Education of producers will be a critical issue, and companies as well as wholesalers are targeting these products and markets and preparing for that effort. Underwriting standards are evolving and tele-underwriting techniques are being developed to reduce the burden on annuity producers or financial planners not familiar with LTCI underwriting. Commission structures are being developed to reward producers for their efforts in selling these plans, not only at issue but in some cases through trail commissions that can be lucrative over time because of the long-term persistency expected on these plans.

Getting combo products in the hands of consumers

In terms of distribution outlets, interest levels are expected to grow among LTCI producers who are familiar with LTCI underwriting and who are seeking lower-cost products to address the long-term care insurance need. Banks and annuity producers are close to customers with funds available, and repositioning of these assets into these new tax-effective protection plans is expected. Financial planners are yet another likely source of this business. Perhaps the most effective distribution mechanisms will evolve from a collaborative effort between different types of distribution systems.

With the new tax law reforms coming into place in 2010, this is a story that will be brought to the market. It should be fascinating over the next few years to see which product designs, which distribution mechanisms, and which companies most effectively address the needs of the consumer with these new products.

The Downside & Things To Know About LTC Combo Plans

- How insurance agents and financial advisors who have been working primarily in their narrow specialties will be able to help clients navigate this new world of long-term care planning choices. Benefits available with life and annuity/LTCI combos are likely to be limited as to benefits paid at time of claim.

- Long-term care benefit qualification must be consistent with HIPAA in order for the combo plan to fall under the PPA guidelines. In order to solicit/sell long-term care insurance in California, Agents need to hold a current license as: Life Agent, Accident and Health Insurance Agent, Life-Only Agent (only if it is a LTC rider on a full life policy), or Fire and Casualty Broker-Agent.

- What sorts of long-term care expenses will the life or annuity combo pay for--nursing home only, assisted living, home care, or all of the above? Will the plan reimburse for incurred cost or provide some sort of indemnity (per diem) benefit based on a day of service incurred? What sorts of assessments and plans of care will the claims process require?

- Underwriting criteria will lead to choices of deferral periods based on insured's health issues. This will be a special challenge to life insurance agents selling annuities, marketers and wholesalers not attuned to underwriting issues in the current SPDA environment.

- 1035 exchange opportunities are likely to occur (moving cash values from life insurance and annuity contracts to those with LTCI benefits).

- Which type of life insurance product, SPDA, fixed, indexed or variable, will be best suited to specific clients? What if they do not perform as anticipated? Will consumers who purchase a combo plan be faced with a lower level of benefits if the underlying life insurance or annuity contract pays the guaranteed rate as opposed to the current rate? Will there be "true-up" provisions which give the insured an ability to "reinforce" their long-term care pay-out in the event that product investment performance doesn't reach expectations.

This complex area of law raises many new questions regarding how agents discuss long-term care needs and solutions with consumers. Full discussion of suitability of specific long-term care products and disclosure of all terms, conditions and

protections will become even more important as will suggesting the correct and suitable solution.

Group Long Term Care

There are several advantages and disadvantages to a group long term care insurance depending on needs and qualification.

Advantages of Group Long Term Care Insurance Plans:

- You may not have to meet any medical requirements to obtain a long term care policy.
- Your relatives may also apply for the policy. Many group long term care insurance plans allow retirees, spouses, parents, and parents-in-law to apply for the long term care coverage.
- Some long term care insurance companies will let you keep the coverage if your employment ends or your employer drops the group plan.
- Group long term care insurance plans with a high proportion of young employees and with 20% or better participation, can often get premiums that are much cheaper than individually underwritten policies.

Disadvantage to Group Long Term Care Insurance Plans:

- Higher rates for younger people. Because younger people are grouped in with older or sick and disabled employees in the group, the average premium for a person under 55 may be higher than an individual plan.
- Higher administrative costs from insurers are passed to participants.
- Group long term care insurance plans may have restricted benefits. Healthy employees can miss many advantages and options. To make the plan more affordable to more employees, the benefit period may be inadequate and inflation protection may not be offered or may also be inadequate.

The LTC group industry is undergoing fundamental change prompted by economic evolution and the metamorphosis of many 21st century businesses. A key part of the change appears to be a slugfest between two forms of worksite LTC: “true group” and “multi-life.”

It’s not a fight to the finish, but a struggle for dominance between the two forms. True group and multi-life will both survive, most likely; but only one is likely to prevail, becoming the clear choice in most workplaces.

Employer-Sponsored True Group vs. Multi-Life

With true group long-term care insurance there is a master policy issued to the employer or sponsor; there is a group premium structure, and typically a guarantee of issue for active employees.

With multi-life LTC insurance, there is no master policy; individual policies are issued to each insured member; and there is generally greater flexibility in policy design. In these ways, there is no difference between an individual and a multi-life policy. The multi-life advantage comes through discounted standard rates and simplified underwriting for active employees.

Both types of coverage are portable, meeting the needs of today’s more mobile employees. Carriers typically drive solicitation and enrollment in true group plans, whereas LTC agents or brokers typically drive solicitation and enrollment in multi-life programs.

True group benefit programs are typically implemented in larger organizations, whereas multi-life programs are suitable for organizations of all sizes.

Trade Association / Discretionary Sponsored Plans

In California, a trade association is defined as an association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering that policy or a certificate within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for a primary purpose other than that of obtaining insurance, have been in active existence for at least one year, have a constitution and bylaws. Trade associations may offer true group or multi-life long term care insurance to its members.

Discretionary sponsored plans are dues-paying membership organizations that may also offer true group or multi-life long term care insurance to its members. As the cost of health and long term care plans grows, more members of groups may seek lower-cost alternatives. Many have turned to these discretionary associations. Some discretionary groups have been accused of being formed solely for the purpose to sell health or long term care insurance.

Agents should take care to understand the durability of insurance coverage behind any association policy. It is also important to note that no group long-term care insurance coverage may be offered or sold to a resident of this state under a group policy ***issued in another state*** unless it meets California standards above.

Common Policy Benefits

Nursing Facility Benefits (10232.95)

Every long-term care policy or certificate that provides ***reimbursement for care in a nursing facility shall cover*** and reimburse for ***per diem expenses***, ***as well*** as the costs of ***ancillary supplies and services***, up to but not to exceed the maximum lifetime daily facility benefit of the policy or certificate.

Residential Care Facility (10232.92)

Section 10232.92 also upgrades and improves an insured's chances of receiving care. Residential care facilities, for example, must now receive a ***minimum benefit amount*** payable for care at no less than 70 percent of the benefit amount payable for institutional confinement. In addition, all expenses incurred by the insured while confined in a residential care facility, for long-term care services that are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual as authorized by Public Law 104-191 and regulations adopted pursuant thereto, shall be covered and payable, up to but not to exceed the ***maximum daily*** residential care facility benefit of the policy or certificate.

While this legislation still does not place residential care at par with institutional care it closes the gap and opens many more long term care options to insureds than those that existed just a few years ago. And, with added competition, costs are likely to be lower than when fewer facilities and service options existed.

Minimum Home Care Standards (10232.9)

Every long-term care policy or certificate that provide benefits of home care or community-based services, shall provide at least the following:

- Home health care.
- Adult day care
- Personal care.
- Homemaker services.
- Hospice services.
- Respite care.

Home care benefits shall not be limited or excluded by any of the following:

- Requiring a need for care in a nursing home if home care services are not provided.
- Requiring that skilled nursing or therapeutic services be used before or with unskilled services.
- Requiring the existence of an acute condition.
- Limiting benefits to services provided by Medicare-certified providers or agencies.
- Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.
- Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.
- Requiring "medical necessity" or similar standard as a criteria for benefits.

Every comprehensive long-term care policy or certificate that provides for ***both*** institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, shall pay a maximum benefit payment for home care that is ***at least 50 percent*** of the maximum benefit payment for institutional care, and in no event shall home care benefits be paid at a rate less than fifty dollars ($50) per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision.

Benefit Eligibility Triggers – Tax Qualified Policies

Policies intended to be federally tax qualified shall establish eligibility based on (10232.8(b)):

1) Impairment in two out of six activities of daily living
2) Impairment of cognitive ability

The definition of activities of daily living for TQ policies are as follows (10232.8(f)):

- **Eating**: Feeding oneself or by intravenous means
- **Bathing**: Washing oneself, including the act of getting in and out of a shower or tub
- **Continence**: Ability to maintain control of bowel and bladder or the ability to perform associated hygiene if unable to maintain control
- **Dressing**: Putting on and taking off all items of clothing, necessary braces, fasteners or artificial limbs
- **Toileting**: Getting to and from the toilet, getting on or off the toilet and performing associated personal hygiene
- **Transferring**: Ability to move into or out of bed, a chair or wheelchair

Policies not intended to be tax qualified establish eligibility based on

1) Impairment in two out of seven activities of daily living
2) Impairment of cognitive ability

The definition of activities of daily living for NTQ policies sold in California are as follows (10232.8(g)):

- **Eating**, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.
- **Bathing**, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
- **Dressing**, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.
- **Toileting**, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.
- **Transferring**, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.
- **Continence**, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.
- **Ambulating**, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

Cognitive Impairment

People who are cognitively impaired typically have some form of dementia or Alzheimer's. A policy's definition of cognitive impairment will generally not refer to activities of daily living since people with dementia can usually perform them.

Assessment and Plan of Care

Long-term care has begun to rely heavily on assessment as a basis for determining eligibility and payment for services, as well as for planning needed care. There are also definitions on the person or licensed practitioner who can perform these assessments.

The Internal Revenue Service defines the ***licensed health care practitioner*** (LHP) in very general terms. They can include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. ***California*** Insurance Code Section 10232.8© narrows the list by specifying the ***role of the LHP*** in the certification, ***assessment, and plan of care*** of the insured for the purposes of the claims process. The LHP must be ***independent of the insurance company*** and "shall not be compensated in any manner that is linked to the outcome of the certification" (CIC 10232.8©. Federal and State law requires the certification of the insured's assessment be renewed annually.

Benefit Eligibility – Non-Tax Qualified Policies (10232.8 CIC)

In every long term care policy or certificate that is NOT intended to be federally qualified the insured must qualify for benefits if either of the following criteria are satisfied:

3) Impairment in ***two of seven*** activities of daily living .
4) Impairment of cognitive ability.

The contract or policy may provide for lesser, but not greater eligibility criteria.

Activities of daily living include eating, bathing, dressing, ambulating, transferring, toileting, and incontinence. "Impairment" means that the insured needs human assistance, or needs continual and substantial supervision.

These ADLs are further defined below:

Eating shall mean reaching for, picking up, and grasping a utensil and cup; getting food or a utensil, and bringing food, utensil and cup to mouth; manipulating food on a plate; and cleaning face and hands as necessary following meals.

Bathing shall mean cleaning the body using a tub, shower or sponge bath, including getting to the basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing and drying.

Dressing shall mean putting on, taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments and artificial limbs and splints.

Toileting shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping clean the body after toileting, and using and emptying a bedpan and urinal.

Transferring shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

Continence shall mean the ability to control bowel and bladder as well as colostomy or catheter receptacles, and apply diapers and disposable barrier pads.

Ambulating shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches or braces.

"Impairment of cognitive ability" means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or other.

The California Commissioner has the right to approve different definitions of activities of daily living if they would result in more policy or certificate holders qualifying for long term care benefits or if federal legislation changes.

The full impact of the assistance and supervision requirements of tax qualified policies has yet to be sorted out. The most obvious difference lies in easier qualification under non-tax qualified contracts where loss of 2 out of 7 ADLs will trigger coverage. Tax qualified plans exclude ambulating, but may accept the inability to move about as a trigger under transferring. Second,

the added step of a licensed health practitioner in tax qualified plans adds one more chore to the process of qualifying that is not a requirement under non-tax plans. Probably the most difficult, however, is the substantial supervision requirement to determine cognitive impairment. Here, a safety issue must be considered. Under non-tax policies, cognitive coverage is often times triggered by a simple lack of thinking, reasoning or orientation: an easier qualification than the tax qualified version. California's SB 870 legislation addresses the mental health issue by mandating that mental illness is no longer limited to Alzheimer's and organic disorders. Rather, eligibility can now occur through "related mental disorders". An obvious goal of this legislation is to bring the eligibility factors between tax and non-tax qualified products closer in sync.

Other criteria for long term care policies benefits and triggers can be levied at the insurance commissioner's discretion.

Benefit Triggers: TQ vs. NTQ

As we have discussed, all California long term care policies require standards in mental and physical condition. Many policies also require that additional ***conditions*** be met before an insured can receive a benefit payment. These conditions are events that must occur, or documents that must be submitted, ***after*** the insured meets the benefit triggers and ***before*** benefits will be paid.

The most common benefit triggers for long term care insurance are:

1) ***Impairment in "Activities of Daily Living"***
2) ***Impairment in Cognitive Ability***

There are some distinct differences in how these triggers are administered between TQ and NTQ policies.

Let's look at some ***examples*** that clearly establish benefit eligibility under California TQ policies:

Paul is 85 and requires more assistance on a daily basis. Moving him from a bed to a chair now requires constant ***"hands-on" assistance*** *lifting help versus a few months ago when it was only necessary to have a caregiver "standby" in case he slipped or fell in the move. Annie is in the late stages of Parkinsons and having difficulty eating. Being ready to remove food from her throat if she chokes is considered* ***"standby assistance****". Both forms of assistance could trigger benefits in TQ and NTQ policies. However, in the case of TQ,, a licensed health care practitioner must certify the need for this assistance for 90 days or more.*

The need to stand by or near an exit door to prevent 74 year old Mark from wandering off is called considered ***substantial supervision****. Whether it meets Federal TQ guidelines depends on whether Mark's wandering could be considered a threat to his health and safety. (It probably is). Most NTQ policies, on the other hand, would consider this a trigger under loss of reasoning or orientation.*

Flexible Benefits (10232.93)

Every long-term care policy or certificate shall define the maximum lifetime benefit as a ***single dollar amount*** . . . not a policyholders lifetime . . . that may be used interchangeably for any home- and community-based services defined in assisted living benefit or institutional care covered by the policy or certificate. There shall be no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home- and community-based care and for assisted living care, and for the limits for institutional care. Nothing in this section shall be

construed as prohibiting limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

Prohibited Practices

Usual and Customary Charges: In long term care, the policy of insurers paying "usual and customary fees" for services is ***prohibited***. That means a LTC patient will not receive a bill from a nursing home asking for the balance due that was not paid by an insurer.

Medical Necessity: Older, non-tax qualified policies all contained medically necessity clauses which allowed a patients doctor to decide if services were needed. They were a good thing for consumers but are prohibited in the tax qualified policies popular today.

Prior Hospital Stay (10232.5)

LTC policies in California ***cannot require*** that an insured be hospitalized before getting benefits., being admitted to a nursing home, receiving community based care, home care, etc. Older policies required a hospital stay of 30 days or more before paying for most benefits.

Here is an example of how such outdate policy requirements impacted policyholders:

Edith bought her long-term care policy in 1986 in California. She was diagnosed with Alzheimer's disease in 2001 and made a claim against the policy for home care benefits in 2005 after paying premiums for 19 years. Her policy required a three-day hospital stay, which Edith had had, but it also required that she be in a nursing home within 30 days of that hospital stay, and that skilled nursing benefits be collected for at least 14 days before the company would then pay for any home care. The condition causing hospitalization had to be the same condition requiring the nursing home stay and her home care. Since Edith did not have a nursing home stay following her hospitalization the company refused to pay her any home care benefits.

Unfortunately Edith's strategy of establishing a private source of payment for any care she might need later in life failed to meet her objective. Edith bought her policy before California prohibited this kind of requirement and since each requirement of her insurance contract had not been met the insurance department was unable to assist her. Edith is using her own resources to pay for care at home, and hopes she will die before she needs nursing home care, a cost which she cannot pay and will require her to apply for Medicaid if she has no insurance benefits to pay for care. She is considering whether she should continue paying the premium for her policy.

Independent Sources (10233)

Before paying benefits for any care covered by the terms of the policy, an insurer may obtain a written declaration by a physician, independent needs assessment agency, or any other source of independent judgment suitable to the insurer that services are necessary.

LTCI Methods of Payment

Most LTC policies are ***indemnity or cash style*** where a fixed ***per diem*** cost of care is covered. The advantage of these contracts, if the fixed amount is adequate, is that they provide extra money for "incidental" expenses which always pop up. Some policies will allow the amount of daily benefit not used to carry over. For example, let's say that the cost of an aide and therapist on a given day costs $150, which exceeds the $100 per diem benefit. A $3,000 monthly benefit would still pay the $150 until the $3,000 total is used up. Some policies provide a weekly

benefit which can be even more helpful because there is less risk of using up all of your benefit early in the month.

Reimbursement plans repay the insured for the actual cost of care up to a predetermined maximum. Rates tend to be lower than indemnity policies. The maximum tax-free benefit that an insured may receive from a long-term care indemnity policy is $290 per day (2010). If the aggregate amount of periodic payments under all long-term care contracts exceeds the dollar cap for the period, then the amount of such excess payments is excludable only to the extent of the individual's costs.

Provider Definitions & Licensing (10232.9 and 10232.92)

Facility Coverage: In California, most skilled, intermediate and custodial care is received in nursing homes that are licensed as "skilled nursing facilities". All long-term care policies except Home Care Only cover this kind of care.

Policies sold after October 2001 (except Home Care Only policies) are required to include a benefit to cover care in an RCF/RCFE. Some insurance policies sold before October 2001 may also include this benefit. RCF/RCFEs are not nursing homes but licensed living arrangements wherein a person can also receive personal care or supervision. Some RCF/RCFEs are large retirement homes while others are small group homes.

Home Care Coverage: Every long-term care insurance policy called "Home Care Only" or "Comprehensive Long-Term Care" must include at least the following 6 Home Care benefits and other consumer protections which should make it easier to receive care at home.

1. Home Health Care is skilled nursing care or other professional services in your residence.

2. Adult Day Care is medical or social care in a daytime program in a licensed facility which provides personal care, supervision, protection and/or assistance with ADLs and taking medications.

3. Personal Care is assistance with any of the ADLs including Instrumental Activities of Daily Living (IADLs) such as using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, doing laundry and light housekeeping.
Under California law, these services may be provided by a skilled or unskilled person as long as they are required in a Plan of Care developed by your doctor or a team of health care workers under medical direction.

4. Homemaker Services is assistance with activities or tasks necessary to or consistent with your ability to remain in your home.

5. Hospice Services are services in your residence designed to provide physical, emotional, social and spiritual support for you, your caregiver and your family when a terminal illness has been diagnosed. Some policies will pay or reimburse the cost for these services in an institutional setting as well.

Under California law, hospice services (like Personal Care and Homemaker Services) may be provided by a skilled or unskilled person so long as they are required in a Plan of Care developed by your doctor or a team of health care workers under medical direction.

6. Respite Care is short-term care provided in a nursing facility, in your home or in a community-based program which is designed to relieve the primary caregiver in your home.

LTC Inflation Protection

Policy Requirement

At the time of purchase, California long term care insurance applicants must be offered the ***option*** to purchase an inflation protection feature that increases benefit levels annually in a manner so that the increases are ***compounded*** annually at a rate of not less than ***5 percent***. Applicants who ***refuse it***, must sign a special ***waiver*** (10237.1)

Why the concern? Well, nursing home costs in California have grown faster than the average rate of inflation. As the chart below shows, some years have seen huge jumps in the cost of nursing care.

Private Pay Nursing Home Cost Increases

1980 - 1999 20 5.8%
1980 - 2013 34 5.4%
1994 - 2013 Most Recent 20 Years 4.5%
2009 - 2013 Most Recent 5 Years 2.8%

Source: California Office of Statewide Housing Planning & Development

Without some ability to keep pace with costs, a policy may have little value for a client 20 or 30 years in the future when he really needs the coverage. Using the chart on the next page, for example, you could predict for a client who is age 55 that at age 75, his nursing care will run a hefty $378 per day at a simple 5% annual increase in nursing care and an astounding $501 per day at a compound 5% annual increase!

Compound Inflation

The table (next page) illustrates the need for inflation protection to cover the rising cost of nursing care. As shown, the average daily cost of nursing care will grow to $374 in 14 years (double) if costs continue rising at a compounded rate of 5 percent (not unlikely in light of recent history). In 20 and 30 years, the average cost will be $502 and $816, respectively. For an average nursing home stay of 2.25 years the current cost of care could run $106,000. In 20 years, this same stay will cost an astounding $253,000!

The real tragedy of the statistics is the amount of out-of-pocket expenses a client will incur if they do not buy inflation protection. Thirty years from now, the extra cost AFTER insurance has paid benefits WITHOUT inflation protection could be a whopping $123,000 every year a client is in a nursing home.

Out-of-Pocket Nursing Home Expenses
Without Inflation Protection
5 Percent Compound Increase in Care

	Daily Nursing Home Costs	Excess Cost Without Inflation protection DAILY	ANNUAL
Today	$189	-	
14 Years	$374	$131	$47,160
20 Years	$501	$312	$112,320
30 Years	$816	$627	$225,720

Simple Inflation

The next table shows somewhat less, but still outrageous out-of-pocket costs when a 5 percent simple increase is applied to a policy without inflation protection.

Out-of-Pocket Nursing Home Expenses
Without Inflation Protection
5 Percent Simple Increase in Care

	Daily Nursing Home Costs	Excess Cost Without Inflation protection DAILY	ANNUAL
Today	$189		
14 Years	$321	$132	$47,520
20 Years	$378	$189	$68,040
30 Years	$472	$283	$101,880

Using either method, it is easy to see that inflation protection can be the ***most important feature*** in a long term care policy. Agents should review possibilities like this with clients to arrive at an informed decision to add or decline inflation protection.

It is important for agents to know that the nursing home rates discussed in our first chart are ***average*** costs statewide. They include Medicare, Medi-Cal and private pay sources. The rate that clients in your community pay may be quite different. For example, in Orange County, California, a Santa Ana nursing home run by Catholic nuns (open to the public) might charge $150 per bed day which is lower than the state average rate. A few miles away in the City of Orange the rate moves to $180 per day while a Laguna Niguel facility commands $225. There is NO average cost that you can depend on. Rates will vary based on services needed, neighborhood location, the cost of labor in the area and the age, ownership and quality of the facility. A “bare bones” nursing home built in a rural area where land costs and labor are less will likely charge less than statewide averages. But a first-class facility built in the heart of San Francisco will charge top dollar.

Agents should have a basic idea of local nursing home costs in order to advise policyholders on the need for more long term care insurance or to explain that there may be shortfalls in coverage if a more expensive nursing facility is chosen. There are many sources to find this information; including physician referrals, local yellow page directories, private referral networks like the

California Registry (800) 444-9191 and the Internet. Private referral services may only recommend specific nursing homes or residential care facilities that "advertise" on their system. Government sponsored referral services such as the Department of Aging's system of 33 Information and Assistance branches located throughout the state, provide a comprehensive list of known facilities in the vicinity of your client's choice. Since they are non-profit, however, they do not recommend specific providers. You and your client still need to "shop" the competition.

CPI Compound Inflation Protection

Very few companies will offer inflation increases tied to the CPI index which has averaged about 2.4% 1983-2012. Long term care costs, as shown above, have, at times, greatly exceeded CPI increases. Some believe a purchaser of long term care insurance will likely be better off electing a fixed compounded percentage, 5% compound if at all possible. Even a 4% compound or a 3% compound option will probably yield higher benefit increases than a CPI based model.

Periodic Increases

Section 10237.1 of the CIC guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status and without regard to claim status or history 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 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

Periodic Increases

Some LTCI policies provide that the insured individual is guaranteed the right to periodically increase benefit levels, without providing evidence of insurability or health status. If one decides to add the offered inflation protection later, the current cost of that benefit at his or her current age will be added to your premium. As a policyholder gets older, however, he may find you can no longer afford to exercise this option because the cost of adding inflation protection becomes too expensive. If the inflation protection option is rejected, a policyholder could eventually lose the right to have it (typically after you reject it 3 times).

Defined By Number of Years or Age

The option to choose inflation protection can also be limited by a certain number of years or a certain age. Here too, rejection of the option more than three times could cause the policyholder to lose inflation protection.

Doing the Best You Can

It should be noted that few things in life come with an absolute guarantee. The lack or loss of inflation protection in a long term care policy means the insured will lose some benefit and may have to pay for these out of pocket. Some might be appalled that they do not have 100% coverage. The author feels that some benefits are better than none, especially when the costs of 100% coverage may put premiums beyond the reach of policyholders and lead to them eventually canceling long term care coverage altogether . . . the result being NO coverage.

Waiver of Premium

Nearly all long term care insurance policies contain a provision that waives the policy's premiums if the insured is eligible to collect benefits. It makes sense that someone needs to be placed in a long term care facility they will need every extra money to cover extra costs without having to worry that their LTCI premiums are paid. However, some insurers waive the premiums on the first day that benefits become payable. Others may require a period of up to 90 days before they can be waived.

Elimination Period

This is the number of days after the effective date of the policy before an insured can collect benefits. Some have likened an elimination period to a deductible in a typical health insurance policy. In essence, no long term care benefits are covered during this period. Once an elimination period is satisfied, it is typically considered satisfied for the life of the policy.

Benefit Period

The benefit period is the amount of time a long term care policy will pay benefits. The can range from 2 years up to lifetime policies. The bulk of policies today, however, use a ***pool of money*** concept. A $200 a day, 5 year benefit policy creates a $365,500 pool of money or bank account. An insured using $200 a day will exhaust the fund in 5 years. If one used only $100 a day the fund could last 10 years.

Restoration of Benefits.

After a treatment for long term care, some policies offer to restore the original maximum amount if the insured are treatment-free for a certain period of time.

Home Modifications

Home Modifications mean modifications made to a home that are primarily being made to ***improve*** the ability to perform the Activities of Daily Living and allow someone to live safely and independently in their home.

Examples of home modifications include: installation of ramps accessibility modifications. Home modification do not typically include: hot tubs, swimming pools, home repair or maintenance; or other modifications. Home modifications can be expensive. Many LTC policies allow insureds to use portions of their benefits to make these modifications and for the use of other ***ancillary supplies and services*** up to, but exceeding the lifetime daily facility benefit amount.

Pooled Benefits and Joint Survivor Policies

Policies are now available that cover more than just one person or more than one type of long term care service. Benefits by these policies are often called ***pooled benefits.***

One type of pooled benefit covers more than one person, such as a husband and wife, two partners, or two or more related adults. This type of benefit is sometimes called a "joint policy" or a "joint benefit." Joint policies provide a benefit amount that applies to all of the individuals covered by the policy. If one of the covered individuals collects benefits, that amount is subtracted from the total policy benefit. For example, if a husband and wife have a policy that provides $150,000 in total benefits, and the

husband uses $25,000 from the policy, $125,000 would be left to pay benefits for either the husband or the wife, or both.

Another kind of pooled benefit provides a total dollar amount that can be used for various long-term care services. These policies pay a daily, weekly, or monthly dollar limit for one or more covered services. You can combine benefits in ways that best meet your needs. This gives you more control over how your benefits are spent. For example, you may choose to combine the benefit for home care with the benefit for community-based care instead of using the nursing home benefit.

Some policies provide both types of pooled benefits. Other policies provide one or the other.

Return of Premium

A return of premium rider is a feature promising the policyholder he can get back a portion or all of his premiums paid into the policy if held for a certain period of time. These riders can be quite expensive -- as much as 40% to 100% more than the original LTC premium. Return of premium riders typically start or “vest” after five years. Some return more as the years go by. The return of premium is paid upon termination of the policy by lapse or death. This protection is marketed to the ***Return of Premium*** policyholder who doubts he will use his coverage but still wants something out of the policy.

The downside to this concept can quickly outweigh the benefit:

- The cost of these additional options represent a potential loss in the time value of money.
- The return of premium benefit can be reduced by any claims filed. Thus, if enough LTC claims are filed, they can wipe out the return of any premium down the road.
- The high cost of the rider may financial inhibit the insured sufficient core protection or some other coverage he really needs.

Return of premiums may also effect taxation of the policyowner. In particular, tax-qualified long term care policies do not allow any cash value or return of premium while the insured is still alive. Any such return will void the taxpayer's qualified status.

Agents must not confuse the ***return of premium rider*** with the ***return of premium on death*** which is a feature of a policy that refunds all or a portion of an insured's premiums to his estate upon death. Typically there us a certain number of years required to hold the policy or a certain age that must be attained to qualify for this benefit. This feature holds appeal for people who think they will die before they need coverage.

Non-Forfeiture Options

These type of benefits are defined as those that will return ***part of*** what the insured paid in premiums if the insured chooses to cancel the coverage or; if the coverage lapses because an individual forgot or could not pay the premium.

Nonforfeiture rights in California were amended in 1999. Typically, LTC policy benefits will not be paid in cash but instead will ***guarantee*** some portion of benefits if coverage is dropped; or the accumulated monies due to advanced premiums, as an example, can be returned; or reduced benefits may be available.

In order to receive a reduced benefit, an individual must have paid premiums for a minimum number of years. (e.g. 10 or 20 years)

Some policies will offer a paid-up premiums feature. This allows the insured to pay higher premiums for a limited number of years, just like whole life insurance.

- 10 pay life
- 20 pay life
- Paid up at age 65

In most cases, any extras offered in a policy will cause the premiums to increase.

California applicants for long term care insurance ***must*** be offered an ***option*** to purchase a shortened nonforfeiture benefit period with eligibility no later than 10 years. The lifetime maximum benefit can be no less than 3 months of nursing care or the amount of the premiums paid, whichever is greater. In essence, the lifetime maximum benefit increases proportionately with the number of years of premium payment. A working couple with a strong current income might consider this. However it has not been a real popular feature because the benefits are typically small and added premiums may be better spent or invested elsewhere. Some experts advise that if a client's budget forces them to choose between a better policy or an important option like inflation protection, opt for the latter.

Chapter 5
California Long Term Care Insurance Provisions

California & HIPAA

For the past 15 years, long term care insurance legislation has received much attention at the federal and state level. California has been at the forefront of many LTC consumer innovations as well as codes bringing insurers in line with HIPAA.

California insurers, for example, must now address many HIPAA eligibility-related criteria including special notices for policies meeting ***tax qualified (TQ) or non tax qualified (NTQ) status.*** Also, if the IRS issues a decision, declaring that the benefits paid under an existing long-term care insurance policies or certificates, are either taxable or nontaxable as income, California insurers offering both forms of policies must offer a holder of either form of policy a one-time opportunity to ***exchange*** the policy from one form into the other form.

The full impact of the assistance and supervision requirements of tax qualified policies has yet to be sorted out. The most obvious difference lies in easier qualification under California non-tax qualified contracts where loss of 2 out of 7 ***activities of daily living*** (see below) will trigger coverage. Tax qualified plans exclude ambulating, but may accept the inability to move about as a trigger under transferring.

The Internal Revenue Service defines the ***licensed health care practitioner*** (LHP) in very general terms. They can include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. ***California*** Insurance Code Section 10232.8(c) narrows the list by specifying the ***role of the LHP*** in the certification, ***assessment, and plan of care*** of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and "shall not be compensated in any manner that is linked to the outcome of the certification" (CIC 10232.8(c). Federal and State law requires the certification of the insured's assessment be renewed annually.

Probably the most difficult, however, is the ***substantial supervision*** requirement to determine cognitive impairment. Here, a safety issue must be considered. Under non-tax policies, cognitive coverage is often times triggered by a simple lack of thinking, reasoning or orientation: an easier qualification than the tax qualified version.

California's SB 870 legislation addresses the mental health issue by mandating that mental illness is no longer limited to Alzheimer's and organic disorders. Rather, eligibility can now occur through "related mental disorders". An obvious goal of this and other California legislation is to bring the eligibility factors between tax and non-tax qualified products closer in sync.

Are California consumers now more informed when making long term care insurance purchases? Yes. Layers of legislation, on the other hand, may prevent or discourage insurers from entering the marketplace. And, a lack of adequate competition can lead to higher premiums and fewer choices for these same consumers.

Post Claims Underwriting (10232.3)

In the early days of selling long term care, some companies engaged in practices called ***post claims underwriting*** (accepting applicants with little or no real health underwriting only to cancel them when they filed a claim based on nondisclosure in the application).

Since post claims underwriting is now ***prohibited*** in California, all applications for long term care insurance, except those that are guarantee issue, shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant. Applications must be delivered with each policy. Each question shall contain only one health status inquiry and shall require only a ***"yes" or "no" answer***, except that an application may include a request for the name of any prescribed medication and the name of the prescribing physician. An omission here may be used as the basis for a denial of a claim or the rescission of a policy.

The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block: *Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or* **rescind your coverage***.*

It is also important to note at this time that that ***NO long term care policy or certificate may be field issued***, meaning issued by a producer or third party administrator. Underwriting authority is with the insurer alone.

Every ***application*** for long-term care insurance shall include a checklist that enumerates each of the specific documents which this chapter ***requires be given to the applicant at the time of solicitation***. The documents and notices to be listed in the checklist include, but are not limited to, the following: (1) The "Important Notice Regarding Policies Available" (2) The outline of coverage (3) The HICAP notice (4) The long-term care insurance shoppers guide (5) The "Long-Term Care Insurance Personal Worksheet" (6) The "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care

If ***replacement*** is not made by direct response solicitation or if replacement is made by direct response solicitation, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted with the application before issuing the policy or certificate, the insurer may only rescind the policy or certificate (rescissions must be filed annually with the commissioner) or deny an otherwise valid claim if there is clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence must:

- Pertain to the condition for which the benefits are sought;
- Involve a chronic condition or involve dates of treatment before the date of application;
- Be material to the acceptance for coverage.
- A copy of the ***completed application must be given to the insured*** when the policy or certificate are delivered.

Every insurer must maintain a record of all policy certificate ***rescissions***, both state and countrywide, except those voluntarily initiated by the insured. In California, this information must be submitted to the Commissioner annually.

The ***contestability period*** for long term care insurance shall be two years.

Suitability Standards

California law requires that insurers design policies and sales materials so that consumers make informed and knowledgeable choices about how to insure against their need for long term care. Among other things, each applicant must be given a comprehensive outline of coverage, information about optional coverage, and copies of information prepared by consumer groups before applying for a long term care insurance policy. They also must be permitted to modify the premiums for (and benefits under) for their policies to accommodate any change in their needs. More on this below.

Post Claim Underwriting

It is also important to note at this time that that ***NO long term care policy or certificate may be field issued***, meaning issued by a producer or third party administrator. Underwriting authority is with the insurer alone based on the submitted application . . . ***no post claims underwriting.***

Checklist

Every application for LTC insurance shall include a ***checklist*** of specific documents that are required to be given to the applicant at the time of solicitation. Both agent and applicant must sign the bottom of the checklist to indicate that they were delivered and received.

Items required on the checklist include the following documents and applicable procedures:

____TQ and NTQ statement (10232.25)
____Outline of Coverage (10233.5)
____HICAP Disclosure (10234.93)
____The Long Term Care Insurance Shopper's Guide
____The long term care personal worksheet (Back of book)
____Replacement of accident and sickness / LTC insurance (10235.16)

Every policy that is intended to be a ***tax qualified*** long term care insurance contracts, including riders, as provided by federal law to be identified as such with a specific disclosure statement. Similarly, a policy not intended to be tax qualified . . . meaning ***non tax qualified*** . . . must be identified as such.

Outline of Coverage rules are extensive and covered later in this section. In a nutshell, it discusses terms, limitations, exclusions and where to get unbiased help

Other documents will be discussed under agent responsibilities.

PreExisting Conditions & Policy Replacement

Policies shall define preexisting conditions as follows: A definition of preexisting condition which is 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 .(10232.4(a)., i.e., preexisting conditions are covered as long if they occurred in the six months preceeding coverage.

Long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance is intended to replace any other accident and

sickness or long-term care insurance presently in force. A special "notice" must include information on preexisting conditions as follows (10235.18(a):

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

Contestability and Completed Applications

The contestability period as defined in Section 10350.2 for long-term care insurance shall be two years.

A copy of the completed application shall be delivered to the insured at the time of delivery of the policy or certificate. (10232.3(g).

Unintentional Lapse (10235.40)

No individual long-term care policy or certificate shall be issued until the applicant has been given the ***right to designate*** at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer shall receive from each applicant one of the following:

(1)A ***written designation*** listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium.

(2)A ***waiver*** signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver shall read as follows:

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

(b)The insurer shall notify the insured of the right to change the written designation, no less often than once every ***two years***.

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

(d)No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, ***at least 30 days*** prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision (a), 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, not less than 30 days after a premium is due and unpaid.

(e)Each long-term care insurance policy or certificate shall include a provision which, in the event of lapse, provides for a ***cognitive reinstatement*** of coverage clause, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within ***five months*** after termination and shall allow for the collection of a past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

Inflation Protection and Waiver

California long term care outline of coverage must include a graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent over the policy period with a policy that does not increase benefits. The graphic comparison shall be reasonable and show benefit levels over at least a 20-year period. (10237.6)

In addition, 10237.5 of the CIC requires an inflation protection provision that increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder. The rejection, to be included in the application or on a separate form, 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 the plan, and I reject 5 percent annual compound inflation protection.

_____ _____

Signature of Applicant Date"

Insurer Reporting Requirements

A) If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted with the application before issuing the policy or certificate, the insurer may only rescind the policy or certificate (rescissions must be filed annually with the commissioner) or deny an otherwise valid claim if there is clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant (10232.3(h) The evidence must:

- Pertain to the condition for which the benefits are sought;
- Involve a chronic condition or involve dates of treatment before the date of application;
- Be material to the acceptance for coverage.
- A copy of the ***completed application must be given to the insured*** when the policy or certificate are delivered.

B) Every insurer must maintain a record of all policy certificate ***rescissions***, both state and countrywide, except those voluntarily initiated by the insured. In California, this information must be submitted to the Commissioner annually (10234.86 CIC)

C) The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter. (10234.95(i) CIC).

D) A copy of the issuer's personal worksheet shall be filed and approved by the commissioner. A new personal worksheet shall be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner. The new personal worksheet shall disclose the amount of the rate increase in California and all prior rate increases in California as well as all prior rate increases and rate increase requests or filings in any other state. The new personal worksheet shall be used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet. (10234.95(c) CIC).

E) Every long-term care insurer shall file with the commissioner within six months of the effective date of this section, its commission structure or an explanation of the insurer's compensation plan. Any amendments to the commission structure shall be filed with the commissioner before implementation. (10234.97(c) CIC).

F) Submit to the commissioner within six months of the effective date of this act, a ***list of all agents*** or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually. (10234.93(a) CIC).

F) The initial premium rate schedules for all individual and group long-term care insurance policies issued in this state shall be filed with and receive the prior approval of the commissioner before the policy may be offered, sold, issued, or delivered to a resident of this state. (10236.11 CIC).

G) No insurer may increase the premium for an individual or group long-term care insurance policy or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner. The insurer shall submit to the commissioner for approval all proposed premium rate schedule increases. (10236.13 CIC).

Policy Terms & Definitions

(a) ***Medicare*** shall be defined as the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended, or Title I, Part I of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import. (10235.2 CIC)

(b) All providers of services, including, but not limited to, ***skilled nursing facilities, intermediate care facilities, and home health agencies*** shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately ***licensed or certified***. (10235.2 CIC)

(c) ***Residential care facility*** means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provide care and services on a 24-hour basis, have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provide three meals a day and accommodate special dietary needs, have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and, have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications. (10232.92 CIC).

Here is an example of how policy terms related to the licensing of caregivers has caused problems for a policyholder:

Nancy purchased a Home Care Only policy in another state in 1997 and later moved to California. When she needed home care recently at age 92 her daughter contacted the company, an assessment was made, and she was approved for home care benefits. The company however, refused to pay the policy's benefits because her personal care services at home were not supervised by a home health agency. Furthermore they argued that her provider is not licensed by California to provide her care. However, the provider she was using at the time the assessment was made did not have a state license because California does not issue a license to deliver personal care services, State certification is only required when services are paid by Medicare or Medicaid. The delivery of personal care services, such as assistance with dressing, bathing, eating, and other tasks, does not require the services or oversight of a licensed skilled care provider that typically charges higher fees and increases the cost of care. Since the policy was issued in another state California has no authority in regard to this claim. The other state was contacted and the company has now issued a check for the services she has already received as an "administrative exception." The company will in the future though, require her to receive services under the supervision of a state licensed Home Health Agency and from a state licensed provider, which will dramatically increase her cost of care without providing her with any additional services, reducing the number of hours her benefits will cover.

Consumer Protection

Shortened Benefit Period (10235.30 CIC)

Long-term care policies in this state must offer, at the time of application, an option to purchase a ***shortened benefit period*** nonforfeiture benefit if the ***insurer has increased premiums*** with the following features:

(1) Eligibility begins no later than after 10 years of premium payments.
(2) The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.
(3) The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.
(4) The lifetime maximum benefit may be reduced by the amount of any claims already paid.
(5) Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.
(6) The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

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

Group and Individual Disclosures

Terms "guaranteed renewable" and "noncancellable" shall not be used in any group and individual direct response or individual long-term care insurance policy or certificate without explanatory language

30-Day Free Look (10232.7 CIC)

An applicant for a long-term care insurance policy or a certificate, other than an applicant for a certificate issued under a group long-term care insurance policy, shall have the right to return the policy or certificate by first-class United States mail within ***30 days*** of its ***delivery*** and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Policyowners shall be notified of this through a notice prominently printed of the first page of the policy or certificate.

The return of a policy or certificate shall void the policy or certificate from the beginning and the parties shall be in the same position as if no policy, certificate, or contract had been issued. All premiums paid and any policy fee paid for the policy shall be fully refunded directly to the applicant by the insurer within 30 days after the policy or certificate is returned.

Right To Reduce Coverage (10235.50 CIC)

Every policy or certificate shall include a provision that gives the policyholder or certificate holder the following rights to reduce coverage and lower premiums:

"Any time after the first year, to retain a policy or certificate while lowering the premium by reducing the lifetime maximum benefit, reducing the nursing facility per diem and reducing the home-and community-based service benefits of a home care only policy and of a comprehensive long-term care policy and/or converting a "comprehensive long-term care" policy or certificate to a "Nursing Facility Only" or a "Home Care Only" policy or certificate, if the insurer issues those policies or certificates for sale in the state."

The premium for the policy or certificate that is reduced in coverage will be based on the age of the insured at issue age and the premium rate applicable to the amount of reduced coverage at the original issue date.

In the event a policy or certificate is about to lapse, the insurer shall provide written notice to the insured of the options to lower premiums by any of the above methods.

In the event of a premium increase, the insured shall be offered the option to lower premiums and reduce coverage.

Right To Increase Coverage (10235.51 CIC)

Every policy or certificate shall include a provision that gives the insured the option to elect, no less frequently than on each anniversary date after the policy or certificate is issued, to pay an extra premium for one or more riders that increase coverage in any of the following ways:

(1) Increase the amount of the per diem benefits.
(2) Increase the lifetime maximum benefit.
(3) Increase the amount of both the nursing facility per diem benefit and the home- and community-based care benefits of a comprehensive long-term care insurance policy or certificate.

The ***premiums*** for added coverage ***may increase*** based on the attained age of the insured, although the premium for the original policy or certificate will not be changed and will continue to be based on the insured's age when the original policy or certificate was issued.

The insurer may require the insured to undergo ***new underwriting***, in addition to the payment of an additional premium, to qualify for the additional coverage. The insurer ***may restrict the age for issuance of additional coverage and restrict the aggregate amount of additional***

coverage an insured may acquire to the maximum age and coverage the insurer allows when issuing a new policy or certificate.

Replacement

California law is very specific in the area of long term care policy replacement responsibility.

Utmost in any replacement is the determination that the insured's position is ***improved***. Agents should be able to ***interpret older policies*** and understand why services may be more restrictive than those described in new policies. This should be explained when the older policy is replaced and agents should accurately identify the reason for the replacement and whether it constitutes a material improvement in the agent certification statement on the application.

In general, an insurer, broker, agent or other person is prohibited from causing a policyholder to replace a long term care insurance policy ***unnecessarily***. California law presumes that ***any third or greater policy sold to a policyholder in any 12-month period is unnecessary*** unless a policy is replaced for the sole purpose of consolidating policies with a single insurer.

Policies issued ***prior to 1/1/97*** fall under special replacement rules. For tax purposes, these policies are considered "grandfathered" in that they receive the same tax benefits as new tax qualified policies. Interestingly, most of these policies feature triggers that make it easier for policyholders to qualify for benefits than do new tax qualified policies. Then again, some of the new policy features may not be present in these older versions, and, if any material modification" is made to upgrade older contracts, their tax qualified status could be lost. Treasury guidelines allow changes in these policies so long as they have been "built-in", e.g., a nonforfeiture rider or inflation protection option.

MATERIAL CHANGE

In the eyes of the law, a material change in a policy can be considered issuance of an entirely new contract, thus voiding Pre-1997 TQ status under federal "grandfather" rules. ***Examples*** of changes that could trigger this include any altering on the timing of benefits, premiums or nonforfeiture rights; a substitution of the insured or a change in the eligibility for membership in a group contract; or exchanging a Pre-97 policy for a new one. Simply exercising an option or right existing in a Pre-1997 contract is NOT material.

As a precaution against losing favorable tax status the California insurance code now requires that if a policy or certificate holder requests a ***material modification*** to his insurance contract, and the policy or certificate was issued prior to 12/31/96, the policyholder shall receive ***written notice*** that the contract changes requested may constitute a material modification that jeopardizes the federal tax status of the contract and to seek appropriate tax advice.

Replacement Form

Long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance is intended to replace any other accident and sickness or long-term care insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or

delivery of a policy or certificate, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of this notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following form:

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

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

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

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

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

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)"

Commission Issues

In any replacement situation, keep in mind that ***agent commissions*** are limited to the difference between replacement and original coverage so long as the insurer declares that a “material improvement” in policy benefits has taken place. Commission or compensation includes remuneration of any kind, including, but not limited to bonuses, gifts, prizes, awards and finder’s fees. Commission structures and any amendments must be filed with the commissioner before implementation or within six months of code changes.

Group Replacements

If a group long term policy is replaced by another policy issued to the same master policyholder (the group), the replacing insurer must:

- Provide benefits identical to or substantially equivalent to the terminating coverage (*lesser or greater coverage may be provided if the Commissioner determines that it is the most advantageous choice for the beneficiaries*),
- Calculate the premium on the insured's age at the time of issue of the group certificate being replaced (the previous insurance),
- If the insurance being replaced was previously replaced, calculate the premium on the insured's age at the time the previous policy was issued, and
- If the replacement coverage adds new increased benefits, the premium for those benefits may be calculated on the insured's age at the time of issue of the new coverage
- Offer coverage to all persons covered under the replaced group policy on its date of termination,
- Not exclude coverage for preexisting conditions if the terminating group coverage would have provided benefits for those preexisting conditions
- Not require new waiting periods,
- Not require new elimination periods,
- Not require new probationary periods,
- Waive any such time periods applicable to preexisting conditions to the extent that similar preconditions have been satisfied under the terminating group coverage, and
- Not vary the benefits or the premiums based on the insured's-health, disability status, claims experience, or use of long-term care services.

Direct response insurers must also send a notice of replacement. However, because an agent is not involved in the transaction the notice may be delivered upon issuance of the policy. Still, the applicant must be afforded the 30-day free look. In any replacement situation the commissioner may waive certain provisions and shall be able to define an "inappropriate replacement" when it is in the best interest of the insured. The Commissioner may also waive any policy replacement provision if it is in the best interest of insureds.

A) The terms "guaranteed renewable" and "non-cancelable" shall not be used in any group and individual direct response or individual long-term care insurance policy or certificate without explanatory language in accordance with the disclosure requirements of Section 2012.70 of this Part.

(1) No such policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable".

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(1) The term "non-cancelable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

Premium Credits (10234.87 CIC)

Under State guidelines, insurers are required to grant policyholders ***premium credits*** for replacement of policies previously issued amounting to ***5 percent of the annual premium*** for each year the previous policy was in force (***not to exceed 50 percent*** of the previous premium). ***Example:*** Old Policy -- Premium of $1,000 annually versus a New Policy -- Premium of $1,500 annually. The credit is 5% for each full year of annual premiums paid. So, an individual with a six-year-old policy would have a $300 credit (6 years X .05= .30 X $1,000 old premium = $300. If the old policy were twelve years old, the credit would $500 calculated at (12 years X .05= .60 X $1000 = $600. However, this exceeds the 50% of old premium rule so it is reduced to $500).

Policy Conversions (10236.5 CIC)

Group insurance issued or delivered in California ***must*** provide for continuation or conversion coverage for the certificate holder if the group coverage ***terminates*** for any reason unless the termination of group coverage resulted from the insured's failure to make any required payment of premium or contribution when due. Or, the terminating coverage is replaced not later than 31 days after termination by new group coverage effective on the day following the termination. The replacement coverage must also provides benefits identical to, or benefits determined by the commissioner to be substantially equivalent to or in excess of, those provided by the terminating coverage.

The premium for the replacement coverage is calculated on the ***insured's age*** at the time of issue of the group certificate for the coverage which is being replaced. If the coverage being replaced has itself replaced previous group coverage, the premium for the newest replacement coverage is calculated on the insured's age at the time the previous group certificate was issued.

Continuation coverage means the maintenance of coverage under an existing group policy when that coverage would be or has been terminated and which is subject only to continued timely payment of the premium. Any insured individual whose eligibility for group coverage is based on his or her relationship to another person, shall be entitled to continuation coverage under the group policy if the qualifying relationship terminates by dissolution of marriage or death.

Conversion coverage means an individual policy of long-term care insurance, issued by the insurer of the terminating group coverage, without considering insurability, containing benefits which are identical, or which have been determined by the commissioner to be at least substantially equivalent, to the group coverage which would be or has been terminated for any reason. In determining whether benefits are substantially equivalent, the commissioner shall consider, if applicable, the relative advantages of managed care plans which use restricted provider networks, considering items such as service availability, benefit levels, and administrative complexity.

The premium for the ***converted policy*** shall be calculated on the ***insured's age*** at the time the group certificate was issued. If the terminating group coverage replaced previous group coverage, the premium for the converted policy shall be calculated on the insured's age at the time the previous group certificate was issued. Before issuing conversion coverage, the insurer may require, if adequate notice is provided to certificate holders in the certificate, that:

(1) The individual must have been continuously insured under the group policy, or any group policy which it replaced, for at least six months immediately prior to termination in order to be entitled to conversion coverage.
(2) The insured must submit written application for a conversion policy within a reasonable period after termination of the group coverage, and the premium paid as directed by the

insurer, in order that the conversion policy be issued effective on the day following termination of group coverage.

(3) The conversion policy contains a provision for a reduction of benefits if the insured has existing long-term care insurance, payable on an expense-incurred basis, which, together with the conversion policy, would result in payment of more than 100 percent of incurred expenses. This provision shall not be included in the conversion policy unless the reduction in benefits is reflected in a premium decrease or refund.

(4) The conversion policy contains a provision limiting the payment for a single claim, spell of illness, or benefit period occurring at the time of conversion, to the amount that would have been payable had the group coverage remained in effect.

If a ***group long-term care policy*** is replaced by another policy to the same master policyholder issued, the replacing insurer shall do all of the following:

(a) Provide benefits identical to the terminating coverage or benefits determined by the commissioner to be at least substantially equivalent to the terminating coverage. Lesser or greater benefits may be provided if the commissioner determines the replacement coverage is the most advantageous choice for the beneficiaries.

(b) Calculate the premium on the insured's age at the time of issue of the group certificate for the coverage which is being replaced. If the coverage being replaced has itself replaced previous group coverage, the premium for the newest replacement coverage shall be calculated on the insured's age at the time the previous group certificate was issued. If the replacement coverage adds new or increased benefits, the premium for the new or increased benefits may be calculated on the insured's age at the time of replacement.

(c) Offer coverage to all persons covered under the replaced group policy on its date of termination.

(d) Not exclude coverage for preexisting conditions if the terminating group coverage would provide benefits for those preexisting conditions.

(e) Not require new waiting periods, elimination periods, probationary periods, or similar preconditions related to preexisting conditions. The insurer shall waive any such time periods applicable to preexisting conditions to the extent that similar preconditions have been satisfied under the terminating group coverage.

(f) Not vary the benefits or the premium based on the insured's health, disability status, claims experience, or use of long-term care services.

Tax Qualified Exchange (10232.2 CIC)

If a policy or certificate issued on a group policy prior to January 1, 1997, ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section 7702B(f) of the Internal Revenue Code, the insurer shall offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.

Long Term Care Personal Worksheet (10234.95 CIC)

A copy of the issuer's personal worksheet shall be filed and approved by the commissioner. A new personal worksheet shall be filed and approved by the commissioner each time a rate is increased ***in California*** and each time a new policy is filed for approval by the commissioner. The new personal worksheet shall disclose the amount of the rate increase in California and all prior rate increases in California as well as all prior rate increases and rate increase requests or filings in ***any other state***. The new personal worksheet shall be used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet.

Options To Increase Coverage

After a client is convinced that long term care insurance is an essential part of their financial planning there are decisions to be made on the many optional benefits available.

- ***Do nursing home / home health care benefits increase automatically?*** *Nursing home costs have been increasing between 8 and 9 percent since 1985. A cost of $110 per day today will run up to $513 in 20 years at 8 percent inflation.*
- ***Is the increase based on the Consumer Price Index, Medical Price Index or is it fixed?*** *No ones knows the future, but if benefits at least kept pace with inflation the policyholder should have some form of additional protection against rising costs.*
- ***Is there a "cap" on the amount benefits can increase?*** *Beware of companies that "cap" their inflation increases to two or three times the base benefits.*
- ***Are future benefit increases available on demand?*** *Some policies offer the option to increase benefits every so often at the client's attained age. Look for additional underwriting and be alert to any condition that eliminates this option if it has been offered and refused by the policyholder a specific number of times.*
- ***What kind of inflation protection is offered?*** *Protection can increase at 5% compounded or 5% simple. The corresponding increase in premium would be about 60% and 50%. A daily benefit of $110 today will grow to $292 in 20 years at 5% compounded vs $220 under 5% simple.*
- ***What is the cost of waiting to buy inflation protection later?*** *Policies that allow the purchase of additional coverage later can be cheap today but expensive down the road. A 65-year old might pay only $770 today for a policy with optional increases compared to $1,598 for one with automatic protection. In 20 years, however, the policy with optional increases could cost over $5,000 compared to the same $1,598 for automatic benefit increase protection.*
- ***If inflation protection is too expensive for a client today, is it cheaper to just increase benefit levels?*** *Perhaps. A premium for higher benefits but no automatic inflation protection will most likely cost less*

INFLATION PROTECTION UNDER CALIFORNIA LAW

- In California, insurers must offer inflation protection at 5% compound annually unless the applicant rejects it. The rejection of inflation protection MUST be verbatim (10237.1 CIC).
- Inflation protection must also be offered to group policyholders (10237.1 CIC)
- Life insurance policies with accelerated benefits are exempt from mandatory inflation protection (10237.3)
- The offer of inflation protection shall not have limits such as age, claim status, claim history, policy term or be reduced due by payment claims (10237.4 CIC).
- The Outline of Coverage, at time of application, shall show a 20-year graph on the effects of inflation, expected premium increases to pay for inflation protection with reasonable illustrations (10237.6 CIC).
- Other allowable forms of inflation protection include automatic, simple or compound methods (USC) , the consumer price index (CPI) or the future price option (FPO)

today. The risk taken is that clients may be unable to afford the coverage needed in 10, 20 or 30 years or simply have to accept lower benefit levels than would have been provided with automatic protection. These are trade-offs that need to be discussed with clients.

Optional benefits can go a long way to solving a client's long term care insurance needs and they should always be recommended. However, agents should be careful of riders that look too good to be true; they probably are. Additionally, it doesn't make sense to sacrifice good carriers and good base benefits for an attractive option with an inferior company with less than comparable base features.

A Word On Specimen Policies & Materials

California requires agents and insurers to make specimen policies available online or by request (10237.93 CIC).

An insurance agent should ***never sell*** an important product like long term care without first obtaining and understanding a specimen policy and outline of coverage from the insurer. One of the most important reasons to ***obtain*** them is the rapid evolution of products, policies and definitions, e.g., What is an "applicant", "certificate", "group policy", etc. Selling without them is like operating a computer without help screens.

For example, a long term care policy that considers a person disabled if someone has to be present to assist when they get out of bed is different than a policy that requires ***hands on assistance*** to actually lift the person out of bed to a chair. One could trigger benefits, the other would not. While this may seem like "splitting hairs" to you, it is a big deal to a policyholder and caregiver who must spend thousands of dollars to hire help for this activity. He and his attorney may just as well ask ***you*** to pay these costs if they were led to believe they were covered.

A close review of a specimen policy and outline of coverage would also uncover the basic ***purpose*** of the policy. For example, a stand alone home health care contract might easily be misconstrued as long term care coverage. A specimen policy would determine if these benefits continue or end when a policyholder enters a nursing home. Could you hear the client's attorney asking you why you did not suggest nursing home coverage? As far-fetched as this seems, be aware that agents have been held liable for not knowing the basic features of policies they sell. Further exposure may accrue if there is a policy option that is widely available at a reasonable cost that the agent failed to present or offer to the client. The best way to cover all the bases is to know all the features and options as explained in the specimen policy. Do not depend on the insurance company literature or illustrations to give all the information needed to properly evaluate a policy.

Additional Insurer Records & Obligations

- Insurers must keep track of the amount and frequency of LTC policies sold and replaced by their agents (10234.86 CIC) and retain auditable procedures for agent compliance (10234.93 CIC).

- Insurers must provide the Commissioner copies of all LTC advertisements and ads must prominently disclose that "an agent will contact you" if that is the case. Agents who do make contact from a cold lead device must also disclose this immediately (10234.9 CIC).

- Agents and insurers must determine and uphold client suitability standards, a client's ability to pay, the applicant's long term care goals, the real value and benefits of any existing

policies, personal LTC worksheet, rate guide, and the duty to disclose that NO LTC is necessary (10234.97 CIC).

- The insurer shall not require an amount greater than one month's premium to be submitted with an application for the policy of insurance if interim coverage is not provided. If interim coverage is provided, the insurer shall not require an amount greater than two months' premium for that purpose. No further premiums may be collected until the policy is delivered to the applicant 10232.65 CIC).

- The insurer shall notify the applicant within 60 days from the date the insurer or insurer's authorized representative or producer receives the application and the amount as to whether or not the applicant will be issued a policy of insurance. If the applicant is not so notified, the insurer or insurer's authorized representative or producer shall pay interest to the applicant on the funds that the applicant submitted with the application, at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from the date the insurer or insurer's authorized representative or producer received those funds until they are refunded to the applicant or are applied toward the premium (10232.65)

- Insurers of long term care policies must belong to the California Life and Health Insurance Guarantee Association in order to create a fund for protecting long term care policies and other contracts where long term care coverage is available from insurer insolvency (1067.02 CIC).

More LTC Coverage Information

Exclusions and Limitations (10235.8 CIC)

No policy may be delivered or issued for delivery in California as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as to the following:

(a) Preexisting conditions or diseases.
(b) Alcoholism and drug addiction.
(c) Illness, treatment, or a medical condition arising out of any of the following:
    (1) War or act of war, whether declared or undeclared.
    (2) Participation in a felony, riot, or insurrection.
    (3) Service in the armed forces or units auxiliary thereto.
    (4) Suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury.
    (5) Aviation in the capacity of a non-fare-paying passenger.
(d) Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under Medicare or other governmental programs (except Medi-Cal or Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.

Claims Denied (10235.9 CIC)

Starting in 1990, every insurer shall report annually by ***June 30*** the total number of claims denied by each class of business in the state and the number of these claims denied for failure to meet the waiting period or because of a preexisting condition as of the end of the preceding calendar year.

Also, the insurer shall provide every policyholder or certificate holder whose claim is denied a written notice within ***40 days*** of the date of denial of the reasons for the denial and all information directly related to the denial. Insurers shall annually report to the department the number of denied claims.

The department shall make ***available to the public***, upon request, the denial rate of claims by insurer.

Here is an example of how a denied claim impacted a policyholder:

Mark and Mary replaced their existing long-term care policies in 1988 with two new policies from specifically because the new policies included a benefit for an alternative plan of care in addition to benefits for nursing home care. These two highly educated elders believed the benefit described in the new policy was superior to their existing policies, and would allow them the flexibility to receive benefits in whatever setting best met their needs, an impression reinforced by the policy language and the agent who sold the policy to them. Eighty nine year old Mark recently needed assistance in caring for his wife who has dementia, and filed a claim for the policy's long-term care benefits. The claim was denied with the explanation that benefits could not be paid for services received in their home under the alternate plan of care benefit, and policy benefits would only be paid when Mary, now 86 years old, is confined to a nursing home. Mr. and Mrs. M have paid approximately $98,000 in premiums for their two policies since 1988 and will apparently receive no benefits unless they each enter a nursing home, regardless of the alternate plan of care promise made to them. In the meantime Mark continues to try to provide care for his wife at home, adamantly refusing to send her away to a nursing home.

Ralph and Riona also bought two of these policies for nursing home care from Continental Casualty Company and the company actually paid for Mr. R's care at home in 2002 under the alternate plan of care benefit. But this year when Mrs. R needed care at home under exactly the same policy and alternate plan of care benefit the company refused saying it was at the option and discretion of the company to provide this benefit and the company was no longer providing this flexibility in benefit payments.

Termination Rights (10235.10 CIC)

Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if that institutionalization began while the long-term care insurance was in force and continues without interruption after termination. This extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. So, an insurer cannot simply cancel an insured who becomes ill without first meeting its benefit obligation under the contract.

Right To Appeal (10235.9 CIC)

Every policy or certificate shall include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments. No termination of coverage may occur during the processing of a claim.

Renewability Of Individual Policies (10235.14 CIC)

Individual long-term care insurance policies shall contain a ***renewability provision***. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall

clearly disclose the term of coverage for which the policy is initially issued, the terms and conditions under which the policy may be renewed, and whether or not the issuer has the right to change the premium. If there is a right to change the policy premium, it shall clearly and concisely describe each circumstance under which the premium may change.

Riders or Endorsements (10235.14(b) CIC)

Riders added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require ***signed acceptance*** by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concurrent increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, that premium charge shall be set forth in the policy, rider, or endorsement.

If a long-term care insurance policy or certificate contains any limitations with respect to ***preexisting conditions***, those limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "preexisting condition limitations."

A long-term care insurance policy or certificate containing any ***limitations or conditions*** for eligibility shall set forth in a separate paragraph of the policy or certificate a description of those limitations or conditions, including any required number of days of confinement, and shall label that paragraph "Limitations or Conditions on Eligibility for Benefits."

Nursing Facility Benefits (10232.97)

In every long-term care policy or certificate that covers care in a nursing facility, the threshold establishing eligibility for nursing facility care shall be ***no more restrictive*** than a provision that the insured will qualify if either one of two criteria are met (10232.97):

(a) Impairment in two activities of daily living.
(b) Impairment in cognitive ability.

Benefit Periods

Choosing the length of time that benefits should be paid is an individual choice. Companies offer, one, two, three, four, five or six years and lifetime options. In a perfect insurance world everyone would want lifetime benefits. But is the price worth it? A nursing home-only policy for a 65 year-old, for example, may run as much as $1,400 per year with a lifetime benefit. A four-year benefit period is about 30 percent less and a two-year benefit would cost one-half the lifetime option.

When selecting a benefit period, keep in mind the following statistics from the an AARP 1997 survey: Nearly 90 percent of all people who enter a nursing home between the ages of 65 and 85 stay an average of 2.5 years; The average duration of home caregiving is 4.5 years.

Here are some additional questions and comments to help you assess this category:

- ***Is there a restoration of benefits clause?*** *If a policyholder receives care in a nursing home and recovers, the policy benefits may be restored to the original level.*

- ***Does the insurer count days or years?*** *Most benefits are expressed in years but insurers actually count days. In some cases insurers will count three or four days as a week. This is a completely unacceptable condition.*
- ***Do benefits paid through an HMO count as a full day?*** *Although it is rare, some policies count a day of care provided through an HMO as less than a full day. This could be a bonus for the insured.*
- ***Do home health care and adult day care benefits pay for a full day?*** *This can be important to the relief and effectiveness of the primary caregiver.*

Dollar Amounts

In California, every long-term care policy must define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services (assisted living, institutional care, etc. Amounts can range from $20 to $500 per day for a variety of services. So, benefit maximums could be stated like this: 1,200 days X $120 daily benefit for a maximum of $144,000 benefits. Here are some important features and questions to keep in mind:

- ***Is the benefit amount enough to meet the cost of local nursing homes?*** *Costs can range from $90 in the mid-west to $500 in New York City. Be sure to advise clients that costs may exceed benefits.*
- ***Does the policy indemnify for a fixed daily amount or simply reimburse for actual costs?*** *Most policies are indemnity plans which can cover incidental costs versus reimbursement contracts which cover actual costs. Reimbursement plans generally pay less, but cost less.*
- ***What is the daily benefit for home care and assisted living?*** *Typical policies cover these conditions at 50 percent of nursing home benefits. Unfortunately, the cost of either can meet or exceed nursing home expenses.*
- ***Can benefits be used as a pool of money for both nursing and assisted living / home care?*** *A pool of money may use the maximum benefits of the policy sooner but at least the cost of BOTH assisted living and home care is covered for the meantime.*
- ***Can the benefit amount be increased later? If so, will underwriting be required?*** *This can be a valuable option for meeting unanticipated care down the road. However, added benefits are usually associated with higher premiums, especially if the new insurance is written at the insured's attained age.*
- ***Can the benefits be decreased if the cost of the policy becomes too much to pay?*** *Coverage will drop, but at least some benefits will be paid.*
- ***Can benefits be purchased jointly for a married couple?*** *The discount is typically 10 to 15 percent.*

Elimination Periods

The choice of an elimination or waiting period depends on a clients needs and ability to cover the early costs in a chronic illness. Elimination period generally run 30, 90 or 180 days with options to lengthen this time more in exchange for reduced premiums. As with other forms of insurance, this trade-off can be attractive. Some would say, however, that the lower premium creates a "false economy" A policy with a 90-day elimination, for example, might cost $300 per year less than a policy with 20-day elimination. After 20 years, a policyholder would save about $6,000 in premiums, but with 5 percent ***inflation***, the 70 additional days of care would cost over $20,000.

Others argue that a longer elimination may be the only way people can afford insurance and that a little “self-insurance” for a short duration is generally not significant when compared to long run premiums. The alternative, they, say could mean no insurance at all.

When evaluating long term care policies look for the definition of an elimination period. What is an actual day? Some policies, for example, only count the ***days actual services are provided***, so if the patient does not have home health care everyday, it would take a long time to satisfy a 100-day elimination period. It would be better to have a policy that counted the ***calender vs. visits*** using all seven days in a week toward the waiting period even though home care was only received on one day of that week. Still others start counting when the physician first certifies the need for long term care. Also, in some cases, family members are allowed to provide care until the elimination period is satisfied. Can insureds accumulate days over a period of time? Are there separate eliminations for different services or providers? If so, a policyholder who needs both may create difficulties in qualifying for benefits. Does the policy offer consecutive days for home health care or adult day services? If these services are used only a few days a week does the policy count consecutive days toward the elimination period?

Case Management

Case Management, also known as Care Coordination, is provided by a ***third party*** to ***manage*** an insured's care and report regularly on the effectiveness of the care provided. The rationale for case management is that just providing an insurance benefit payment will not be sufficient in all cases. Some beneficiaries will be unable to secure and coordinate their own care because of their functional/cognitive limitations or the complexity and fragmentation of home and community-based services. Care management can also be very helpful to family members who do not live near their chronically ill parent or relative. Additionally, Care Management, in conjunction with a policy that offers interchangeable benefits and a “bucket of money” is of major value to the policyholder because it provides the opportunity to extend the insurance benefit through the efficient use of coordinated Formal and Informal Care. This, in turn, will result in avoiding or delaying the need for Medi-Cal to fund their long-term care.

Case management is not always an option. All California Long Term Care Partnership policies, for example, are required under law to authorize "Only policies and contracts that provide all of the following items shall be certified by the department: (1) Individual assessment and case management by a coordinating entity designated and approved by the department…”

Also, ***tax-qualified policies,*** while not requiring case managers, do require a pre-admission certification that an insured’s condition will last for 90 days, i.e., the condition is **chronic. Chronically ill** status shall be determined by a ***licensed health care*** **practitioner** who is independent of the insurer as defined below. A “licensed health care practitioner” means a physician, registered nurse, licensed social worker, or other individual who may be defined by the Department of the Treasury. The practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification. In the event that it is determined that the insured DOES NOT meet the “chronically ill” definition, the insurer shall notify the insured that he is entitled to a second assessment by another licensed health care practitioner. The assessments must be performed promptly with written certification (provided every 12 months) to determine if the insured continues to meet the definition of “chronically ill”. Alternatively, if the insured does NOT get a pre-admission certification for some reason and the condition lasts for 90 days, coverage is automatically triggered. A written ***plan of care*** (needs, type, frequency, providers, cost, etc) must also be developed by the licensed health care practitioner, the cost of which shall not count against the lifetime maximum of the policy or certificate.

Agents should be careful not to confuse a case manager with the term ***care advisory*** used by CalPers as well as other group products issues inside and out of California. Care Advisory Services services help with long-term care choices, benefits, and services and even help an insured find quality providers for the care they need. They do not, however, assess the level of care, nor design a plan of care traditionally filled by trained long term care case managers.

Bed Reservation

If an insured needs to go to a hospital during a nursing home stay, a bed reservation benefit will hold his bed at the nursing home. Without this benefit, the insured or his family would have to pay the nursing home or find a new one if the bed was given to someone else. Fourteen days might be a typical period of time that a bed reservation may be covered by a policy.

Assisted Living

Every long term care policy covering confinement in a nursing facility must cover ***assisted living care*** coverage in a residential care facility or a residential care facility for the elderly as defined in the Health and Safety Code. ***Assisted living facilities differ from nursing care in the degree of assistance needed. Outside California***, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support the need and care for impairment in activities of daily living or impairment in cognitive ability. These facilities must also provide 24 hour care, have trained and ready-to-respond employees on duty, provide three meals a day (including special diets) have agreements to ensure that residents receive needed medical services from a physician or nurse in case of emergency, and provide necessary assistance in the management of prescribed medications.

The minimum benefit for this optional coverage shall be no less than **70 percent** of the maximum benefit for institutional care. A residential care facility means a licensed facility providing on-going care and related services on a 24-hour basis with trained and ready-to-respond employees on duty at all times. All expenses incurred by an insured while confined in a residential care facility that are necessary to diagnostic, preventative, therapeutic, curing, treating, mitigating and / or maintenance-oriented shall be covered, not to exceed the maximum daily benefit. Eligibility for care in a residential care facility shall be no more restrictive than it is for home care benefits for both tax qualified and non-tax qualified policies.

Tax Qualified Benefit

Your client may be able to deduct part of the premium for a tax-qualified long-term care policy from their taxes as a medical expense. In addition, they are generally not required to claim your qualified long-term care policy benefits as taxable income. However, in the case of an indemnity policy, there is an annual dollar cap.

All policies sold before January 1, l997, are automatically tax-qualified. Policies sold on or after January 1, 1997, may be either tax-qualified or non-tax-qualified. To determine whether a policy is tax-qualified, look for a statement on the policy similar to this:

This policy is intended to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, Section 7702B(b)

Policies intended to be federally qualified long term care contracts must comply with ***IRS 97-31 definitions*** and provide that the ***chronically ill*** insured qualifies for benefits if there is:

- Impairment in two out of six activities (ambulating is now added to TQ policies in California) of daily living expected to last at least 90 days
- Impairment of cognitive ability needing substantial supervision

To claim a tax deduction for long-term care premium payments, your out-of-pocket medical expenses, including long-term care premiums, must be more than 7.5 percent of your adjusted gross income. The maximum amount of long-term care premium you can deduct depends on your age at the end of each tax year.

Home Modification

Some policies will pay for stair lifts, ramps, grab bars, and other forms of home alternation that allow an insured to better receive care at home.

Caregiver Training

Insurers are beginning to realize that good care can come from within an insured's family, especially if there is some training and/or reimbursement incentive. Some policies now allow this training under home care benefits. The daily benefit for informal care is typically one-half the home care benefit.

Waiver of Premium

Most companies offer a waiver of premium if confined to a nursing home for a specified period of time. This means that once this time requirement is met the insured will not have to pay any additional premiums on the policy until the confinement is over. Some policies will refund premiums to the insured if the insured is confined and the premiums are paid in advance, i.e. full years premium. A typical waiver of premium time requirement is 90 days. Some policies do not require these days to be consecutive.

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

Agent Responsibilities & Prohibitions

It should be clear at this time that the marketing of long-term care requires agent skills in many venues: Social Security, Medicare, Medi-Cal, physical and mental health assessment, public assistance, taxes, asset evaluation and more. In addition, agents must comply with on-going changes in policies and the law. This section deals with many ethical and legal decisions you will confront in marketing long-term care. Remember, you are guiding clients in a decision that may be one of the most important they will ever make.

Consumer Protection Issues You Should Know

The insurance producer has the ***duty of honesty, good faith and fair dealing***. In addition, he must make sure to avoid any of the following which shall be construed as being an unfair practice, unfair methods of competition, or unfair and deceptive acts (10234.8 CIC).

Following are a few examples of what not to do in the selling of long term care insurance:

- Making unfair or inaccurate comparisons
- Advising or selling excessive insurance
- Falsifying records for purposes of defrauding any company or person
- Misrepresenting insurance company assets
- Misrepresenting the terms of an insurance policy
- Rebating-giving something of value in order to induce someone to buy the insurance policy
- Defamation of any insurance company
- Using unverified numbers in advertising financial standings
- Replacing previously owned long term care policies unnecessarily
- Having a history of replacing policies with a high lapse rate
- Telling anyone that dividends are guaranteed
- Misleading anybody regarding estimating the amount of a potential dividend
- To make any misleading statement or representation in order to induce someone to buy an insurance policy
- Making any false or injurious statement about any insurance company.
- It is unlawful to try to induce a person to let their insurance policy lapse or be forfeited in order to purchase a new insurance policy
- Cannot imply, in any way, that your insurance policy is endorsed or guaranteed by any state or other governmental body.
- Using advertising materials that have not been reviewed or using unethical approaches to contact prospects.
- Failing to follow all California rules regarding disclosures, continuing education, buyer notification (including insurance shopper's guide), inquiries regarding client's existing insurance
- Lack of concern for suitability of the product sold to the actual needs of the client.

In addition to these unfair trade practices the following acts are prohibited:

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

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

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

Senior Marketing Abuse **--** Complicated policies loaded with fine print and the culpability of seniors as consumers could be fertile territory for abuse for some agents. Likewise, the mere expectation of needing long term care strikes at the heart of the elderly since it means a loss of one's health and independence. These are reasons why seniors are vulnerable and why you must be sure not to use scare tactics and stories of people being thrown out in the streets

because they lack long term care coverage and lack the financial ability to provide for themselves.

These are some of the same points that lead to the passage of California's ***SB 620*** in late 2003. While this bill did not specifically address long term care contracts, the potential abuse of marketing insurance to anyone over age 65 is clear:

- Advertisements directed to produce leads must disclose that an agent may ***contact*** that person if that is the fact.
- Emphasis is placed on the illegality of marketing materials that deceive or mislead the prospect as to the agent or company's true status, character or capacity. For example, it would be illegal under this legislation to use initials or logos similar to the Social Security Administration (SSA), that might induce someone into thinking that your company was somehow associated with the SSA.
- It is a violation to make a senior believe that he would lose some right, privilege or benefit if he fails to respond to your ad.
- ***Limits using terms like "seminar", "class" or "informational meeting"*** when the true intent is to present an insurance product.
- Want to ***visit a senior***? Under this legislation you must now deliver a notice to him in writing no less than 24 hours prior to any initial meeting. For pre-existing insurance relationship a notice must still be delivered prior to the meeting. And, at any time a senior request you to leave, you must do so immediately!

Virtually all forms of communication you have with your client are considered ***advertising***. And, when it comes to advertising, ***all*** statements, representations and sales presentations must be free from any form of information that can be construed as being misleading or untruthful in any way. Some examples include;

- All conversations regarding insurance must be identified by the agent as being ***insurance*** and cannot disguise the product.
- Sales promotions cannot be misleading in any way.
- The agent must fully disclose the name of the insurance company represented at all times.
- Agents must insure that when making presentations, in any type media, that the materials being used are truthful and all reacquired information is being disclosed.

Long Term Care Training (10232.93 CIC)

Long term care insurance companies in California must establish marketing procedures to assure that any ***comparison of policies*** by its agents will be fair and accurate AND that ***excessive insurance is not sold or issued***. Insurers must also submit to the Insurance Commissioner a list of all agents or other insurance representatives authorized to sell individual long term care insurance policies updated every six months.

Further, insurers must verify that their agents complete the following special ***continuing education*** requirements before they solicit individual consumers for the sale of long term care insurance:

- For ***junior agents*** (less than four years in business), eight hours of California-specific long-term care annually.
- For ***senior agents*** (more than four years in business). Eight hours of California-specific long term care by the end of each renewal period.

These education requirements are ***part of, not in addition to*** the 24 CE credits an agent must complete every two years.

Example: Agent Bob's license renews in December. After he completes an approved 8-hour long term care training course, he need only 16 hours of other CE credits to fulfill his 24 hour bi-annual requirement.

Agents selling the ***California Partnership*** must complete a different 8-hour training course in addition to the conventional 8-hour long term care course cited above before soliciting clients. Partnership training, however, is ***optional***.

Agents over 70 years of age, with 30 years or more of continuous licensing, may be waived from CE requirements. However, if this same agent is receiving LTC commissions or continuing to solicit LTC insurance he must continue to take the 8-hour LTC training every renewal period. Similarly, "***out-of-state***", non-resident licensees MUST complete LTC training even though they may be exempt from normal CE requirements through state CE ***reciprocity***.

LTC Suitability (10234.95 CIC)

In ***issuing and marketing*** long term care, agents must be informed about suitability standards for their clients. It is probable that your company has additional criteria on LTC suitability which you must ***understand and follow.*** One important fact to remember about any suitability guideline is that a determination that LTC is ***not applicable*** for a particular client should be respected. It is critical to conform your product recommendations to the ***applicant's goals or needs.*** Court cases against agents are growing daily where suitability issues were ignored, leading to unnecessary or inappropriate coverage and possible bad faith litigation.

Another basic concept in assessing suitability is the determination that the policy sold ***improved the insured's position***. It would be hard to defend a pattern of selling where policies resulted in client's receiving fewer benefits or the same benefits at an increase in premium.

The personal worksheet fills an ***important role***. This worksheet provides some ***minimum*** suitability guidelines agents should follow. However, if a prospect declines to sign it or provide financial information, agents or insurers must send the applicant a letter similar to the *"Long Term Care Insurance Suitability Letter"* contained in the Long Term Care Model Regulations of the National Association of Insurance Commissioners (see back of this book) as an alternative. This letter documents the need for obtaining information and runs down a list of things applicants should know before buying long term care coverage. Unless the client chooses to sign and return the form to proceed with the application, the application is automatically suspended.

The insurer shall ***report annually*** to the insurance commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter. NOTE: These rules do not apply to life insurance policies that accelerate benefits for long term care. Life policies with ***long term care riders are also exempt*** from these suitability standards.

Long Term Care Personal Worksheet (10234.95)

SB 1052 introduced an entire insurance code devoted to ***client suitability standards.*** Insurance companies must immediately develop and train agents in the use of suitability standards and make them available to the Insurance Commissioner. In determining client

suitability for long term care insurance or replacement/conversion of same, the agent and insurer shall consider the following:

1) The ability to pay (***affordability***) for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
2) 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;

3) The ***value***, 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.

In making a reasonable effort to determine a client's suitability for long term care coverage, the agent and insurer must address specific requirements concerning the NAIC Personal Worksheet, the disclosure of any potential rate increase and comply with HIPAA privacy restrictions.

The ***purpose*** of the long term care personal worksheet (see back of book for sample) is to gather sufficient information to determine if the client has sufficient income and assets to afford long term care insurance. How does the worksheet help the agent gauge suitability? The worksheet advises that if assets are less than $30,000, or more than 7 percent if income will be used to pay for LTC premiums, the applicant should consider other options to finance this care. If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has refused to provide the information, the application may be rejected

Agents ***must*** return three completed Personal Worksheets to his insurers prior to consideration of the application for coverage: one copy for the insurer; one for agent record keeping; and one for the consumer. The worksheet should be printed in not less than 12-point type and be filed and approved by the Commissioner.

Insurer's must rely on the worksheet for appropriateness of coverage. Group long term care applicants and life riders are exempt from this worksheet requirement. Of course, any ***information*** on the worksheet is ***confidential*** and must not be disseminated outside the company or agency.

Consumer Decline of Information (10234.95)

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. Alternatively, the issuers shall send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. 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.

30-Day Free Look

An applicant for a long-term care insurance policy or a certificate, other than an applicant for a certificate issued under a group long-term care insurance policy, shall have the right to return the policy or certificate by first-class United States mail within ***30 days*** of its ***delivery*** and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Policyowners shall be notified of this through a notice prominently printed of the first page of the policy or certificate.

The return of a policy or certificate shall void the policy or certificate from the beginning and the parties shall be in the same position as if no policy, certificate, or contract had been issued. All premiums paid and any policy fee paid for the policy shall be fully refunded directly to the applicant by the insurer within 30 days after the policy or certificate is returned.

Outline of Coverage

Agents are required to provide a prospective applicant for long term care insurance an Outline of Coverage (OOC) ***at the time of initial solicitation*** in such a way as to prominently direct the attention of the prospect to the document and its purpose, i.e., it should be a freestanding document. If the agent solicited the prospect, the agent must deliver the Outline of Coverage ***prior to*** the presentation of an application or enrollment form. In the case of a direct response solicitation, the Outline of Coverage must be provided ***along with*** any application or enrollment form.

The Outline of Coverage is a ***mandatory***, freestanding document (10 point or larger type) that should not include advertising and must provide the following information in the order in which it is given in the following section.

Minor changes in the OCC are allowed, but it must ***clearly*** identify the name, address, and telephone number of the insurance company. It must identify the policy as an individual or group coverage. It must also show the policy number or group master policy and certificate number.

On page one of the Outline of Coverage the following statement must be ***prominently displayed***:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

On the same page, AB 1483 requires the following words if the policy is intended to be a "tax qualified" contract as provided by Public Law 104-191 (HIPAA): (SECTION 10232.1a)

"This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits"

For a "non-tax qualified" policy, the words below must be prominently displayed:

"This contract for long term care insurance is not intended to be a federally qualified long term care insurance contract."

Page one of the Outline of Coverage must also display the words ***"Nursing Facility Only/Residential Care Facility Policy***" where a policy or certificate includes benefits which are limited to the provision of such institutional care. Likewise, where benefits are limited to the provision of home care services, the words ***"Home Care Only"*** shall be prominently displayed on page one of the form and the outline of coverage.

Policy Replacement

As we explained earlier, an insurer, broker, agent or other person is prohibited from causing a policyholder to replace a long term care insurance policy ***unnecessarily***. California law ***defines any third or greater policy sold to a policyholder in any 12-month period as unnecessary*** unless a policy is replaced for the sole purpose of consolidating policies with a single insurer.

A key determination in any decision regarding unnecessary replacement is whether or not the new policy ***improved the insured's position***.

Insurers are also duty bound to track the number of replacement policies each agent writes. Under State guidelines, insurers are required to grant policyholders ***premium credits*** for replacement of policies previously issued amounting to 5 percent of the annual premium for each year the previous policy was in force (not to exceed 50 percent of the previous premium). ***Example:*** Old Policy -- Premium of $1,000 annually versus a New Policy -- Premium of $1,500 annually. The credit is 5% for each full year of premiums paid. So, an individual with a six-year-old policy would have a $300 credit (6 years X .05= .30 X $1,000 old premium = $300. If the old policy were twelve years old, the credit would $500 calculated at (12 years X .05= .60 X $1000 = $600. However, this exceeds the 50% of old premium rule so it is reduced to $500).

In ***any replacement situation***, keep in mind that agent ***commissions are restricted*** to the difference between replacement and original coverage so long as the insurer declares that a "material improvement" in policy benefits has taken place. Commission or compensation includes remuneration of any kind, including, but not limited to bonuses, gifts, prizes, awards and finder's fees. Commission structures and any amendments must be filed with the commissioner before implementation or within six months of code changes.

Replacement Notice (10235.16 CIC)

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

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

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

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

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an

application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____(Date)

_____
(Applicant's Signature)"

For group coverage not subject to the 30-day return provision of Section 10232.7, the notice shall be modified to reflect the appropriate time period in which the policy may be returned and premium refunded.

The replacement notice shall include the following statement except when the replacement coverage is group insurance as described in subdivision (a) of Section 10231.6:

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

____ Additional or different benefits (please specify) _____.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other (please specify) _____.

_____
(Signature of Agent and Name of Insurer)
_____
(Signature of Applicant)
_____
(Date)

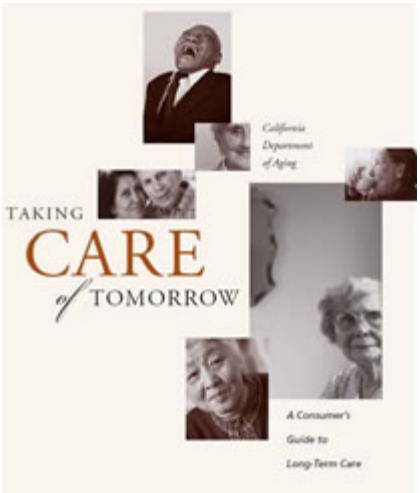
Consumer Protection

Every application for long-term care insurance shall include a checklist that enumerates each of the specific documents that this chapter requires be given to the applicant at the time of solicitation. The documents and notices to be listed in the checklist include, but are not limited to, the following:

(1) The "Important Notice Regarding Policies Available" pursuant to Section 10232.25.

(2) The outline of coverage pursuant to Section 10233.5.

(3) The HICAP notice pursuant to paragraph (8) of subdivision (a) of Section 10234.93. Long term applicants must be advised where to go for additional long term care information and advice. Agents must provide the California Department of Insurance ***toll free consumer service phone . . . (800) 927-HELP*** as well as the location and phone of ***HICAP . . . (800) 434-0222.*** They help seniors and others review life insurance policies, file



medical claims, advise on long term care services and counsel on other consumer health concerns.

(4) The California Department of Aging's ***Taking Care of Tomorrow Booklet***.: A basic consumer's guide to long term care. This booklet can be accessed at www.aging.ca.gov.

(5) The "Long-Term Care Insurance Personal Worksheet" pursuant to subdivision (c) of Section 10234.95.

(6) The "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance" pursuant to Section 10235.16 if replacement is not made by direct response solicitation or Section 10235.18 if replacement is made by direct response solicitation. Unless the solicitation was made by a direct response method, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

(7))If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim, upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence shall:

(8) Rights to reduce, add, or purchase new coverage (10235.50 CIC)

(9) Rights to choose a paid-up benefit following a rate increase (10235.35 CIC).

(10) Right to request and receive a sample (specimen) policy (10234.93 CIC)

(11) Right to appeal contract language, decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments.(10235.94 CIC)

(12) Agents shall not ***unnecessarily*** replace a client's long term care insurance policy (10234.85 CIC)

(13) Insurers must provide the Commissioner copies of all LTC advertisements and ads must prominently disclose that "an agent will contact you" if that is the case. Agents who do make contact from a cold lead device must also disclose this immediately (10234.9 CIC)

(14) Agents and insurers must determine and uphold client suitability standards, a client's ability to pay, the applicant's long term care goals, the real value and benefits of any existing policies, personal LTC worksheet, rate guide, and the duty to disclose that NO LTC is necessary (10234.97 CIC)

(15) Agents must maintain records pertaining to, but not limited to, all client applications, types of policies issued, premiums, commissions, correspondence, illustrations, etc for a minimum of five years.

(16) Advise applicants about the ***long term care rate guide***, prepared by the insurance commissioner. This guide details a history of the rates for all policies issued in California for the current year and for four preceding years, and a comparison of the policies, benefits, and sample premiums for all policies currently being issued for delivery in California. It compares the different types of long-term care insurance and coverages available to California consumers and a specimen outline of coverage for each product currently marketed by each insurer listed in the rate guide, as well as, a premium history of each insurer that writes long-term care

policies for all the types of long-term care insurance and coverages issued by the insurer in California.

Product Issues

Additional issues agent must know and disclose to long term care applicants include the following:

Maximum Benefit 10232.93): Policies and agents need to distinguish between the maximum benefit amount which MUST be disclosed in the policy as a single dollar amount or ***pool of money*** And the fact that there is ***no limit*** on any specific covered benefit except for a daily, weekly or monthly limit set for home/community care and for assisted living or institutional care. In addition, clients need to know that any unused benefits remain available.

Minimum Home Care Standards (10232.9): Clients should be apprised that every long term care policy that purports to provide benefits of home care or community-based services shall at least provide: home health care, adult day care, personal care, homemaker services, hospice services and respite care.

Ancillary Supplies and Services (10232.95): Long term care policies that provide reimbursement for care in nursing facilities must cover and reimburse for per diem expenses as well as ancillary supplies and services up to, but exceeding the lifetime daily facility benefit amount.

Prexisting Conditions: No long-term care insurance policy or certificate other than a group policy or certificate, shall use a ***definition*** of preexisting condition which is 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. ***Every long-term care insurance policy or certificate shall cover preexisting conditions*** that are ***disclosed on the application no later than six months following the effective date of the coverage*** of an insured, regardless of the date the loss or confinement begins. The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

Preexisting Conditions in Replacement Policies: State law provides that a replacement LTC policy or certificate may not contain new preexisting conditions or probationary periods.

Residential Care Facility Required: Every long term care policy covering confinement in a nursing facility must cover ***assisted living care*** coverage in a residential care facility or a residential care facility for the elderly as defined in the Health and Safety Code. An ***assisted living provider*** is defined as facilities / homes that provide 24 hour care, have trained and ready-to-respond employees on duty, provide three meals a day (including special diets) have agreements to ensure that residents receive needed medical services from a physician or nurse in case of emergency, and provide necessary assistance in the management of prescribed medications. ***Outside California***, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support the need and care for impairment in activities of daily living or impairment in cognitive ability.

Out-of-Pocket Expenses: Agents need to know and explain to applicants that any out of pocket expenses they make toward their long term care do not reduce policy benefits they receive.

Inflation protection: Inflation protection can be a valuable option to recommend, although expensive. Where inflation protection coverage is refused, agents must now obtain a ***special waiver.*** Further, a special graphic comparison of the benefit levels with and without inflation protection must be shown.

Commissioner Waiver: The state commissioner has the power to waive a specific provision in a specific long term care policy if it is found to be in the interest of the insured or it is determined to be reasonably necessary.

Rate Stabilization

A potential "black eye" for the long-term care insurance industry is uncontrolled, rampant ***premium increases***. The problem is that companies are unwilling to guarantee long term care insurance rates far into the future because they have too little data to accurately predict how many people will file claims, how large those claims will be and how many people will let their policies lapse. Insurers do promise they will not raise premiums due to age or health for existing policyholders, but that does ***not guarantee*** that the premium will stay the same. While insurers do not raise ***individual policyholder premiums*** they can and do raise rates for policyholders ***as a class***. A class of business might be considered all retired teachers in the state of California who are over the age of 73. The most painful example involves 6,000 people holding policies from United Equitable, an early seller in the business. In some states, these policyholders have experienced rate increases of 100 percent or more.

Many states do not track premium increases but they have been estimated to be, on average, between 25 and 100 percent since the 1980's. Worse yet, because insurers may raise rates in one state and not another, and because there is little information on the subject, it's impossible to pinpoint companies most likely to raise rates. That makes things tough for consumers and agents alike.

Company Responsibilities

Rate stability is one of the most ***important regulatory issues*** in long term care insurance. Unlike regular health insurance, LTCI ***pre-funds*** an event that, for the most part, occurs once -- an much later in life. Policyholders, typically pay premiums for 15 years or more, before accessing benefits. Since many long term care insurance buyers are on fixed incomes, a large rate increase can often compromise their ability to keep their policies. This can result in years of premium payments lost and an uncovered long term care event.

The California rules and regulations are complex. In a nutshell:

- All new business premiums must be submitted to the State (10236.1 CIC)
- Rate revisions filed on or after January 1, 2010, shall have benefits deemed reasonable in relation to the premium if the premium rate schedules have a lifetime expected loss ratio of at least 60 percent of the premium scale in effect on December 31, 2009, plus 70 percent of premium increases filed on or after January 1, 2010, calculated in a manner that provides for adequate reserving of the long-term care insurance risk (10236.1 CIC)
- Rate increases are subject to California Department of Insurance approval (10236.13 CIC)
- If an insurer increases premiums beyond a specific percentage, an insured can choose to either reduce their benefits or elect to stop paying premiums and retain a reduced level of coverage (nonforfeiture).

- What rates are stabilized? Rate stabilization targets the insurer's actuarial certification that long term care policy premium rates are sufficient to cover anticipated costs under moderately adverse experience, and that the rates are reasonably expected to be sustainable over the life of the policy form with no future premium increases expected.
- There is also a ***Contingent Nonforfeiture Benefit*** that is often included in most tax qualified policies that provides for a "shortened benefit period" only in the case that the insurance company raises it's rates beyond a certain percentage point based on the age you are when the policy goes into effect.

  For example, if you are 65 when you buy the LTCi policy it may stipulate that the insurance company may not raise the rates more than 60% beyond the original premium. So if the insurance company raised it's rates significantly and went past that point, you could elect to cancel coverage and still have paid-up coverage based on the shortened benefit period descibed above. This kind of nonforfeiture benefit is usually built into many tax qualified policies these days and does not cost more.

  The main difference between the two nonforfeiture benefits is that in the case of the one where you pay extra for it, you have to cancel the policy in order to trigger it. In the case of the contingent nonforfeiture benefit, the insurance company triggers that option if it raises rates significantly above your original premium.

Agents & Rate Stability

At a minimum, agents should caution clients that premiums may rise -- as much as 50 percent. Additionally, agents should advise consumers that information on rate increases and other important long term care insurance coverage issues is available in the ***Long Term Care Consumer Rate Guide.***

The ***purpose*** of providing an unbiased rate guide is to help consumers understand the potential for premium increases before they purchase long term care insurance. In California, the insurance commissioner prepares and updates a Consumer Rate Guide ***annually***.

Rate stability and client suitability standards go ***hand in hand*** because part of determining that an LTC plan is right for a consumer is knowing he can afford them today and in the future if premiums rise. California's SB 1052 introduced an entire insurance code devoted to *client suitability standards*. Insurance companies must immediately develop and train agents in the use of suitability standards, which reflect the ***1996 National Association of Insurance Commissioners (NAIC) Suitability Standards***, and make them available to the Insurance Commissioner. In determining client suitability for long term care insurance the agent and insurer shall consider the following:

1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
2) 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;
3) The value, benefits and costs of the applicant's existing insurance, if any, when compared to the benefits and costs of the recommended purchase or replacement.

The ***recommended method*** to obtain this information includes a presentation to the applicant, at or prior to the application, of the *"Long Term Care Personal Worksheet"* contained in the Long Term Care Model Regulations of the National Association of Insurance Commissioners. The purpose of the NAIC worksheet (see back of book for sample) is to gather sufficient information to determine if the client has sufficient income and assets to afford long term care insurance.

The worksheet advises that if assets are less than $30,000, or more than 7 percent if income will be used to pay for LTC premiums, the applicant should consider other options to finance this care. Agents may use suitability standards in their marketing.

The proposed worksheet used by the insurer in issuing and marketing and shall contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type and be filed and approved by the Commissioner.

A completed worksheet shall be returned to the issuer by the agent prior to the issuer's consideration of the application for coverage. Insurer's must rely on the worksheet for appropriateness of coverage. Group long term care applicants and life riders are exempt from this worksheet requirement. Of course, any information on the worksheet is confidential and must not be disseminated outside the company or agency.

If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has refused to provide the information, the application may be rejected.

Alternatively, issuers may send the applicant a letter similar to the *"Long Term Care Insurance Suitability Letter"* contained in the Long Term Care Model Regulations of the National Association of Insurance Commissioners (see back of this book). This letter documents the need for obtaining information and runs down a list of things applicants should know before buying long term care coverage. Unless the client chooses to sign and return the form to proceed with the application, the application is automatically suspended.

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.

The insurer shall report annually to the insurance commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter. NOTE: These rules do not apply to life insurance policies that accelerate benefits for long term care.

More On California Rate Stability -- SB 898

Senate Bill 898 is a rate stabilization bill that goes beyond the NAIC model to create one of the Nation's more stringent standards for long-term care insurance premium pricing and regulation. Here is a short review of its provisions:

- The premium rates for policies issued after January 1, 2003 (or, in some cases July 1, 2003) are subject to actuarial review by the Department.
- Rate increases on policies will be subject to additional review and justification requirements.
- Clients who purchase a policy which uses pre-SB 898 rates, must be offered the SB 898 rates/policy within 12 months of the availability of the new SB 898 policy (underwriting may be required).

The California rules cover the following:

1. Initial Loss Ratio: Expected loss ratio based on at least 58%, calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(a) Statistical credibility of incurred claims experience and earned premiums.
(b) The period for which rates are computed to provide coverage.
(c) Experienced and projected trends.
(d) Concentration of experience within early policy duration.
(e) Expected claim fluctuation.
(f) Experience refunds, adjustments, or dividends.
(g) Renewability features.
(h) All appropriate expense factors.
(i) Interest.
(j) Experimental nature of the coverage.
(k) Policy reserves.
(l) Mix of business by risk classification.
(m) Product features, such as long elimination periods, high deductibles, and high maximum limits.

2. Initial rate filings must be ***certified by an actuary*** performing the review to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated. The certification may rely on supporting data in the filing. The actuary performing the review may request an actuarial demonstration that the assumptions the insurer has used are reasonable. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and creditable data from other studies, or both. An actuarial certification consisting of at least all of the following:

(A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.
(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration.
(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.
(D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include all of the following: (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held. (ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience. (iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted). (iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if that statement cannot be made, a complete description of the situations in which this does not occur and the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subdivision (a) based on a standard age distribution.
(E) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. (c) Premium rate schedules and new policy forms shall be filed by January 1, 2002, for all group long-term care insurance policies that an insurer will offer, sell,

issue, or deliver on or after January 1, 2003, and for all previously approved individual long-term care insurance policies that an insurer will offer, sell, issue, or deliver on or after January 1, 2003, unless the January 1, 2002, deadline is extended by the commissioner. Insurers may continue to offer and market long-term care insurance policies approved prior to January 1, 2002, until the earlier of (1) 90 days after approval of both the premium rate schedules and new policy forms.

3. All ***actuaries*** used by the commissioner to review rate applications submitted by insurers pursuant to this chapter, whether employed by the department or secured by contract, shall be members of the American Academy of Actuaries with at least five years' relevant experience in long-term care insurance industry pricing. If the department does not have actuaries with the experience required by this section, the commissioner shall contract with actuaries to review all rate applications submitted by insurers pursuant to this chapter. If the department has actuaries that have experience required by this section, but not enough of those experienced actuaries to perform the volume of work required by this chapter, the commissioner may contract with independent actuaries, as necessary. If the commissioner contracts with independent actuaries, the commissioner shall promulgate regulations no later than January 1, 2002, to maintain the confidentiality of rate filings and proprietary insurer information and to avoid conflicts of interest.

4. No insurer may increase the premium for an individual or group long-term care insurance policy or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner. The insurer shall submit to the commissioner for approval all proposed premium rate schedule increases, including at least all of the following information: (a) Certification by an actuary, who is a member of the American Society of Actuaries and who is in good standing with that society, that: (1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated. (2) The premium rate filing is in compliance with the provisions of this section.

5. An ***actuarial memorandum*** justifying the rate schedule change request that includes all of the following: (1) ***Lifetime projections*** of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale. (A) Annual values for the five years preceding and the three years following the valuation date shall be provided separately. (B) The projections shall include the development of the lifetime loss ratio. (C) For policies issued with premium rate schedules approved, the projections shall demonstrate compliance with subdivision (D) In the event the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, then: (i) The projected experience should be limited to the increases in claims expenses attributable to the changes in law or regulations. (ii) In the event the commissioner determines that potential offsets to higher claims costs may exist, the insurer shall be required to use appropriate net projected experience. (2) ***Disclosure of how reserves*** have been incorporated in this rate increase. (3) ***Disclosure of the analysis*** performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary. (4) A statement that ***policy design***, underwriting, and claims adjudication practices have been taken into consideration. (5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file ***composite rates*** reflecting projections of new certificates.

6. Approval of all premium rate schedule increases shall be subject to the following requirements: (a) Premium rate schedule increases shall demonstrate that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following: (1) The accumulated value of the initial earned premium times 58 percent. (2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis. (3) The present value of future projected initial earned premiums times 58 percent. (4) Eighty-five percent of the present value of future projected premiums not in paragraph (3) on an earned basis. (b) In the event the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, a premium rate schedule increase may be approved if the increase provides that 70 percent of the present value of projected additional premiums shall be returned to policyholders in benefits and the other requirements applicable to other premium rate schedule increases are met. (c)

7. All present and accumulated values used to determine rate increases should use the maximum valuation interest rate for contract reserves. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

8. No approval for an increase in the premium schedule shall be granted unless the actuary performing the review for the commissioner certifies that if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated. The certification may rely on supporting data in the filing.

9. Premium rate schedule increases that have been approved shall be subject to updated projections, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years. If the commissioner has determined that the actual experience following a rate increase does not adequately match the

   projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums, the commissioner may require the insurer to reduce the difference between the projected and actual experience. If the commissioner demonstrates, based upon credible evidence, that an insurer has engaged in a persistent practice of filing inadequate premium schedules, the commissioner may prohibit the insurer from filing and marketing comparable coverage for a period of up to five years or from offering all other similar coverages, and may limit marketing of new applications to the products subject to recent premium rate schedule increases. This shall not apply to life insurance policies and certificates that accelerate benefits for long-term care.

The thrust of these aggressive requirements is to make insurers ***accountable*** for designing and pricing long term care plans with a reasonable chance of surviving claims. The goal is to set premiums that will remain stable for the longest possible time. The demand for actuarial compliance and review in the California SB 898 requirements raises the bar on NAIC Model rate stability evaluation.

Chapter 6

Administration and Enforcement

Authority

Violation of any long term care insurance law is a serious matter. The Insurance Commissioner has the ***administrative authority to assess penalties, authorize a private right of action and order reasonable attorney fees to the prevailing party.***

The Insurance Commissioner may also ***authorize actions for code violations against an insurer or agent by district attorneys, attorney general and city attorneys.***

These actions and authorities can be found in the ***California Insurance Code, Section 10234***.

Further, the commissioner may waive a specific provision or provisions with respect to a specific long-term care insurance policy or certificate as long as:

(a) The waiver would be in the best interest of the insureds.
(b) The policy or certificate could not be effectively or efficiently achieved without the waiver.
(c) The waiver is necessary to the development of an innovative and reasonable approach for insuring long-term care.
(d) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the waiver is reasonably related to the special needs or nature of such a community.
(e) The waiver is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Penalties (See Attachment III)

Policyholders have a right to bring ***action*** against agents with an award of reasonable attorney fees to the prevailing party. Also, the Attorney General, District Attorney or any City Attorney may bring an action against an agent or insurance company upon demonstrating that a law has been broken.

Any resulting monetary penalties that are already "built-in" to existing law include the following:

Agents
* $250 for first violation
* $1,000 for subsequent or knowing violation
* $5,000 for inappropriate policy replacement
* Maximum $25,000 per violation

Insurers
* $5,000 for first violation
* $10,000 for subsequent or knowing violation
* $10,000 to $500,000 for business practice infractions

These penalties are paid directly into to the State's ***Insurance Fund***.

There are also ***non-monetary penalties*** that may be invoked such as ***suspension or revocation of license, suspension of the insurer's Certificate of Authority to do business and/or an order to cease marketing or cease activity.*** Anyone charged with a violation of long term care insurance laws is afforded due process.

Before any license action an agent must be ***notified in writing*** (by registered mail) the action proposed and the facts surrounding the charge. He is entitled to ***respond*** to the charge in writing and/or request a ***public hearing*** before the Administrative Law Bureau ***within 30 days***. After which, the commissioner issues a ***final order***, the contents of which may or may not assess a penalty or remedy. Even after an ALB hearing, the commissioner ***retains rights*** to assess penalties and remedies as above. A long term care task force has also been created to report on code violations and make recommendations on future changes and additions to the law.

In addition to the controls above, the Department of Insurance retains rights for an Administrative Procedure Act hearing (Section 11370 of the Government Code) to issue, amend or clarify code regulations. The procedure for an APA hearing involves a 30 day notification. If the action involves a "cease and desist" order to an agent or insurer, a hearing with the Commissioner may be requested.

Lapse and Replacement

Special rules clearly target the exposure of agents with ***higher-than-normal policy replacements*** and lapses. While replacement and lapses do not alone constitute a violation of insurance law, it is clear the DOI wants to monitor potential abuses more closely. Further, with mandatory premium credits in place it may be economically unfeasible for agents to consider or recommend aggressive replacement of previous policies unless warranted.

Rules governing replacement and the consequences of such an action depend on when the policy was issued. In general, an insurer, broker, agent or other person is prohibited from causing a policyholder to replace a long term care insurance policy unnecessarily. In California, the code also presumes that ***any third or greater policy sold to a policyholder in any 12-month period is unnecessary*** unless a policy is replaced for the sole purpose of consolidating policies with a single insurer. Under new guidelines, insurers are required to grant policyholders ***premium credits*** for replacement of policies previously issued amounting to 5 percent of the annual premium for each year the previous policy was in force (not to exceed 50 percent total). Further, insurers are required to "track and report" a list of the top 10% of agents with active policy lapse ratios**.**

How are replacement and lapse experience monitored? Through required reporting by your insurer. Here are the requirements they must follow:

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

- Every insurer shall report annually by June 30, the 10 percent of its agents in the state with the ***greatest percentage*** of lapses and replacements.

- Every insurer shall report annually by June 30, the number of ***lapsed policies*** as a ***percent of its total annual sales*** in the state, as a percent of its total number of policies in force in

the state, and as a total number of each policy form in the state, as of the end of the preceding calendar year.

- Every insurer shall report annually by June 30, the ***agents with greatest lapse*** and replacement rate, ***percentage of lapsed policies*** and ***percentage of replacement policies*** sold as a percent of its total annual sales in the state and as a percent of its ***total number of policies in force*** in the state as of the end of the preceding calendar year.

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

Chapter 7
Advertising and Marketing

Advertisment Filings

Every insurer providing long-term care coverage in California shall provide a copy of ***any advertisement*** intended for use in California to the commissioner must be filed for review ***at least 30 days before dissemination***. The advertisement shall comply with all laws in California. In addition, the advertisement shall be retained by the insurer in accordance with Section 10508 for at least three years. Agents do not necessarily file advertising with the California Department of Insurance. However, agents do sign agency agreements that may require all ads be reviewed by the insurer's compliance department prior to dissemination to clients.

Specific Language

Advertisements directed to produce leads from any person over age 65, must contain specific language and specifically disclose that ***an agent may contact*** that person if that is the case. There is also emphasis on the illegality of marketing materials that deceive or mislead the prospect as to the agent or company's true status, character or capacity. For example, it would be illegal under this legislation to use ***initials*** or logos similar to the Social Security Administration (SSA), that might induce someone into thinking that your company was somehow associated with the SSA. It would also be in violation to make a senior believe that he would lose some right, privilege or benefit if he fails to respond to your ad. There are also ***limits on advertising "seminars", "classes" or "informational meetings"*** when the true intent is to present an insurance product. Want to visit a senior's home? Under this legislation you must now deliver a notice to him in writing no less than 24 hours prior to any initial meeting. For pre-existing insurance relationship a notice must still be delivered prior to the meeting. And, at any time a senior request you to leave, you must do so immediately!

Internet Advertising

A person who is licensed in this state as an insurance agent or broker, advertises insurance on the Internet, and transacts insurance in this state, shall identify all of the following information on the Internet, regardless of whether the insurance agent or broker maintains his or her Internet presence or if the presence is maintained on his or her behalf:

(1) His or her name as it appears on his or her insurance license, and any fictitious name approved by the commissioner.
(2) The state of his or her domicile and principal place of business.
(3) His or her license number.

A person shall be deemed to be transacting insurance in this state when the person advertises on the Internet, regardless of whether the insurance agent or broker maintains his or her Internet presence or if it is maintained on his or her behalf, and does any of the following:

(1) Provides an insurance premium quote to a California resident.
(2) Accepts an application for coverage from a California resident.
(3) Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

Insurer Marketing Practices

Regarding long term care insurance ***marketing guidelines***, every insurer of long-term care in California shall establish ***auditable procedures,*** including but not limited to the following:

- Establish marketing procedures to assure that any ***comparison of policies*** by its agents or other producers will be fair and accurate.
- Establish marketing procedures to assure ***excessive insurance*** is not sold or issued.
- Submit to the commissioner within six months of the effective date of this act, a ***list of all agents*** or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.
- Provide ***training*** and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete ***8-hour training requirements*** that, for resident licensees, shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section.
- Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: ***This policy may not cover all of the costs*** associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
- No insurer, broker, agent, or other person shall cause a policyholder to ***replace a long term care insurance policy unnecessarily***. Nothing in this section shall be construed to allow an insurer, broker, agent, or other person to cause a policyholder to replace a long term care insurance policy that will result in a decrease in benefits and an increase in premium.
- Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.
- Every insurer shall provide to a prospective applicant, at the time of solicitation, ***written notice that the Health Insurance Counseling and Advocacy Program (HICAP)*** provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.

Agent Responsibilities

These were discussed in detail in an earlier section. In a nutshell, ***agents should***:

- Provide fair and accurate comparisons.
- Sell to a client's goals and needs without selling excessive insurance.
- Determine an applicant's existing coverage
- Provide the California Department of Aging shoppers guide prior to an application

Agents ***should not*** be involved in the following advertising practices:

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

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

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

Chapter 8
The California Partnership

Introduction

In September 1994, California implemented a major new program to help people with moderate incomes and assets purchase high quality long-term care (LTC) insurance.

This program, known as the California Partnership for Long-Term Care (CPLTC or Partnership), is a partnership between the State of California and select insurance companies that offer policies containing special consumer protections.

This program also provides education to consumers and special support to insurance agents in an effort to help individuals realize their potential risk of needing LTC, and how high quality LTC insurance provides a viable option for funding these costs.

What Is Special About the California Partnership

- Partnership product allows a dollar-for-dollar offset of benefit with Medi-Cal spend-down recovery, i.e., partnership insured's have some protection against losing all their assets in the event of a long term care issue.

- The Partnership product is only appropriate for a narrow segment of individuals who fit a certain income and asset profile . . . typically, moderate income individuals.

- Special Partnership certification (training) is required in order to sell Partnership product. This involves and initial 8-hour "classroom only" course and classroom continuing education.

How Does This Partnership Work?

While the Partnership policy is attractive to wealthier purchasers who tend to buy lifetime coverage, its special asset protection feature is important to people who can only afford policies of shorter duration. The asset protection feature of this program is its guarantee that the State and Federal Government will provide a financial back stop should the LTC benefits provided by a Partnership policy be insufficient to meet the needs of the purchaser. Individuals who buy Partnership policies are entitled to keep additional assets equal to the amount their policy pays out, should they ever need to apply for Medi-Cal for health or LTC benefits. In the absence of such protection, single individuals can only retain $2,000 in non-exempt assets in order to qualify for Medi-Cal benefits. This special asset protection helps assure consumers who can only afford premiums for a one or two-year policy, that should they exhaust their policy benefits they won't have to become impoverished before they can receive Medi-Cal benefits. Individuals who purchase Non-Partnership policies and use up their policy benefits must "spend down" their assets to poverty level in order to receive Medi-Cal assistance.

This special asset protection provision, only available in Partnership policies, provides one dollar of asset protection for each dollar paid out in Partnership policy benefits. This $-for-$ protection allows for a variety of product designs ranging from one year to lifetime coverage. The Partnership policies offer everyone high quality benefits and $-for-$ asset protection against the costs of LTC, including consumers who can afford lifetime coverage. Most important, however, Partnership policies provide people with moderate incomes the option of choosing a

shorter duration policy with the “high quality protection” they need and can afford, and eliminate the fear they might end up in poverty because their LTC costs used up their policy benefits. The purchase of "high quality protection,” which includes such provisions as automatic built-in inflation protection, adequate daily per diem, a “monthly” rather than a “daily” cap on home and community-based benefits, care management, etc., is a major objective in the design of the Partnership product. Middle-income individuals with LTC insurance policies without these protections are at serious risk of depleting their policy benefits, becoming impoverished, and having to turn to Medi-Cal to pay their ongoing LTC costs, in spite of having purchased LTC insurance.

The impoverishment protection offered by Partnership policies provides an especially good option for the elderly, who are often less able to afford longer duration high quality policies of four years or more. Here are a few examples on how the Partnership’s special asset protection feature works:

TABLE 1
California Partnership for Long-Term Care

Assets	LTC Insurance Payouts	Medi-Cal Spend Down Requirement
Person A	$50,000	$50,000	$0
Person B	$200,000	$200,000	$0
Person C	$1,000,000	$500,000	$500,000
Person D	$200,000	$0	$200,000

In Table 1:

Person A is an unmarried man with $50,000 of savings that would have to be “spent down” to $2,000 to qualify for Medi-Cal. Without LTC insurance, this person could quickly wipe out his savings should LTC be required. Person A, however, purchased a Partnership plan that would pay out $50,000 of benefits, the average costs of a nursing home in his community for a year. Person A uses up all $50,000 of insurance benefits and still needs nursing home care. In applying for Medi-Cal, Person A shows the eligibility worker a form issued by his insurance company indicating a total of $50,000 of Partnership insurance benefits were paid out. Medi-Cal will allow Person A to keep $50,000 in additional savings and still qualify for Medi-Cal. Person A is in a nursing home for a year and a half after applying for Medi-Cal, during which time Medi-Cal paid out $40,000 worth of claims for LTC and other medical costs. At the time of Person A’s death, Medi-Cal begins action to collect from his estate. However, once again, Medi-Cal recognizes that Person A received $50,000 of Partnership insurance benefits, which protected an equal amount of his estate against Medi-Cal estate collection. Person A is able to pass on $50,000 in inheritance to his heirs.

Person B has $200,000 of savings and chose to purchase a Partnership policy that would pay out $200,000 worth of benefits, about 4 years of today’s nursing home costs in Person B’s community. Unfortunately, Person B ended up receiving services in her home for a year before spending the last 7 years of her life in a nursing home. The policy benefits of $200,000 were used up after about 4 years. When she applied for Medi-Cal she was able to keep an additional $200,000 of savings, and this amount was protected from Medi-Cal recovery in her estate at the time of her death. The money was used to provide for her granddaughter’s college education.

Person C anticipated having assets of $1,000,000 by the time she might need LTC, but chose to protect only a portion of her assets by purchasing a Partnership policy that would pay out $200,000 in benefits. Person C did not need her policy benefits for about 20 years after she purchased the policy. Because of the automatic inflation protection built into the Partnership

policy, both the value of the Partnership benefits and the amount of asset protection had grown to $500,000 by the time she went into a nursing home, where she remained for four years before her policy was exhausted. Person C was allowed to keep $500,000 of additional assets at the time she qualified for Medi-Cal. In addition, at the time she passed away Medi-Cal exempted from recovery $500,000 of her estate.

Person D represents an individual who either did not purchase LTC insurance or bought a non-Partnership policy. Person D ended up needing to apply for Medi-Cal to pay his ongoing nursing home costs. However, he was required to “spend down” his non-exempt assets to only $2,000 before becoming eligible for Medi-Cal. His home was considered “exempt” property and was disregarded for the purpose of qualifying for Medi-Cal. When he died Medi-Cal placed a lien against his home, in order to recover the value of the Medi-Cal claims paid during the time he was in the nursing home.

To really appreciate the above examples, it is important to understand the basics of how Medi-Cal eligibility and estate recovery works. Under current law, $2,000 of assets is disregarded as “exempt property” in determining a single person’s eligibility for Medi-Cal. The Medi-Cal applicant’s residence can also be disregarded, as well as one car and a limited number of other assets. Additional assets can be retained if an individual is in a nursing home and his or her spouse is living in the community. The asset protection provided by the Partnership is in addition to any other assets Medi-Cal allows a person to keep and still qualify for Medi-Cal.

What Other Policy Provisions are Unique to Partnership Products?

While the Partnership policy offers excellent protection for everyone, it is specifically designed for individuals with moderate incomes who are unlikely to be able to afford significant rate increases, or out-of- pocket expenses at the time they need LTC benefits. The following provisions are, therefore, included in all Partnership policies:

1) Required inflation protection is set at 5 percent compounded annually. Persons 70 years of age or older have a choice between a 5 percent compound or a 5 percent simple annual inflation adjustment. This inflation protection not only helps minimize out of pocket expenses due to inflation, but also proportionately increases the level of asset protection.

2) Policies can not be sold that provide less than 70 percent of the average daily nursing home costs in the State. For example, in 2009, the average daily private pay rate (ADPPR) for nursing facility care is $220. However, while the 2009 ADPPR for nursing facility care is $220, the minimum daily benefit for Partnership policies that can be sold in California is $150 with a $105 (70 percent) Residential Care and Assisted Living Benefit

3) The home and community-based care benefit in the Partnership Comprehensive policy is capped as a “monthly” rather than a “daily” benefit. As an example, a policyholder buys a Comprehensive Policy with a home and community-based care benefit of $55 a day. A person needing home care seldom uses a fixed amount per day. With a “monthly” cap, the policyholder has a $1,650 bucket of money to be used for home care ($55 X 30 days in the month). This provides a flexible way for the policyholder to combine the availability of informal care with formal care, and reduce or avoid out of pocket expenses while maximizing the policy benefits.
4) Care Management/Care Coordination, independent of the insurance company, provides all policyholders with the benefit of having a qualified licensed health care professional evaluate their need for care, and, with the policy holders input, develop a plan of care which lists informal and formal services necessary to help them maintain as much independence in the most efficient way possible. All treatment plans must include a non-inclusive list of providers in the community appropriate to provide the necessary care. Policyholders can also choose to have the care manager/care coordinator help them access the care and monitor the appropriateness

of that care. This benefit helps maximize the value of the policy benefits, as well as provide assistance to an individual and most often a family during a time of crisis. Care Management Provider Agencies providing services to Partnership policyholders must be approved by the Partnership to assure they have staff with the appropriate experience and credentials, as well as methods to assure the quality of their services. The State of California has no regulatory oversight of care management organizations other than those that provide services to Partnership policyholders.

5) Prior to 2002 the Department of Insurance (DOI) policy approval process only included the review of policy premiums and actuarial memorandums for Partnership policies. Subsequently, the DOI reviews all policies' premiums and actuarial memorandums. There are requirements that any request for Partnership rate increases are based on the entire pool of Partnership purchasers, and be subject to a rate cap. Partnership regulations provide for the DOI to disapprove a Partnership policy filing by a company with a history of rate increases.

6) Provisions related to protecting the policyholder against possible lapse were championed by the Partnership, and are now required in all policies being marketed in California.

7) All Partnership policies have the benefit of a stringent review by expert staff at the Department of Heath Care Services (DHCS). In addition, a review is completed on all policies by the DOI to help assure provisions are accurately described in a way that is most understandable by the consumer.

8) In September 2008, California Senate Bill 483 (Chapter 379, Statutes of 2007-2008), was signed by the Governor to implement 2006 changes to federal law. Those federal changes limit the amount of equity individuals can have in their principal residence and receive medical assistance for home and facility care services under the Medi-Cal program. In SB 483, California exercised its option to increase the equity limit from the federal minimum of $500,000 to $750,000. SB 483 goes even further by providing complete protection from the equity limit to Partnership policy holders who use benefits under their policies. These new requirements will only be applicable after regulations have been adopted to implement SB 483. The Department of Health Care Services is in the process of preparing regulations as required by SB 483.

What Else is Unique?

1) The DHCS requires agents to take specific continuing education (CE) training to be authorized to market Partnership policies. The training consists of an initial 8 hours of classroom only CE on the Partnership, and thereafter an additional 8 hours of classroom only CE on the Partnership every two-year license approval period. Regulations provide that agents who fail to comply with this CE requirement shall not sell Partnership policies, and companies are required to enforce this requirement or jeopardize their relationship with the CPLTC. Also, Partnership course instructors must pass an exam before they are allowed to teach.

2) The DHCS provides services to help agents expand their understanding of the Partnership product, the importance of these quality consumer protections, and ways they can better serve their clients. These services include agent seminars, educational material, agent flyers and newsletters, a web-based interactive tool agents utilize to educate their clients about planning for LTC, and a comprehensive Website (www.dhs.ca.gov/cpltc).

3) DHCS collaborates with its issuer partners in finding ways to reach out to Californians with information that will help them become aware of the risks of needing LTC, the benefits of LTC insurance, and the availability of the Partnership policy. Some of the current consumer education and outreach efforts include a consumer website (www.dhs.ca.gov/cpltc), consumer education videos, educational pamphlets, Public Service Announcements on radio and

television, participation on radio and television talk shows and other media events, print advertising, publication of articles in magazines and newspapers, participation in health forums, and presentations to consumer groups.

What Types of Coverage is Offered:

Two types of Partnership policies are available: a “Nursing Facility and Residential Care Facility Only” Policy and a “Comprehensive” Policy. The comprehensive policy covers care in a nursing home and residential care facility, as well as the full range of home and community-based care services.

The California LTC Partnership & The Deficit Reduction Act of 2006

Section 6021 of the DRA expands Long Term Care Partnerships to other states as it now provides portability of asset protection in Partnership policies with other state Medicaid programs. If a Partnership policyholder from one state applies to another state's Medicaid program, asset protection can be honored on a **dollar for dollar** basis. To qualify for asset protection, a LTC Partnership policyholder must qualify and be approved under the other state's Medicaid program. Also, both states must have a reciprocity agreement with each other **at the time** of application to the other state's Medicaid program.

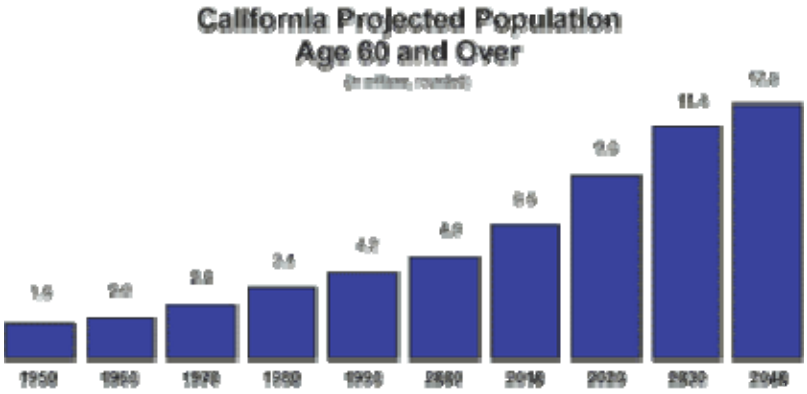
Chapter 9
Alternatives for Long Term Care

According to the *American Medical Association*, the elderly paid out more money to cover nursing home expenses than any other aspect of their health care.

Even so, a majority can't meet the staggering costs on their own, and Medicare coverage is limited. Faced with an average outlay of $45,000 to $60,000 a year in most states, and double or triple that in some urban areas, many of the elderly in nursing homes are faced with watching a lifetime of savings evaporate within a few years.

A Word About California Long Term Care Needs

Long term care conditions in California are ***different*** from the rest of the United States. Why? The sheer numbers in California are significant. Regardless of the proportions, thousands more nursing beds and care personnel are needed in our state versus Arizona, for example, simply because the huge base of our population.



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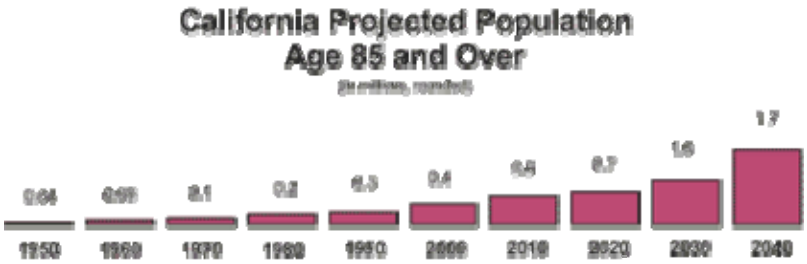


Source: California Department of Aging Website 8/8/10

The elderly population (age 60 and over) in California has grown rapidly throughout this century. Between 1950 and 1990, the elderly population grew from 1.6 million to 4.2 million, an increase of 157 percent. This trend will continue, as the elderly population is expected to reach 12.5 million by 2040, an increase of 232 percent from 1990. The highest growth rates will occur in the next 30 years, largely due to the aging of the Baby Boomers (persons born between 1946 and 1964). The first wave of Baby Boomers will turn 60 during the period between 2000 and 2010,

resulting in a 32 percent increase, and will increase another 38 percent by 2020. Beginning in 2010, 1 in 5 Californians will be 60 years of age or older.

Within populations, different age groups may increase in numbers at very different rates. Over time, the elderly population itself has become "older" and will continue to do so. In 1990 the oldest old age group (age 85 years and over) comprised 7 percent of the elderly population, compared to only 2.6 percent in 1950. By 2000 this will climb to 9 percent. Between 2030 and 2040, when the first of the Baby Boom generation reaches age 85, the percent of elderly who are in the oldest age group will reach 14 percent.

The rapid increase in the oldest old population is perhaps best seen when their growth is compared to that of the total population. While the total population will approximately double in size between 1990 and 2040, the oldest old will experience nearly a 6-fold increase, growing from just under 300,000 to over 1.7 million persons. As a result, whereas only 1 in 99 persons in 1990 were in the oldest old age group, 1 in 34 persons will be in this age group by 2040. Because the oldest old often have severe chronic health problems which demand special attention, the rapid growth of this population group has many implications for individuals, families, and governments.

Again, total numbers are important. When one considers the average life span of 72 for men and 79 for women, the California health care industry can expect the “pool” of potential long term care prospects to increase substantially over the next 30 years as people. Of course, ***half of these people may live longer than the average life span age and half may not.***

Also, in watching the need for long term care facilities, it is a well known fact that people who are ***healthy enough to qualify*** for long term care insurance at age 60 or 65 can be expected to live even longer than the average life span. Since California elderly have characteristically ***fewer*** severe disabilities than the rest of the country we can expect that more Californians will qualify for long term care insurance and more likely to live long enough to use them.

It follows that the huge numbers in long term care age categories and the ability to qualify for long term care insurance will create a growing need for more nursing facilities and home care services throughout the state. If there is a problem that stands out in the California equation it is the percentage of elderly who continue to be Medi-Cal financed. Statistics form the Office of Statewide Housing and Planning Development show that almost 65% of the state’s total patient bed days in LTC facilities are Medi-Cal financed. This is very high despite the fact that the state’s percentage of elderly with incomes below poverty is ranked 2nd lowest in the country. One can conclude that there are more individuals using the public long term care system than should be allowed. As federal and state budgets move toward better cost containment and enforcement, many of these public insureds will need to convert to private coverage and/or long term care financing alternatives.

Alternatives To Long Term Care Insurance

What are the ***options*** for covering long term care costs other than LTC insurance? They are many and diverse and there is not likely a single solution. Similarly, some combination of the choices below and a “bare bones” long term care policy or rider could fit the needs of those unwilling or unable to pay for a full benefit LTC coverage:

Life Insurance With Long Term Care Benefits

Many new "combo" or "linked benefit" products have surfaced that attach long term care benefits to life insurance. While agents need to caution clients that these benefits could be less

than a stand alone policy, they ***can*** cover a portion of long term care expenses. People with some savings and the support of family as ***caregivers*** are the primary markets to purchase LTC riders.

Who else would use these policies? Anyone who cannot see themselves paying years of long term care premiums for coverage they may never use. And, if the long term care benefits in the policy are not needed; a sudden death, for example, their heirs are at least entitled to the policies death benefit.

Of course, without inflation protection, even the long term care benefits in the examples above can be eroded quickly. If such protection is available as an additional rider it should be considered. The result will probably be a significant reduction in the current interest rate or higher premiums and only a comparison analysis with a stand alone long term care policy can ferret out its feasibility.

Private Pay / Savings / Investments

As you will see throughout this course, it is imperative that we in the LTC industry start educating clients that in the not-to-distant future, quality care is the responsibility of the individual. Some of this care can be financed through LTC insurance (discussed below), but a portion may also be the responsibility of each client in the form of private pay -- supporting LTC costs through private investments and savings.

In fact, integrated somewhere in American values is the concept that people should take primary responsibility for their own lives and their personal expenses. We are encouraged to earn our own way. Health care provisions can be seen as a personal investment, planned and funded by the individual. Unfortunately, this is not a subject people like to discuss, much less set aside a percentage of their paycheck to finance.

That is why it is the job of agents in the U.S. to explain the need for private pay and LTC insurance. For example, it might surprise a lot of clients to learn that despite all the talk about Medicare and Medi-Cal, most long-term care is paid privately (approximately 49%). This means that most patients pay for long-term care out of their own pockets, or their ***family pays***, whether the care is skilled, intermediate or custodial. With government cutbacks can anyone expect this to improve?

The massive amount of care provided by family members and other unpaid caregivers adds another dimension to the social costs of long-term care. More than 70% of those receiving long-term care must rely exclusively on unpaid caregivers. Can baby boomers and other rely on their children for the same contribution of time and effort?

Home Equity Conversion

A home equity conversion mortgage is a special type of reverse home mortgage that is available to people who are over the age of sixty two, have a good amount of equity in their home and use that home as their main place to live. A reverse loan is one that is procured based on how much equity exists in the applicant's home. The money is loaned out at an adjustable interest rate and is not paid back to the reverse mortgage lenders until the house is sold or the occupants leave the home for the last time.

Loans of this type typically have the largest advances to the applicant than any other type of home reverse mortgages. This means a ***larger cash payout*** that is given out at a ***lower interest rate*** than is usually available through other reverse mortgages. Although some reverse

mortgages can only be used for a stated purpose, the HECM's can be used for anything the home owner wants to use it for.

In addition to meeting the age requirements, the home must be a listed as a single family residence in a one to four unit building, condominium or part of a planned unit development. The home must be at least one year old and meet the minimum property standards of HUD. Finally, counseling must be done by an approved HUD counseling agency.

Annuities

For years, the insurance industry has designed annuity contracts that appeal to the liquidity needs of seniors and other market groups.

Immediate annuities offer some tax advantages and a stable income for life. Let's looks at an example of how this might work as a long term care solution:

Rose, 79, had been having memory problems for years. However, it wasn't until two and half years ago that her doctor diagnosed Alzheimer's and started her on memory enhancement drugs . The drugs seemed to help, and luckily her son and daughter both still lived in the area and dropped by at least once a week to check on her.

Then Rose started slowly getting worse. The kids would find the stove left on when they came to visit. Papers and garbage were in piles around the house. At that point, Rose and the kids mutually decided that they would sell the house and Rose would move in with her daughter. This arrangement worked for about a year when Rose started leaving the house and getting lost. She was also undergoing a seeming personality change – previously warm and easy-going she was becoming increasingly belligerent and intransigent.

Her daughter, Gina, decided she was going to have to move her mother into an Alzheimer's facility. However, Gina was completely shocked when the only facility in the area she felt comfortable putting her mother charged $6,300 a month. Gina looked into LTC insurance for her mother but was told that there was no way to get her mother covered if she had Alzheimer's and if she already needed care. They still had about $325,00 left from the sale of the house but, at best, that money would last four years. After that, neither she nor her brother would be able to continue to afford the payments.

Rose went into the Alzheimer's facility and Gina looked into alternative financing arrangements. Luckily her mother had signed both a Power of Attorney and a Living Will years earlier - when she first started to experience mild forgetfulness. What Gina and her brother finally decided on was to put $200,000 into a Medically Underwritten Immediate Annuity that would pay $5,000 for the rest of Rose's life. They were able to pay the rest of the monthly fees out of Roses pension and social security income. That left over $100,000 in the estate in case of any emergencies. By doing this they knew that no matter what happened to the stock market or interest rates the insurance company would pay $5,000 a month and they still had a cushion of savings in case there was a change in the facility costs or anything else came up.

Most new generation annuity contracts offer ***free withdrawals*** that allow the owner to withdraw 10 percent or 15 percent of the account value every year. These withdrawals can be used for any purpose including medical costs and long term care. So,, a policyholder can deposit a larger sum of money and use it at will to cover long term care expenses as they develop.

More significant are the ***nursing home and terminal illness waivers*** found in many competitive annuity products. Now the contract owner can withdraw . . . ***penalty free . . .***large

portions of the account value (usually up to 50 percent) without penalty or surrender charges so long as the proceeds are used for nursing care or terminal illness expenses.

Another application might be to place a large sum in a deferred annuity or single premium contract with a long term care rider . . . i.e., a LTC combo plan. Here, the policyholder retains access to principal and his heirs receive a death benefit when he dies. If a long term care illness develops, he is entitled to a predetermined amount of benefits based on his original investment.

Drawbacks to both long term care riders and annuity coverage should be noted: Benefits paid may be less than the standard long term care policy, particularly in areas such as home health care and assisted living. Similarly, the duration of payments will most certainly be limited. And, without inflation protection, the proceeds may not cover all actual LTC costs. "Pot of money" approaches will most likely be exhausted in a matter of years or sooner and few, if any, can be expected to provide lifetime benefits. Then again, such long term benefit durations in stand alone long term care insurance, while available, are very costly leading to few takers anyway.

Life / Viatical Settlements

A viatical settlement is a transaction whereby a non-related party purchases all beneficial interest in a life insurance policy insuring the life of a terminally ill person. Since many long term care patients are terminal, they may consider selling the proceeds of their life insurance policy before they die to use the funds for current, more pressing medical needs and expenses.

The theory behind these transactions may sound gruesome but can be beneficial for both parties. Think of it, by the time a terminally ill person considers "selling" his or her life insurance policy, they are typically on their "last leg", financially speaking. The income realized from the sale of the life insurance policy can be ***very welcome***.

The mechanics of the transaction are fairly simple. A third party "broker" or viatical company pays the terminally ill person a percentage of the death benefit and becomes the owner and beneficiary of the policy. The terminally ill person receives a lump sum of money to use ***now***. When he dies, the proceeds of the policy go to the viatical company. Viatical companies are usually funded through investors and buy all kinds of policies, term, whole life, universal life, group life, etc. The policy must have been in force for at least two years and not be subject to a contestability period. In some cases the viatical company even continues paying the premium on the policy to keep it going. Also, viatical

companies are known to work with a combination of ***accelerated death benefits AND viatical settlements*** to net an even greater sum of cash for the seller of the policy.

More and more, people diagnosed with other terminal illnesses are turning to viatical settlements to meet their financial needs -- ***including long term care***. The list includes terminal sufferers with cancer, "Lou Gehrig's Disease, cardiovascular illness and more. As a matter of fact, the statistics point to a larger market for viatical settlement from terminally ill patients with cancer who, in 1995, represented 78 percent of all hospice care admissions versus AIDS at only 4 percent. The industry is expecting more cases from non-AIDS related illnesses as more people learn about the product.

A real boost to viatical settlements should also come as a result of HIPAA (The Health Insurance Portability and Accountability Act) of 1996 which allows people diagnosed with a terminal illness to sell their life insurance policies to viatical settlement companies for a ***tax free lump sum payment***. This tax free provision will apply ONLY to people whose life expectancy is

less than 24 months and the purchasing company must be licensed by the state in which the viator (seller) resides.

Policies of all sizes are viaticated and twenty-one states have adopted all or a portion of the regulations for viatical settlements set forth by the National Association of Insurance Commissioners. And the Viatical Association of America has established minimum standards of consumer protection for its viatical company members.

Medicare and Medi-Cal

Medicare is a federal health care program funded by federal tax dollars. Because it is related to the Social Security Program, eligibility is based on a person's work history or relationship with another individual with a work history (i.e., spouse or dependent child). Medicare was designed to pay for physician and hospital care for people who are elderly or disabled. As described in "***Taking Care of Tomorrow, A Consumer's Guide to Long Term Care***", produced by the California Department of Aging, which must be provided to every consumer at the time of solicitation.

"Most long term care is furnished in nursing homes to people which chronic, long-term illnesses or disabilities. The care they receive is personal care, often called custodial care. Medicare does not pay for custodial care. Medicare pays less than 10% of all nursing home costs. To qualify for the Medicare nursing home benefit, you must spend three full days in acute care hospital within 30 days of your admission to a nursing home. You must also need skilled nursing care seven days a week, and/or rehabilitation services at least five days a week. Medicare will not pay for your stay if you need skilled nursing or rehabilitation therapy only once a week. The longest nursing home stay that Medicare will pay for completely is 20 days. After the first 20 days, if you still require skilled care, Medicare will pay only a part of the nursing home bill. You will have to pay a copayment for each day of the next 80 days if Medicare continues to pay for your stay.

Will Medicare Pay if I Need Care in My Home? "Taking Care of Tomorrow" answers: "Yes, but only if you meet certain requirements of the Medicare program …… You must be homebound and require skilled nursing or rehabilitation services. The services you receive must be from a home health care agency that participates in Medicare. You may also receive some personal care services along with the skilled services.

However, Medicare does not pay for general household services such as laundry, shopping or other home care services that are primarily needed to assist people in meeting their personal care needs….."

NOTE: PLEASE SEE MORE ON MEDI-CAL IN THE ADDENDUM

Medi-Cal, as originally intended, was created to help the "medically needy", aged, blind and disabled citizens who lacked access to the health care system. Unfortunately, the system has inadvertently fostered generation after generation of poverty level families who use the system to pay for their health care. Many seniors who end up on Medi-Cal have spent many productive years paying taxes and contributing to society. Combine this dependence with our rapidly expanding elderly population and you understand why the system has . . . **and will** . . . have trouble supporting long-term care.

Medi-Cal, is funded by both federal and state tax dollars and provides health care coverage for approximately 6 million eligible beneficiaries. Medi-Cal is designed to provide services for people with low income and few assets. The program provides health care services to people on public assistance and to others who cannot afford to pay for their health care. Medi-Cal pays

for hospital, medical, prescription drug, and “medically necessary” nursing home care. California does not consider a person’s impairment in their ability to perform Activities of Daily Living in determining eligibility for Medi-Cal’s nursing home benefit.

The important concept to keep in mind here a person pretty much needs to go through a majority of their assets before Medi-Cal will help them with long term care expenses. And, the process of "divesting" oneself of assets to make this happen is not all the easy and riddled with legal and tax loopholes. There is no easy solution and even when long term care insurance is purchased there is no guarantee that someone won't still end up on Medi-Cal after insurance benefits run out. For those without a lot of assets, unable to afford LTCI premiums or where inflation has diluted these insurance benefits, Medi-Cal is their only safety net.

Finally, it is necessary to point out that not everyone should purchase LTC insurance, especially where more assets and family support is high.

Reverse Annuity Mortgages

A RAM is a type of reverse mortgage in which a lump sum is used to purchase an annuity that gives the borrower a monthly income for life. This income can be used for long term care expenses or to purchase long term care insurance.

There are three main types of reverse mortgages: (1) the federally insured Home Equity Conversion Mortgage (HECM), administered by HUD; (2) single-purpose reverse mortgages, usually offered by state or local government agencies for a specific reason; and (3) proprietary reverse mortgages, offered by banks, mortgage companies, and other private lenders and backed by the companies that develop them.

A RAM can help senior citizens use their home equity to stay in their homes if their income is less than their monthly needs. These people are sometimes described as “house rich but cash poor. ” To qualify, a homeowner must be at least 62 years old and have paid off all or most of his home mortgage. There are generally no income requirements (but see CHFA loans, below), and no medical tests or medical histories are required. HECMs impose certain additional requirements, such as free mortgage counseling from an independent government-approved “housing agency” and limits on the amount that can be paid.

Most reverse mortgages can be paid out in a lump sum, in monthly advances, through a line of credit, or a combination these methods. RAMs are paid in a lump sum, which is used to purchase an annuity that provides the borrower with monthly income. The loan advances are not taxable to the borrower and generally do not affect Social Security or Medicare benefits.

Informal Care By Family or Friends

According to the AARP, ***family caregivers*** are considered to be the backbone of the long-term care system in the United States. They provide about 80 percent of the care for people who need help with daily activities, such as bathing and dressing, taking medications, and paying bills. This form of care is generally unpaid ("informal" caregiving) compared to caregiving services from paid workers ("formal" caregiving). One study (Arno et al., 1999) estimated the value of family caregiving at $196 billion in 1997, assuming that the average annual number of hours of informal caregiving was replaced with paid services.

The 1997 National Alliance for Caregiving/AARP national survey reported that two in 10 working caregivers turned down chances to work on special projects; almost as many avoided work-

related travel. Forty percent of the survey respondents said that caregiving affected their ability to advance in their jobs.

In October 2000, Congress enacted the National Family Caregiver Support Program (NFCSP) under the Older Americans Act. This program provides support services for family members caring for persons with disabilities and grandparents caring for grandchildren. Program components include education and training, counseling, support groups, and respite care. Congress appropriated $154 million in 2009.

Until passage of the NFCSP, state general revenues provided the bulk of public funding for family caregiving. Other sources of state revenue for caregiver services have included casino funds (for respite care in New Jersey), lottery money, and tobacco settlement funds. States can also cover respite care under Medicaid Home and Community-Based Waiver programs.

Examples of comprehensive statewide family caregiver programs include:

- *California's Caregiver Resource Centers*
- Cancer Care
- *Pennsylvania's Family Caregiver Support Program*

Twenty-two states help family caregivers with their financial burdens by providing ***tax credits*** or deductions. State tax credit programs build on the federal tax credit, which reduces the amount of income taxes a family owes. If payment is made by an employed caregiver to a third party for expenses incurred for the care of a dependent person, the federal dependent-care tax credit can be claimed. California's $500 caregiver tax credit expired in 2005. There is an effort, however, to revive it.

What is the future of informal family caregiving? Well, considering we will enjoy even longer life spans and the trend away from government help for long term care, the odds for the demand for formal and informal in-home and nursing home services will increase substantially. Just how much family members can continue doing remains to be seen.

Is family caregiving important in the selling of long term care insurance? You bet. The degree family support, or lack thereof, a client has can make the difference in the type of policy you suggest.

Take, for example, a client who has absolutely no family support network to help with home care. He might have less of a need for a comprehensive policy with a huge home care benefit, opting instead for strong nursing home coverage. Likewise, a client who has willing children but they have children of their own and busy careers is not likely to see his family as frequent caregivers. Contrast these policyowners with a couple that is in good health with a strong likelihood that one or the other spouse will be healthy enough to assist at home and a good volunteer family support system may possible since their children and close relatives live locally. A strong home care option that allows for benefits to be paid where the caregiver is a family member or close friend may be a good suggestion.

Medicare and Long Term Care

It needs to be noted that there was ***never*** any provision in the Medicare Catastrophic Coverage Act to pay for the cost of long-term health care. In fact, benefit booklets explain that Medicare hospital insurance (Part A) helps pay for medically necessary care in a Medicare-approved hospital, skilled nursing facility, and hospice. Skilled nursing facility care is not the same as custodial nursing home care.

Skilled nursing care is acute care, while custodial is long-term care. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not certified by Medicare. So in conclusion, Medicare will provide for less than 2% of long-term care health payments. Medicare will, however, provide payment for health care for individuals over the age of 65 and certain individuals under the age of 65 with significant disabilities. Medicare is basically a ***health insurance*** program. The benefits available under Medicare are similar to those under most health insurance plans in the way they cover long-term care -- it's not a covered event.

Medicare Supplement Insurance

There are many gaps in coverage left by Medicare such as limited benefit periods, deductibles, coinsurance and exclusions that can be filled with a private Medicare supplement policy . . . sometimes called ***Medigap Coverage.*** Unfortunately, like Medicare this conventional insurance restricts coverage to skilled care . . . and not chronic conditions.

Aggressive Medigap plans extend coverage to “at-home recovery” (short term assistance with activities of daily living) and skilled care may provide for items like IV’s, bedsore care and physical therapy. But once health progress stops, the condition is termed ***chronic*** and ***no longer covered.*** That is why someone like an Alzheimer’s patient is considered under these plans to need little or no skilled care. He is not covered by Medicare or a supplement plan yet cognitive impairment may limit his abilities to perform simple activities such as bathing or eating. Patients like this move through the evolution process . . . from acute to chronic conditions leading to the need for nursing home care or advanced home health assistance. The Health Care Administration estimates that Medicare and private insurance like Medicare supplement plans provide only 12 percent of the nation’s total nursing home care expenses.

Taking No Action

Though the subject of this course is long term care insurance, one of its major drawbacks is whether an individual, such as a retiree, can afford the cost. For a portion of retirees, the answer is no. The average annual per capita income for someone 65 or over is about $20,000. If a 65 year-old with average income could pay about $2,000 each year for a good long-term care policy with inflation protection 10 percent of his/her annual income would be exhausted each year. Add other expenses and you can see that it may be quite difficult for the elderly to handle these kind of premiums. Again, this is where agents must counsel clients on the need for “some” benefits or perhaps **taking no action at all**. Why? Perhaps your client already has ***large assets, is not eligible for LTC, or has an uninsurable preexisting condition.***

As good as LTC coverage seems, it is extremely important for you to know and point out to your clients that ***the purchase of long term care insurance does not ensure that someone will avoid ALL long term care costs***. A person who owns a policy could still end up on an ***assistance program*** like Medi-Cal. How does this happen? Like other forms of insurance, people buy less than they need, or, they refuse a valuable option like inflation protection leading to coverage short falls. There is also the possibility that their insurer waivers their specific condition or simply goes out of business.

Taking no action may also be an inevitable conclusion when clients you meet have ***large assets***, ***no medical eligibility and/or a preexisting (uninsurable) health condition***. Lending them hope that they can be helped can do substantial damage where continued rejections may inflict severe disappointment leading to the potential for emotional distress. Please be considerate of your senior clients -- their medical conditions often leave them with the

sensation that they have no control over their lives. Adding additional trauma can only add to these problems.

Family Paid Premiums

Not all clients an afford long term care insurance premiums. Oddly enough, these same people might not be poor enough to qualify for Medi-Cal, i.e., they are in the middle. The suggestion here might be to see if the family can afford to cover the cost of insurance.

Referral to HICAP

In California, the Department of Aging offers counseling services to all parties interested in locating long term care providers. Known as Health Insurance Counseling and Advocacy Program or HICAP, they help seniors and others review life insurance policies, file medical claims, advise on long term care services and counsel on other consumer health concerns. They also provide follow-up to ensure that these services were received. A complete list of HICAP offices is provided at on the Department of Aging Website -- www.aging.state.ca.us

As an agent, ***you are responsible*** to know the name, address and telephone number (not older than six months) of the local HICAP program in the area in which you are selling. Be sure to visit the Department of Aging website to fulfill this requirement.

Alternative Care Facilities:

Senior citizens needing daily living assistance are always looking for alternatives from having to enter a nursing home.

Two of these alternatives include the Life Care Communities (LCC) and the Continuing Care Retirement Communities (CCRC). Many communities require individuals to carry a Medicare-supplement policy in addition to Parts A and B of Medicare. This requirement, often written into the contract, ensures that the Retirement Communities do not have to pay for acute illnesses.

Some Communities also require that individuals carry long-term care insurance. Since these facilities aren't generally funded in advance, the policies help pay for resident's care. Some facilities that require long-term care policies want residents to buy the policies they have pre-selected. Others may require the purchase of a long-term care policy but don't specify the specific policy that they would prefer.

Additional alternatives include family care at home, retirement communities (fewer services may be offered) and fraternal, religious and union sponsored facilities ranging from simple board and care to assisted living and even nursing care.

Attachments

I MEDICARE REQUIREMENTS
II TAX TREATMENT OF LONG TERM CARE
III CALIFORNIA LAWS AND PENALTIES
IV LONG TERM CARE PERSONAL WORKSHEET
V LONG TERM CARE INSURANCE SUITABILITY LETTER
VI NURSING HOME BILL OF RIGHTS

Attachment I

California Department of Insurance
MEDI-CAL REQUIREMENTS
REQUIRED ATTACHMENT

Revised: 04/15/2013 LTC8

Medi-Cal Requirements

Data reproduced from the 2013 Before You Buy guide, with the approval of the California Partnership for Long-Term Care.

When to Apply for Medi-Cal

Medi-Cal eligibility is not automatic. You must apply for Medi-Cal to become eligible for public assistance. To become eligible for Medi-Cal, you must:

- Be aged, blind, or disabled;
- Be a citizen or have satisfactory immigration status; and
- Meet the Medi-Cal property and asset requirements.

Once your eligibility has been determined, you may be required to pay, from your income, a monthly “share of cost” for your care.

Once accepted by Medi-Cal, you are eligible for all services that Medi-Cal covers. Medi-Cal services may be different than those you received under your private long-term care insurance. For example, Medi-Cal has no limits on the number of days covered, if they are medically necessary. **However, Medi-Cal will not pay for your stay in a Residential Care Facility.** Medi-Cal will pay for some nursing services in the home, including services in a Residential Care Facility, if that is where you live, and if you are temporarily or permanently unable to leave your home. For example, if you are recently discharged from a hospital, Medi-Cal will pay for follow-up care which can be provided in your home.

Medi-Cal Property and Asset Limitations

There are property/asset limits for the Medi-Cal program. If your property/assets are over the Medi-Cal property limit, you will not get Medi-Cal unless you lower them according to the program rules.

The county looks at how much you and your family have each month. If your property/assets are below the limit at any time during that month, you will get Medi-Cal, if otherwise eligible. If you have more than the limit for a whole month, you will be discontinued until you are once again below the limits.

The home you live in, furnishings, personal items, and one motor vehicle are not counted. A single person is allowed to keep $2,000 in property/assets, the limit is higher if you are married or have a family.

For more information, please ask your county welfare office (usually the Department of Social Services) for a form called “Medi-Cal General Property Limitations for all Medi-Cal Applicants” (MC Information Notice 007).

Medi-Cal Property and Asset Limitations for Married Couples When One Spouse is in a Nursing Home

If one spouse (husband or wife) goes into a nursing home, and the other spouse is still at home, the spouse at home may keep up to $115,920 while the institutionalized spouse may keep $2,000 (this is the amount allowed in 2013; the amount is adjusted by the annual increase of the Consumer Price Index). California Department of Insurance *Eight-Hour Mandatory Long-Term Care Course* Attachment I

In 2013, the spouse at home may keep all of the couple’s income he/she receives in his/her own name. If this amount is under $2,898 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse’s income up to at least $2,898 per month. This is referred to as the at-home spouse’s “monthly maintenance needs allowance.” (This amount is also adjusted annually by the cost of living increase.)
The at-home spouse may retain additional income or assets through a “fair hearing,” or by court order. The spouse in the nursing home is permitted to keep $35 a month for personal needs.

Medi-Cal Share of Cost

If you are on Medi-Cal, you may need to use some portion of your monthly income from Social Security, a pension, etc. to pay for your health and long-term care expenses. Your income will probably not be enough to pay the entire bill, so Medi-Cal will pay the rest of your nursing home bill or any other medical expenses you may have.
You will be allowed to keep a certain amount of your income each month. In 2013, you may keep the following “Maintenance of Need” amount:

- If you are living in the community, an individual may keep $600*, a married couple $934*; or
- If you are in a nursing home, an individual may keep $35 for personal needs. If he or she has a spouse at home, the at-home spouse may keep all of the couple’s income he/she receives in his/her name. If this amount is under $2,898 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse’s income up to at least $2,898 per month.

In determining your share of cost, Medi-Cal will calculate the applicant’s/institutionalized spouse’s total monthly income. This figure is your net income. The county will subtract the allocation to the at-home spouse, if applicable. Then the “Maintenance of Need” amount is subtracted from your net income. The remaining amount is your monthly share of cost – the amount you would have to spend on medical or long-term care before Medi-Cal begins payment.

For more detailed information on how the Medi-Cal share-of-cost is calculated, contact your county Department of Social or Human Services (also known as the county welfare office).

*There may be other adjustments allowed based on individual circumstances.

Attachment II

California Department of Insurance
TAX TREATMENT OF LONG TERM CARE
REQUIRED ATTACHMENT

Revised: 04/15/2013

Tax Treatment of Long-Term Care Insurance & Expenses
Introduction

Federal and state tax codes have a purpose beyond raising revenue. Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The 1996 Health Insurance Portability and Accountability Act (HIPAA – Public Law 104-191, 110 Stat. 1936, 2054 and 2063) is one of the most far-reaching laws passed by Congress in the latter part of the 20th century. The effects of HIPAA are so complex that federal and state governments as well as the insurance and health care industry continue to grapple with it.

By including long-term care insurance in HIPAA, Congress attempted to fulfill a number of different public policy objectives including: (1) classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief; (2) categorizing long-term care insurance as accident and health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and (3) providing the general public an incentive to purchase private long-term care insurance.

In addition, as Federal and State governments recognized that long-term care expenses were having a significant financial impact on state Medicaid (Medi-Cal) budgets, Congress was attempting to shift the financial burden of Medicaid to the private sector by providing general tax incentives to purchase long-term care insurance in anticipation of the huge number of baby boomers who may need care in the future.

Note: ***The information provided in this treatise gives a broad description of the tax issues related to long-term care and long-term care insurance. Since most agents are not Certified Public Accountants (CPA's) or tax preparers, they should be very cautious and understand their limitations in advising insured's about their specific tax situation and circumstances. Agents should always refer clients to a tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several examples provided in this Attachment that should be included in the course.***
HIPAA Definitions That Apply to Long-Term Care Expenses and Insurance

Introduction The Internal Revenue Code (IRC) allows deductions for medical and dental expenses under certain circumstances (IRC Sec. 213d). Prior to the passage of HIPAA, a broad range of long-term care expenses were generally not deductible. Part of Congress' intent in enacting HIPAA was to provide tax relief to individuals and families that were incurring long-term care costs. However, part of the challenge facing legislators was determining which expenses would qualify.

Qualified Long-Term Care Services/Chronically Ill Individual
The broad and expanding nature of long-term care expenses made it difficult to stipulate a "laundry list" of qualified services. The IRS defines "qualified long-term care services" as:

Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.

This is a wide-ranging universe of potential services. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a threshold for initiating benefits by tying services to a state of disability defined as a *chronically ill individual*. A chronically ill individual must be certified by a licensed health care practitioner, within the previous 12 months, as meeting one of the following tests:

- The individual is unable, for at least 90 days, to perform at least two activities of daily living (ADL's) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. (See Internal Revenue Service Notice 97-31, issued May 6, 1997 or California Insurance Code (CIC) section 10232.8(e)(1 – 6) for the definitions of the ADL's.)
- The individual requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Federal and State laws require the certification of the insured's status as a "chronically ill individual" to be renewed annually. It is only when an insured meets this definition that favorable tax treatment for the cost of long-term care services will be granted.

Licensed Health Care Practitioner

The Internal Revenue Service defines licensed health care practitioner (LHP) in very general terms. It may include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. California Insurance Code section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and "shall not be compensated in any manner that is linked to the outcome of the certification".

90-Day Certification for Activities of Daily Living

Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it could have had the unintended consequence of allowing taxpayers to deduct expenses associated with short-term disabilities due to the broad nature of the definition of qualified *long-term care service*.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be recertified by the LHP (licensed health professional) at least annually.

IRS Publication 502 stipulates that the 90-day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification

may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

Substantial Assistance

For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both *hands-on assistance* and *standby assistance*.

- Hands-On Assistance: means the physical assistance of another person without which the individual would be unable to perform the ADL.
- Stand-By Assistance: means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

Severe Cognitive Impairment and Substantial Supervision

Notice 97-31 defines a *severe cognitive impairment* "as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning." Note that the 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be recertified every 12 months to ensure that they still qualify for benefits. Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

Tax Qualified Long-Term Care Insurance

Introduction

Prior to HIPAA, neither long-term care insurance premiums nor benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as accident and health insurance or disability insurance for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free.

HIPAA requires that long-term care insurance policies comply with its guidelines to be considered "qualified" long-term care insurance. As such, qualified long-term care insurance policies are accident and health policies and the tax treatment or their benefits are generally the same as other A & H plans.

Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance. However, HIPAA was silent as to the tax treatment of benefits received from non-qualified policies issued after January 1, 1997. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

Benefits

Congress created a generalized structure to which qualified LTCi products must adhere. For purposes of HIPAA, a qualified long-term care insurance policy must pay benefits using no less

than 5 or no more than 6 of the following activities of daily living: eating; toileting; transferring; bathing; dressing; and/or continence.

Tax qualified long-term care insurance is generally treated the same as an accident and health insurance policy. Some of the rules include:

1. Reimbursement method long-term care insurance benefits pass tax-free
2. Per diem and cash method policy benefits received are subject to an annually adjusted limit amount of $320/day in 2013 (indexed upwards annually by approximately 5 percent)
3. Premiums are generally deductible
4. Premiums paid by an employer for an employee are 100 percent deductible and do not count as income to the employee
5. Certain tax deductibility limitations apply to individuals, sole proprietors, owners of S-corporations, and LLP's
6. Individuals with Health savings accounts can utilize these funds to pay for qualified long-term care insurance subject to limitations discussed below
7. Qualified long-term care insurance cannot be included in a Section 125 Cafeteria Plan or flexible spending arrangement
8. Qualified long-term care insurance policies may not use "medical necessity" as a benefit trigger and must coordinate benefit payment with Medicare

Required Consumer Protection

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of Senate Bill 1943, Chapter 1132, Statutes of 1992, that included protections related to the following: guaranteed renewal or non-cancellation of the policy; prohibitions on exclusions and limitations; extension of benefits and conversions; replacement; unintentional lapse; post claim underwriting; requirement to offer inflation protection and rejection by consumer; restrictions on preexisting conditions and probationary periods; disclosure; and, non-forfeiture provisions.

IRS Reporting Mechanism

HIPAA also establishes a reporting mechanism for benefits received under all long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an IRS 1099 LTC Form issued by the carrier. Benefits reported on the 1099 must also be disclosed on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does indicate the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional questions to the taxation of non-qualified benefits because it provides a vehicle for these benefits to be taxed. Despite continuing confusion, neither the Department of the Treasury nor Congress has clarified this matter.

Tax Treatment of Pre-1997 Long-Term Care Insurance Policies
Introduction

Policies issued prior to January 1, 1997, created a challenge under HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for "grandfathered" policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury

indicated that long-term care insurance policies issued prior to January 1, 1997, meeting "long-term care insurance requirements of the State in which the contract was … issued" would be grandfathered in for the purposes of tax qualification unless the policyholder made a "material change" to the policy.

Definition of "Material Change"

Although the interim directive did not define "material change", the final regulations issued in December 1998 identified criteria for which a "material change" would result in a policy losing its tax qualified status. The following are treated as "material changes" and considered issuance of a new contract with the resulting loss of tax qualified status:

- A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company;
- A substitution of the insured under an individual contract;
- A change (other than a non-material change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract.

The following, however, are actions that are not considered "material changes" and will not jeopardize the policy's grandfathered status:

- Regarding premiums: a change in the mode of premium payment; an increase or decrease in premiums for all contracts that have been issued on a guaranteed renewable basis; a reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family; a reduction in premium due to a reduction in coverage made at the request of a policyholder; a reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status); the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder.
- Regarding riders: the addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract; the deletion of a rider or provision of a contract (called an HHS – Health and Human Services – rider) that prohibited coordination of benefits with Medicare.
- Other actions include: the effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract; the substitution of one insurer for another in an assumption reinsurance transaction; the expansion of coverage under a group contract caused by corporate merger or acquisition; the extension of coverage to collectively bargained employees; the addition of former employees.

Note: ***The critical message for consumers is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised. A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90-day certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for long-term care.***

Long-Term Care Insurance Premium Deductibility

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent Department of the Treasury rulings have created four primary deductibility scenarios for tax qualified long-term care insurance. They are: health savings accounts; individual deductibility; deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) and limited liability corporations (LLC); and, deductibility for employee/owners of C-corporations. The tax incentives that allow for premium deductibility may help the self-employed and employees of companies that provide employer-paid long-term care insurance. To a lesser extent, some individual taxpayers, who are not self-employed may benefit from the premium deductibility allowed by HIPAA.

Health Savings Accounts (Medical IRA Account)

Health Savings Accounts (HSA) and their predecessor MSA's, were established under HIPAA and more recent reforms. Those consumers under age 65, who are willing to take on the responsibility of a larger medical insurance deductible in favor of lower premiums, are provided a tax incentive to do so. Simply stated, the consumer purchases a qualified high deductible medical insurance plan. They are then allowed to make a pre-tax contribution to their HSA account not to exceed (in 2013) $3,250 (individual) or $6,450 (family). "Catch-Up" contribution provisions allow HSA holders to add an additional $1,000 to their account if they are age 55 or older. The money placed in the HSA account grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for unreimbursed medical expense allowed by IRC Sec. 213(d), deductibles and co-insurance. The money in the HSA can also be used to pay the premiums on a tax qualified long-term care insurance policy up to the age banded limits listed below.

HSA's are achieving acceptance in individual and group health insurance markets. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional "low-deductible" plans and the "high-deductible" plans that qualify for the HSA program. HSA's represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

Individual Deductibility

Taxpayers who itemize their deductions may benefit from the deductibility of qualified long-term care insurance premiums. Based on the taxpayer's age, only a portion of the long-term care insurance premium is deductible. Taxpayers over age 60 with above average income and assets may be interested in long-term care insurance. These individuals may itemize their deductions because they own property and the standard deduction is not in their best interest. Expenses for medical care and insurance premiums are deductible to the extent that they exceed 10% of adjusted gross income. Prior to HIPAA, most taxpayers in this circumstance would not exceed 10% of their adjusted gross income in unreimbursed medical expenses. However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy. However, unlike other accident and health insurance premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted. In 2013, the age "banded" amounts that may be applied towards the taxpayer's un-reimbursed medical expenses are:
Banded Age Limits Individuals/Couples

- Under Age 40 $ 360/$720
- Ages 41 - 50 $ 680/$1,360
- Ages 51 - 60 $1,310/$2,620
- Ages 61 - 70 $3,640/$7,280
- Ages 71 + $4,370/$8,740

Individual taxpayers under age 61 who itemize their deductions may not get much of a tax relief by including the allowable long-term care insurance premium amount in their unreimbursed medical expenses. However, someone age 61+ may benefit. Individual taxpayers, who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The deductible premium amount allowed is limited by the age-banded amount in that tax year.

The following is a thumbnail example of how this may work for a hypothetical husband and wife, both ages 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of $9,000. Assume, for the purposes of this example, that this couple has an adjusted gross income of $100,000 therefore they must exceed $10,000 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

- Amount Allowed For TQ-LTCi $7,820
- Medicare Supplement Premiums $5,000
- Medicare Part B Premiums $3,000
- Other Allowable Medical Expenses $3,000
- (Rx, eyeglasses, dental)

Total $18,820

In this example, the taxpayers would be allowed to deduct $8,820 ($18,820 minus their $10,000 threshold) of un-reimbursed medical expenses. If they are in a combined federal and state income tax bracket of 35%, their tax savings would equal $3,087 ($8,820 x 35%). This would amount to an approximately 35% premiums savings ($3,087 □ $9,000). The deductible amount allowed for long-term care insurance premiums is not enough to trigger a deduction for these taxpayers; neither are the stand-alone deductions for the other unreimbursed medical expenses. However, the combination of all of them provides this hypothetical couple with a savings. It is important to note that most agents are not qualified tax advisors and as such need to be cautious in their recommendations. Clearly, if the agent inquires as to the unreimbursed expenses illustrated above they may spot a potential tax savings for the consumer and refer them to their tax advisor.
Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses.

Deductibility for the Self-Employed

Premiums for qualified long-term care insurance paid by an employer on behalf of an employee are deductible to the employer as an accident and health insurance premium. That being said, if the employee is an owner of the business entity some limitations apply.

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships ("LLP") and limited liability corporations ("LLC"). An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only. The profit or loss from the business entity is passed through to the owners pursuant to their share of

ownership. Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees. Spouses of owners of S-corporations, LLP's and LLC's are considered owners regardless of their direct or indirect participation in the business' activities. With respect to accident and health insurance coverage purchased by one of these entities for a non-owner-employee, premiums are fully deductible. There is no imputed income to the employee of premiums and the benefits pass tax free at the time of the claim.

Beginning in 2003 premiums for accident and health insurance are 100% deductible for owners of these entities. It is not necessary for these taxpayers to exceed 10% of adjusted gross income to benefit from the tax code for these expenses. Tax qualified long-term care insurance (considered accident and health insurance for these purposes), falls into this general rule and the 10% AGI threshold does not come into play. The amount allowable for deduction is limited by the previously discussed age-related schedule.

Consider a self-employed husband and wife, both age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of $6,000 per year. They would be allowed to deduct $2,620. If they are in the combined Federal and State tax bracket of 35% their tax savings would be $917 or approximately 15% of premium. Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 15% of the premium paid. Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses.

Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several examples provided in this Attachment that should be included in the course.

Deductibility in Closely-Held C-Corporation

The fine-line difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners. Therefore, premiums paid by the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees is deductible to the corporation. There is no imputed income to the employee stockholder for premiums paid and the benefits will pass tax-free at time of claim. Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive "like" benefits. Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits. Both are incorrect. The Internal Revenue Code section 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable class of employees who are eligible for the benefit, is not allowed. The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as "officer employees" can be created for the corporation who are eligible for a specific accident and health insurance benefit. However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and tax advisors to be judicious in recommending and establishing classes eligible for coverage. It is also important for the corporation to establish the plan in their Minutes and to clearly identify the classes of employees that are eligible for

benefits. Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation. There is no income imputed to the employee and the benefits pass tax free at time of claim; however it is important to consult with a tax advisor.

New Trends: LTC Insurance, Life Insurance, Annuities and Benefit Riders

The Pension Protection Act of 2006 (PPA), like HIPAA, is a significant piece of legislation that addresses hundreds of disparate issues. Also like HIPAA, a very small portion (section 844) deals with long-term care insurance and riders that are part of life insurance or annuity contracts. PPA affirms HIPAA as it pertains to life insurance contracts and accelerated benefit riders (ABRs). Over the years, accelerated benefit riders have appeared in various life insurance policies with a promise to pay part of the death benefit (generally 2% to 4% monthly) if a qualifying event other than death occurs; e.g. disability, critical illness, cancer, terminal or chronic illness.

Section 101(g)(1) of the Internal Revenue Code governs the accelerated payment of death proceeds on the life of a terminally or chronically ill insured. HIPAA added section 7702B to the IRC which specified the definition of 'chronic illness'. Essentially, if the qualifying event for benefits matches the chronic illness definition established by HIPAA, the early payout of the death benefit for long-term care expenses will not be taxed as income. However, the payments cannot exceed the per diem limits ($320 in 2013 and must comply with other provisions of the NAIC Model for long-term care insurance.

Per PPA, the premiums (or charges) for this coverage can be deducted from the internal growth of the annuity without a taxable event (income) to the annuitant. In addition, if the annuitant qualifies for care, the long-term care benefits payments from the annuity will be received income tax free. One of the central points is that the long-term care benefits must be consistent with the HIPAA--if it looks like qualified long-term care insurance, it is qualified long-term care insurance. A typical product design for a single premium deferred annuity (SPDA/LTCI) combo product will provide a long-term care benefit that is generally a multiple of the annuity account value. The payout will be delivered over a certain number of months, 24, 36 or 48. While examples will vary by insurance carrier, age and health conditions, let's say that the insured wants $6,000 per month of benefit for 48 months ($6,000 X's 48 = $288,000). To get that $288,000 benefit, the policy holder may have to place $100,000 into the SPDA combo product. A risk charge will be taken from the accumulation of the product to provide the additional $188,000 of coverage. The first money out of the SPDA to pay the long-term care benefit will be the insured's initial premium to the plan. If the policyholder dies before their contribution is exhausted a beneficiary will receive the difference. Once benefits are paid beyond the initial premium the insurance company will continue to pay benefits until they are exhausted. The risk charge for the benefit beyond the premium will generally be between one-half to 1.25 basis points. In other words, if a typical SPDA was paying a return of 5.5%, the combo plan may only pay 4.5%. Again, since the long-term care benefit under the program qualifies under IRC section 7702B, the cost of the long-term care benefit will not be a taxable event to the insured. Long-term care benefit payments will reduce the basis of the annuity for income tax purposes. This may create a larger tax burden on heirs of the annuity owner after death.

Here are some key points for agents to think about when discussing "combo products" with consumers:

1. How insurance agents and financial advisors who have been working primarily in their narrow specialties will be able to help clients navigate this new world of long-term care planning choices. Benefits available with life and annuity/LTCI combos are likely to be limited as to benefits paid at time of claim.

2. Long-term care benefit qualification must be consistent with HIPAA in order for the combo plan to fall under the PPA guidelines. In order to solicit/sell long-term care insurance in California, Agents need to hold a current license as: Life Agent, Accident and Health Insurance Agent, or Life-Only Agent (only if it is a LTC rider on a full life policy).

3. What sorts of long-term care expenses will the life or annuity combo pay for--nursing home only, assisted living, home care, or all of the above? Will the plan reimburse for incurred cost or provide some sort of indemnity (per diem) benefit based on a day of service incurred? What sorts of assessments and plans of care will the claims process require?

4. Underwriting criteria will lead to choices of deferral periods based on insured's health issues. This will be a special challenge to life insurance agents selling annuities, marketers and wholesalers not attuned to underwriting issues in the current SPDA environment.

5. 1035 exchange opportunities are likely to occur (moving cash values from life insurance and annuity contracts to those with LTCI benefits).

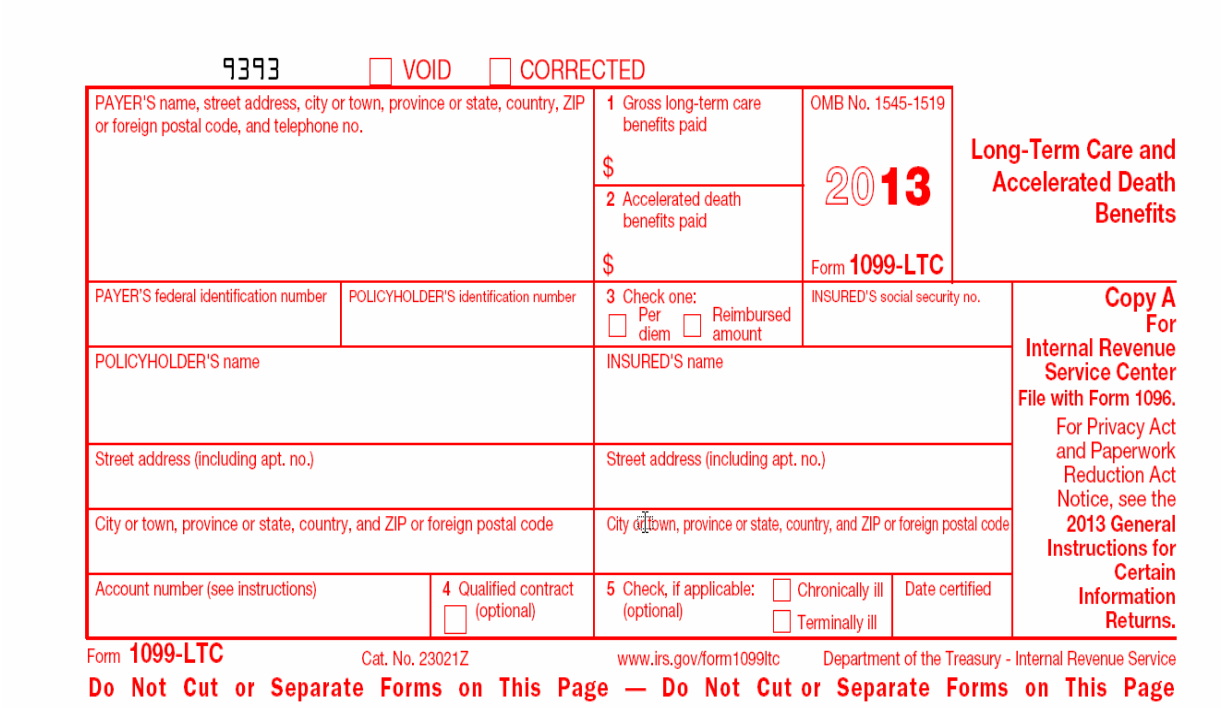
6. Which type of life insurance product, SPDA, fixed, indexed or variable, will be best suited to specific clients? What if they do not perform as anticipated? Will consumers who purchase a combo plan be faced with a lower level of benefits if the underlying life insurance or annuity contract pays the guaranteed rate as opposed to the current rate? Will there be "true-up" provisions which give the insured an ability to "reinforce" their long-term care pay-out in the event that product investment performance doesn't reach expectations.

Conclusion

This complex area of law and especially the advent of "combo products" (life and annuity) raise many new questions regarding how agents discuss long-term care needs and solutions with consumers. Full discussion of suitability of specific long-term care products and disclosure of all terms, conditions and protections will become even more important as will suggesting the correct and suitable solution.

Finally, all insurance agents should be keenly aware that the information provided in this treatise gives a broad description of the tax issues related to long-term care insurance. Since most agents are not Certified Public Accountants (CPA's) or tax preparers they should be very cautious and understand their limitations in advising insured's about their specific tax situation and circumstances. Agents should always refer clients to insured's tax advisor for the final analysis of the tax impact of long-term care insurance and expenses.

Form 1099 LTC



9393 ☐ VOID ☐ CORRECTED

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no.	1 Gross long-term care benefits paid $	OMB No. 1545-1519	Long-Term Care and Accelerated Death Benefits
	2 Accelerated death benefits paid $	2013 Form 1099-LTC	

PAYER'S federal identification number	POLICYHOLDER'S identification number	3 Check one: ☐ Per diem ☐ Reimbursed amount	INSURED'S social security no.	Copy A For Internal Revenue Service Center File with Form 1096. For Privacy Act and Paperwork Reduction Act Notice, see the 2013 General Instructions for Certain Information Returns.
POLICYHOLDER'S name		INSURED'S name		
Street address (including apt. no.)		Street address (including apt. no.)		
City or town, province or state, country, and ZIP or foreign postal code		City or town, province or state, country, and ZIP or foreign postal code		
Account number (see instructions)	4 Qualified contract ☐ (optional)	5 Check, if applicable: (optional) ☐ Chronically ill ☐ Terminally ill	Date certified	

Form 1099-LTC Cat. No. 23021Z www.irs.gov/form1099ltc Department of the Treasury - Internal Revenue Service

Do Not Cut or Separate Forms on This Page — Do Not Cut or Separate Forms on This Page

Form 8853

Form **8853**

Department of the Treasury
Internal Revenue Service (99)

Archer MSAs and Long-Term Care Insurance Contracts

► Information about Form 8853 and its separate instructions is available at www.irs.gov/form8853.
► Attach to Form 1040 or Form 1040NR.

OMB No. 1545-0074

2012

Attachment Sequence No. 39

Name(s) shown on return

Social security number of MSA account holder. If both spouses have MSAs, see instructions ►

Section A. Archer MSAs. If you have only a Medicare Advantage MSA, skip Section A and complete Section B.

Part I Archer MSA Contributions and Deductions. See instructions before completing this part. If you are filing jointly and both you and your spouse have high deductible health plans with self-only coverage, complete a separate Part I for each spouse.

1	Total employer contributions to your Archer MSA(s) for 2012	1	
2	Archer MSA contributions you made for 2012, including those made from January 1, 2013, through April 15, 2013, that were for 2012. Do not include rollovers (see instructions)	2	
3	Limitation from the Line 3 Limitation Chart and Worksheet in the instructions	3	
4	Compensation (see instructions) from the employer maintaining the high deductible health plan. (If self-employed, enter your earned income from the trade or business under which the high deductible health plan was established.)	4	
5	Archer MSA deduction. Enter the smallest of line 2, 3, or 4 here. Also include this amount on Form 1040, line 36, or Form 1040NR, line 35. On the dotted line next to Form 1040, line 36, or Form 1040NR, line 35, enter "MSA" and the amount	5	

Caution: *If line 2 is more than line 5, you may have to pay an additional tax (see instructions).*

Part II Archer MSA Distributions

6a	Total distributions you and your spouse received in 2012 from all Archer MSAs (see instructions)	6a	
b	Distributions included on line 6a that you rolled over to another Archer MSA or a health savings account. Also include any excess contributions (and the earnings on those excess contributions) included on line 6a that were withdrawn by the due date of your return (see instructions)	6b	
c	Subtract line 6b from line 6a	6c	
7	Unreimbursed qualified medical expenses (see instructions)	7	
8	Taxable Archer MSA distributions. Subtract line 7 from line 6c. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to line 21, enter "MSA" and the amount	8	
9a	If any of the distributions included on line 8 meet any of the Exceptions to the Additional 20% Tax (see instructions), check here ► ☐		
b	Additional 20% tax (see instructions). Enter 20% (.20) of the distributions included on line 8 that are subject to the additional 20% tax. Also include this amount in the total on Form 1040, line 60, or Form 1040NR, line 59. On the dotted line next to Form 1040, line 60, or Form 1040NR, line 59, enter "MSA" and the amount	9b	

Section B. Medicare Advantage MSA Distributions. If you are filing jointly and both you and your spouse received distributions in 2012 from a Medicare Advantage MSA, complete a separate Section B for each spouse (see instructions).

10	Total distributions you received in 2012 from all Medicare Advantage MSAs (see instructions)	10	
11	Unreimbursed qualified medical expenses (see instructions)	11	
12	Taxable Medicare Advantage MSA distributions. Subtract line 11 from line 10. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to line 21, enter "Med MSA" and the amount	12	
13a	If any of the distributions included on line 12 meet any of the Exceptions to the Additional 50% Tax (see instructions), check here ► ☐		
b	Additional 50% tax (see instructions). Enter 50% (.50) of the distributions included on line 12 that are subject to the additional 50% tax. Also include this amount in the total on Form 1040, line 60, or Form 1040NR, line 59. On the dotted line next to Form 1040, line 60, or Form 1040NR, line 59, enter "Med MSA" and the amount	13b	

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 24091H Form **8853** (2012)

Form 8853 (cont)

Form 8853 (2012) Attachment Sequence No. 39 Page 2

Name of policyholder (as shown on Form 1040) | Social security number of policyholder ▶

Section C. Long-Term Care (LTC) Insurance Contracts. See Filing Requirements for Section C in the instructions before completing this section.

If more than one Section C is attached, check here . . . . . ▶ ☐

14a Name of insured ▶ b Social security number of insured ▶

15 In 2012, did anyone other than you receive payments on a per diem or other periodic basis under a qualified LTC insurance contract covering the insured or receive accelerated death benefits under a life insurance policy covering the insured? . . . . . ☐ Yes ☐ No

16 Was the insured a terminally ill individual? . . . . . ☐ Yes ☐ No

Note: If "Yes" and the only payments you received in 2012 were accelerated death benefits that were paid to you because the insured was terminally ill, skip lines 17 through 25 and enter -0- on line 26.

17	Gross LTC payments received on a per diem or other periodic basis. Enter the total of the amounts from box 1 of all Forms 1099-LTC you received with respect to the insured on which the "Per diem" box in box 3 is checked		17	
	Caution: Do not use lines 18 through 26 to figure the taxable amount of benefits paid under an LTC insurance contract that is not a qualified LTC insurance contract. Instead, if the benefits are not excludable from your income (for example, if the benefits are not paid for personal injuries or sickness through accident or health insurance), report the amount not excludable as income on Form 1040, line 21.			
18	Enter the part of the amount on line 17 that is from qualified LTC insurance contracts		18	
19	Accelerated death benefits received on a per diem or other periodic basis. Do not include any amounts you received because the insured was terminally ill (see instructions)		19	
20	Add lines 18 and 19		20	
	Note: If you checked "Yes" on line 15 above, see Multiple Payees in the instructions before completing lines 21 through 25.			
21	Multiply $310 by the number of days in the LTC period	21		
22	Costs incurred for qualified LTC services provided for the insured during the LTC period (see instructions)	22		
23	Enter the larger of line 21 or line 22	23		
24	Reimbursements for qualified LTC services provided for the insured during the LTC period	24		
	Caution: If you received any reimbursements from LTC contracts issued before August 1, 1996, see instructions.			
25	Per diem limitation. Subtract line 24 from line 23		25	
26	Taxable payments. Subtract line 25 from line 20. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21. On the dotted line next to line 21, enter "LTC" and the amount		26	

Form 8853 (2012)

Attachment III

California Department of Insurance APPLICABLE LAWS & PENALTIES REQUIRED ATTACHMENT

Revised: 04/15/2013 LTC8

LONG-TERM CARE INSURANCE CODE	APPLICABLE LAW	PENALTY
Long-Term Care Insurance Sections 10230-10237.6	**§10233.3; §10234.85; §10234.86; §10234.87; §10234.97** Various requirements for the replacement of LTC policies. **§10234.95** All sales of LTC insurance shall meet the "suitability" standards.	*All violations of Chapter 2.6 subject to the following penalties in addition to court penalties, attorney's fees and costs per §10234.2.:* □ **§10234.3(a):** Penalty of not less than $250 for each 1st violation; not less than $1,000 and not more than $25,000 for each subsequent or knowing violation; for inappropriate replacement of LTC coverage, penalty not more than $5,000 for each violation. □ **§10234.4(a):** Suspend or revoke license. □ **§10234.4(c):** Ordered to cease marketing LTC insurance in California.
GENERAL PROVISIONS **Misrepresentation of Policies Section 780** **Twisting Section 781**	**§780** Prohibited statements re: terms, benefits, privileges or future dividends of policy. **§781(a)** Twisting: prohibited statement known to be a misrepresentation to induce person to take out a policy, refuse a policy and take out another, let lapse, forfeit of surrender policy. **§781(b)** Prohibited misleading statement or comparison of insurers or policies to induce person to let insurance lapse, forfeit, change or surrender policy.	**Section 782:** Any person who violates section 780 or 781 is punishable by fine not to exceed $25,000, or if victim loss exceeds $10,000, the fine not to exceed 3 times the loss suffered by the victim, by imprisonment not to exceed 1 year or by both a fine and imprisonment. Restitution to victim pursuant to Section 1202.4 of the Penal Code shall be satisfied before any fine imposed by this section is collected. **Section 783:** Any insurance agent, broker or solicitor who knowingly violates section 780 or 781 may have their license suspended for up to three years after a hearing.

Unfair Practices Sections 790-790.15

§790.01 Applies to insurers, agents, etc. and "all other persons engaged in the business of insurance".
§790.02 Prohibits use of unfair trade practices or unfair method of competition or deceptive act or practice in the business of insurance.
§790.03 Lists in detail prohibited acts such as: misrepresentations about the terms of any policy issued or the benefits or advantages promised; prohibits making, disseminating, causing to be made or disseminated in any manner any known or reasonably should be known, untrue, deceptive, misleading statement.
§790.037 Unfair practice selling health care products; cold lead advertising; appointments; Medicare products restrictions on sales discussions.

All violations of Article 6.5 subject to penalties as follows:

- **§790.035(a):** Civil penalty of NTE $5,000.00 for each act. If act or practice is willful, civil penalty NTE $10,000.00 for each act.

- **§790.05:** Cease and Desist Order; subsequent violations license may be suspended/revoked for up to one year.

- **§790.06:** Prosecution of acts not defined in §790.03-Cease and Desist Order.

- **§790.07:** Violation of Cease and Desist Order; penalty NTE $5,000; if willful, penalty NTE $55,000 plus penalty under §790.05.

- **§790.08**: Provides that the penalties in this Article are in addition to any other powers of the Commissioner to enforce the laws.

OTHER RELEVANT INSURANCE CODE SECTIONS

Insurance Information & Privacy Protection Act Sections 791-791.28

§791.03 Prohibits the use of "pretext interviews" to obtain information in connection with an insurance transaction (i.e. "free lunch" seminars).

All violations of Article 6.6 subject to penalties as follows:

- **§791.17:** Cease and desist order issued.

- **§791.19:** Violation of Cease & Desist order: Penalty of not more than $10,000 for each violation; or not more than $50,000 if frequent violations constitute general business practice.

Suspension & revocation of license for knowing violation.

Medicare Supplement Insurance Sections 10192.1-10192.24

§10192.18 Application forms require certain questions to determine if applicant already has a policy or certificate; must be signed by applicant and agent.
§10192.21(b) Prohibits sale of a Medicare supplement policy or certificate if individual already has one.
§10192.23 States time periods for replacement of policies.

All violations of Article 6 subject to the following penalties:

- **§10192.165(a) & (c):** Court penalties including damages & restitution.

- **§10192.165(b)(1):** Penalty of no less than $250 for first violation by agent, broker, other person/entity engaged in business of insurance.

- **§10192.165(b)(2):** Penalty of no less than $1,000 and no more than $25,000 for each second, subsequent or knowing violation.

- **§10192.165(d):** Order to cease marketing any Medicare supplement policy or certificate.

- **§10192.165(e):** Any person who knowingly or intentionally violates this Article is punishable by imprisonment in county jail NTE one year, or by imprisonment per Penal Code §1170 or a fine NTE $10,000 or both.

Attachment IV

Long-Term Care Insurance Personal Worksheet (Sample)

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone. By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (non-cancelable/guaranteed renewable):

The Company's Right to Increase Premiums:

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

_ From my Income _ From my Savings/Investments _ My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a non-cancelable policy.

What is your annual income? (check one)

_ Under $10,000 _ $[10-20,000] _ $[20-30,000] _ $[30-50,000] _ Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

_ No change _ Increase _ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) _ Yes _ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

_ From my Income _ From my Savings/Investments _ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering?

Number of days: _____ Approximate cost: $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

_ From my Income _ From my Savings/Investments _ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

_ Under $20,000 _ $20,000-$30,000 _ $30,000-$50,000 _ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

_ Stay about the same _ Increase _ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure

_ The answers to the questions above describe my financial situation.

OR
_ I choose not to complete this information.
(Check one)

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures.

_ I understand that the rates for this policy may increase in the future.
(This box must be checked)

Signed:

(Applicant) (Date)

[I explained to the applicant the importance of completing this information.

Signed:

(Agent) (Date)

Agent's Printed Name:]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:]

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Attachment V

Long Term Care Insurance Suitability Letter (Sample)

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

(note to insurers: Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next sixty (60) days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next sixty (60) days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

____**Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this _____ coverage. Please resume review of my application.
Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

_ **No.** I have decided not to buy a policy at this time.

_____ _____
APPLICANT'S SIGNATURE DATE
Please return to [issuer] at [address] by [date].

Attachment VI

Nursing Home Bill of Rights (Sample)

Under federal regulations, all nursing homes must have written policies that describe the rights of residents. The nursing home is required by law to make this policy statement - the "Nursing Home Resident's Bill of Rights" - available to any resident who requests it. The following outlines the issues that should be covered in the bill of rights.

1. The Right To Be Informed Of Your Rights And The Policies Of Time
The nursing home must have written policies about your rights and responsibilities as a resident. You must sign a statement saying that you have received and understood these rights and the rules of the home when you are admitted.

2. The Right To Be Informed About The Facility's Services And Charges
Every resident has the right to be fully informed of the services available in the facility and of the charges related to those services. This includes charges for services not covered under Medicare or Medicaid and charges that are not covered by the facility's basic rate.

3. The Right To Be Informed About Your Medical Condition
Every resident has the right to be fully informed of his/her medical condition, unless the physician notes in the medical record that it is not in the patient's interest to be told.

4. The Right To Participate In The Plan Of Care
Every resident must be given the opportunity to participate in the planning of his/her medical treatment. This includes the right to refuse treatment.

5. The Right To Choose Your Own Physician
Every resident has the right to choose his/her own physician and pharmacy. Residents do not have to use the nursing home's physician or pharmacy.

6. The Right To Manage Your Own Personal Finances
You can either manage your own funds or authorize someone else to manage them for you. If you authorize the home to handle your funds, you have the right to:

- Know where your funds are and the account number
- Receive a written accounting statement every 3 months
- Receive a receipt for any funds spent
- Have access to your funds within 7 banking days

7. The Right To Privacy, Dignity And Respect
Every resident has the right to be treated with consideration, respect, and with full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs.

8. The Right To Use Your Own Clothing And Possessions
Every resident may retain and use his/her personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, or constitute a hazard to safety.

9. The Right To Be Free From Abuse And Restraints
Every resident has the right to be free from mental and physical abuse, and free from chemical and physical restraints except as authorized in writing by a physician for a

specified and limited period of time, or when necessary to protect the patient from injury to him/herself or to others.

10. The Right To Voice Grievance Without Retaliation
Every resident should be encouraged and assisted to exercise his/her right to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of his/her choice without fear of coercion, discrimination, or reprisal.

11. The Right To Be Discharged Or Transferred Only For Medical Reasons Residents may only be discharged or transferred for medical reasons, or for his/her welfare or that of other residents. You must be provided with 30-days advance written notice of the transfer or discharge. The law gives you the right to appeal your discharge or transfer.

12. Your Rights Of Access
Residents may receive any visitor of their choosing and may refuse a visitor permission to enter their room or may end a visit at any time

- Residents have the right to immediate access by family and reasonable access to others
- Visiting hours of at least 8 hours must be posted in a public place
- Members of community organizations and legal services may enter any nursing home during visiting hours
- Communication between the resident and visitor are confidential
- Visitors may talk to all residents and offer them personal, social, and legal services
- Visitors may help residents claim their rights and benefits through individual assistance, counseling, organizational activity, legal action, or other forms or representation.

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