Long-Term Care

In this section, you will focus your attention on long-term care insurance. You will learn specific terms and definitions, policy components and features, and the ways to issue long-term care contracts. After completing this section, you should know the coverages available in long-term care insurance, and be able to explain major regulations that apply to long-term care policies.

TERMS TO KNOW

Activities of daily living (ADLs) — a person's essential activities that include bathing, dressing, eating, transferring, toileting, continence
Benefits triggers — criteria that must be met in order to be eligible for benefits
Good faith — honest or sincere intent
Guaranteed renewable — a policy that is written on a noncancellable basis with the right to renew guaranteed
Suitability — a requirement to determine if an insurance product or an investment is appropriate for a particular customer

A. Product Overview

Educational Objective:

V.A.1. Regarding long-term care insurance, be able to identify:

a. Why this coverage might be needed
b. Standard levels of care
c. Places services are generally provided
d. The triggers for policy benefits (activities of daily living — ADLs, cognitive impairment, or Alzheimer's disease)
e. Marketing standards and responsibilities including Health Insurance Counseling and Advocacy Program (HICAP)
f. Available forms of LTC coverage
g. Guaranteed renewability and rates

Long-term care (LTC) insurance includes any insurance policy, certificate, or rider that provides coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital.

Long-term care insurance includes all products containing any of the following benefit types:

- Institutional care including care in a nursing home;
- Convalescent facility;
- Extended care facility;
- Custodial care facility;
- Skilled nursing facility;
- Personal care home;
- Home care coverage including home health care;
- Personal care;
- Homemaker services;
- Hospice or respite care; or
- Community-based coverage including adult day care, hospice, or respite care.

Long-term care insurance includes disability-based LTC policies, but does not include insurance designed primarily to provide Medicare supplement or major medical expense coverage.

In California, long-term care insurance contracts may be designed to pay for care only in one of the following settings:

- In a facility;
- In a person's home (or the home of another); or
- In any "community-based" setting, such as adult day care or hospice care.

Long-term care contracts can also be designed to be "comprehensive" – paying for care in either a facility setting or in home-based or community-based care settings.

Although long-term care insurance could be added by rider to either a Medicare supplement or health insurance policy, it does not pay for any Medicare or other major medical expenses.

The following are **standard** levels of care:

- Skilled nursing care;
- Intermediate nursing care;
- Nonskilled nursing care;
- Assisted living;
- Personal care;
- Home health care; and
- Home care and community-based care

B. Why This Coverage Might Be Needed

Although Medicare and Medigap policies provide elderly insureds with protection against the cost of medical care, these programs do not provide coverage for long-term custodial or nursing home care. Medicare will cover nursing home care if it is part of the treatment for a covered injury or illness. Medicare and Medicare supplements pay for skilled nursing care, but the coverage is limited. Medicaid does pay for nursing home care, but it provides coverage only for those that qualify with low income and low assets.

Medicare does not pay for more than 100 days in a skilled nursing facility, and even then, it does not cover 100% of the cost. Medi-Cal can pay for skilled or other levels of long-term care in a facility, but Medi-Cal has to meet "spend down" tests and "asset recovery" after death.

A person could pay for some or all the expenses of long-term care out of his/her own resources, the resources of family members or others. But LTC insurance may be the most cost-effective means of maintaining ones independence, physically and financially.

C. Levels Of Care

Generally, long-term care policies will cover 3 levels of care: skilled nursing care, intermediate care, and custodial care. In addition to these levels of care, the long-term care policy may provide coverage for home health care, adult day care, hospice care or respite care, all of which can be received at home.

1. Skilled Care

Skilled care is daily nursing and rehabilitative care that can only be provided by medical personnel, under the direction of a physician. Skilled care is almost always provided in an institutional setting. Examples of skilled care include changing sterile dressing and physical therapy given in a skilled nursing care facility. **Care that can be given by nonprofessional staff is not considered skilled care.**

2. Intermediate Care

Intermediate care is occasional nursing or rehabilitative care provided for stable conditions that require daily medical assistance on a less frequent basis than skilled nursing care. It is ordered by a physician, and skilled medical personnel would deliver or monitor this type of care. Intermediate care could be as simple as giving medication to a group in physical therapy once a day or changing a bandage. It may be carried out in a nursing home, an intermediate-care unit or in the patient's home.

3. Custodial Care

Custodial care is care for meeting personal needs such as assistance in eating, dressing, or bathing, which can be provided by nonmedical personnel, such as relatives or home health care workers. Custodial care can be provided in an institutional setting or in the patient's home. In other words, it involves caring for a person's activities of daily living, and not hospital or surgical needs.

Know This! Skilled care and intermediate care require the assistance of medically licensed personnel. Custodial care may be administered by nonmedical personnel.

4. Personal Care

Personal Care includes hands-on services to assist an individual with activities of daily living, and can be provided by a skilled or unskilled person.

D. Places Where Services Are Generally Provided

1. Nursing Home

Nursing home care coverage usually pays a specified amount for the time the insured spends in a nursing home, or for medical services received in a setting other than a hospital. Nursing home care is usually provided as one of the following:

- *Skilled nursing care* — the highest level of nursing care that requires the greatest expertise from the caretaker;
- *Intermediate nursing care* — similar to skilled nursing care, except for the patient does not require continuous attention; or
- *Custodial care* — the most basic level of nursing care, which normally requires assistance with the activities of daily living.

2. Assisted Living

Assisted Living offers help with nonmedical aspects of daily activities in an atmosphere of separate, private living units. In addition to providing meals, transportation for medical appointments, activities, and pleasure trips, assisted living may provide:

- Linens and personal laundry service;
- Assistance with dressing and bathing;
- Reminders regarding medication; and
- Assistance with eating.

3. Residential Care Facilities

Residential Care is provided while the insured resides in a retirement community or a residential care facility for the elderly (RCFE). In some arrangements, the degree of independence is the same as living in one's own home; however, this care provides a physical and social environment that contributes to continued intellectual, psychological and physical growth. These facilities are commonly for the middle and upper classes because of the costs.

4. Home Setting

Home health care is care provided by a skilled nursing or other professional services in one’s home. Home health care includes occasional visits to the person’s home by registered nurses, licensed practical nurses, licensed vocational nurses, or community-based organizations like hospice. Home health care might include physical therapy, occupational therapy, speech therapy, and medical services by a social worker.

5. Home Care

Policies with benefits limited to home care services (including residence and community-based) must be clearly labeled "Home Care Only" on the policy first page and the outline of coverage.

6. Hospice

Hospice is a facility that provides short-term, continuous care in a home-like setting to terminally-ill people with life expectancies of 6 months or less.

7. Respite Care

Respite Care is designed to provide relief to the family caregiver, and can include a service such as someone coming to the home while the caregiver takes a nap or goes out for a while. Adult day care centers also provide this type of relief for the caregiver.

8. Adult Day Care

Adult day care is care provided for functionally impaired adults on less than a 24-hour basis. It could be provided by a neighborhood recreation center or a community center. Care includes transportation to and from the day care center, and a variety of health, social and related activities. Meals are usually included as a part of the service.

E. Triggers For Benefits

Long-term care policies which intend to be federally tax-qualified (benefits received not subject to income tax), and to provide benefits for care received in a person's home or other community-based setting, will qualify an insured for benefits if he/she is determined to be a chronically ill individual who is impaired in at least **2 of the activities of daily living** (ADLs) or if the person has a severe cognitive impairment. To be considered a chronically ill individual or to have a severe cognitive impairment, a person's condition must be assessed by a health care practitioner who is not an employee of the insurer.

The 6 defined **activities of daily living** are the following:

1. Eating — taking in food and feeding oneself;
2. Bathing — bathing without assistance;
3. Continence — bowel and bladder control;
4. Dressing — clothing oneself;
5. Toileting — personal cleansing and grooming; and
6. Transferring — mobility, being able to move from one place to another in the home.

A **cognitive impairment** is an organic process (or the result of an accident) which results in a person’s inability to understand or appreciate the nature of his/her surroundings and the danger he/she represents to himself/herself or others. **Impaired** means that the individual requires either substantial supervision (stand-by assistance) or actual hands-on assistance with his/her ADLs.

F. Ways To Issue Contracts

Educational Objective:

V.A.1.f. Be able to identify LTC coverage methods:

i. LTC Insurance definition:
  1). Tax qualified
  2). Non-tax qualified
  3). California Partnership for Long-Term Care (CCR 58056)

ii. Endorsement/rider to life or annuity policies
iii. Range of daily and policy limits
iv. Suitability standards (CIC10234.95(c))

V.A.1.g. Be able to identify guaranteed renewability and rates.

1. Individual and Group

Long-term care insurance policies may be purchased on an individual basis, much like other individual health insurance policies. An individual policy provides benefits to a single individual and is issued based upon individual underwriting considerations.

Long-term care insurance may be purchased on a group basis, either at an insured's place of employment or as a member of an association. Group LTC policies must provide the insured, who would otherwise lose his or her coverage, with the right to continue or convert the LTC coverage into an individual policy without proof of insurability.

2. Tax qualified and Nonqualified

A long-term care insurance policy meets the definition of a qualified long-term care insurance contract if all of the following are present:

- The only insurance protection provided under the contract is coverage of qualified long-term care services;
- The contract does not pay or reimburse expenses incurred for services that are reimbursable under Title XVIII of the Social Security Act;
- The contract is guaranteed renewable;
- All premium refunds and dividends are used to reduce future premiums or increase future benefits to offset inflation; and
- The contract satisfies certain consumer protection provisions concerning model regulation and model act provisions, disclosure, and nonforfeitability.

Only products that meet the Qualified LTC definitions are eligible to be marketed as Partnership LTC plans.

The following chart compares qualified LTC plans with nonqualified LTC plans:

	QUALIFIED	NONQUALIFIED
Premiums	Can be included with other annual uncompensated medical expenses for deductions from income	May or may not be deductible by the insured
Benefits	Generally will not be counted as income.	May or may not count as income.
Benefit trigger	Federal law requires an insured be unable to perform 2 ADLs without substantial assistance	Benefit triggers are not restricted to 2 ADLs
Medical necessity	Cannot be used as a trigger for benefits	Can be offered as benefit triggers
Chronic illness or disability	Must be expected to last for at least 90 days	No requirement for 90-day period
Cognitive impairment	A person must require substantial supervision to trigger coverage	No restrictions on coverage

3. Endorsement to Life Policy

An alternative to purchasing an LTC insurance policy is an agreement by a life insurance company, known as **living benefits,** to advance a life insurance policy benefits rider. Living benefit riders agree to pay a part of the policy death benefit to insureds in order to pay for long term care or nursing home care, should the need arise. The rider will generally stipulate the conditions under which the benefit is triggered (attaining age 65 to 85, etc.). The advance is treated as a lien against death benefit of the policy.

G. Daily Benefits And Policy Maximum Limits

The benefit amount payable under most LTC policies is usually a specific fixed dollar amount per day, regardless of the actual cost of care. *For example*, if an insured has a fixed daily coverage of $100 and the care facility only charges $90 a day, the insurance company will pay the full amount of $100 a day. Some policies pay the actual charge incurred per day. Most LTC policies are also **guaranteed renewable**; however, insurers do have the right to increase the premiums.

Know This! LTC policies must be guaranteed renewable.

H. Guaranteed Renewability And Rate Increases

A long-term care policy issued to an individual must contain a renewability provision that prominently appears on the first page of the policy. Renewal provisions may not be less favorable than **guaranteed renewable** or noncancellable. The insurers who issue LTC policies may not cancel, nonrenew or otherwise terminate coverage solely on the grounds of the age or deterioration in mental or physical health of the insured.

The NAIC model regulations for long-term care insurance require that all insurers maintain and make available to the applicants the Long-term Care Insurance Personal Worksheet. On the premium section of the worksheet, the insurer must disclose all rate increases for all policies issued by the insurer or purchased from another insurer. The worksheet must also include a statement informing consumers of the availability of the rate guide that compares the policies sold by different insurers.

I. California Insurance Code Requirements

1. Prohibited Provisions

There are a number of **prohibited provisions** identified in the Code. LTC contracts **cannot** be issued under a renewal provision less favorable to insureds than guaranteed renewable for life. They **cannot** be cancelled, nonrenewed, or terminated for any reason other than nonpayment of premium. Additionally, long-term care contracts are prohibited from establishing a new waiting period for benefits if a policy is replacing or is being converted from another contract from the same insurer (with the exception of an increase in benefits, which may be temporarily excluded for up to 6 months).

Other prohibited provisions include the following:

- Limiting benefits to skilled nursing facilities only;
- Paying significantly different benefits for levels of facility care lower than skilled nursing;
- Defining benefits payable based on a definition of usual and customary, usual and reasonable, or similar language;
- Terminating coverage or increasing premiums for a spouse following divorce from an insured;
- Providing a payment for an additional, specific benefit which is less than 5 times the daily facility benefit; or
- Providing a daily amount for home-care or community-based care benefits which is less than that required by the Insurance Code (at least $50 per day or 50% of the facility-care benefit, whichever is higher).

2. California Partnership for Long-Term Care

LTC partnerships allow those who have exhausted or at least used some of their private LTC benefits to apply for Medicaid coverage without having to meet the same means-testing requirements. The partnership between LTC coverage and Medicaid works by disregarding some or all assets of applicants for Medicaid who have exhausted private LTC benefits and by exempting those assets from estate recovery after the insured's death. The partnership program was created to encourage those who would not otherwise do so to purchase LTC insurance, to reduce the incentives to transfer assets to qualify for Medicaid sooner, and to contain Medicaid spending on LTC services.

As a condition of issuer participation in California LTC partnerships, issuers must provide written evidence to the Department of Insurance that procedures are in place to assure that no agent, broker, solicitor, or individual will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a Partnership Long-Term Care Insurance Policy or Certificate unless that person has completed **8 hours of education on long-term care in general**, and **8 hours** of training in *a live classroom setting* **on the California Partnership for Long-Term Care in particular**. Such assurances must be provided in the form of a document signed by the agent, broker, solicitor, or individual and a representative of the company attesting to the completion of the required training and submitted to the Department of Insurance.

3. Marketing Standards and Responsibilities Including HICAP

The Insurance Code defines a variety of marketing standards to which insurers and its agents must adhere. Among them are the following:

- Procedures to insure that excessive insurance will not be sold or issued;
- That agents meet the continuing education requirements;
- A notice to applicants and insureds that the Health Insurance Counseling and Advocacy Program (HICAP) exists to aid persons, free of charge, in understanding and determining whether a particular long term care insurance policy is in their best interest;
- A current list of Area Agencies on Aging or other HICAP providers in California; and
- Several other publications, such as the Department of Aging's long term care insurance shopper's guide, are required to be given to every prospect or applicant.

A part of this section in the Insurance Code is a discussion of inappropriate practices, such as twisting, the use of high pressure tactics and the ramifications of **cold lead advertising.** In any advertisement or other marketing device intended to result in a person inquiring about long term care insurance, the advertisement or response card must clearly indicate whether an agent will contact the individual.

J. Consumer Protection Regarding Long-Term Care

Educational Objective:

V.A.2. Regarding consumer protection, be able to identify the provisions about:

a. The requirement for producers to complete LTC training prior to selling products (CIC 10234.93)
b. Duty of honesty, good faith, and fair dealing (CIC 10234.8)
c. Replacement of LTC insurance unnecessarily (CIC 10234.85)
d. Disclosure requirements for cold lead advertising (CIC 10234.9(c) and 10234.93(b)(3))
e. Suitability standards (CIC 10234.85)
f. Replacement coverage (CIC 10234.97(a) and (b))

1. LTC Training Requirements

Each agent authorized to solicit long-term care insurance **must satisfy the training and continuing education requirements**. The training requirements are as follows:

- 8 hours of LTC training annually for the first 4 years after the original license is issued; and
- 8 hours of training every 2-year license term thereafter.

The required LTC training is **included** in the hours required for overall continuing education, not added to them. Note that long-term care training is **not required** when an agent is transacting accelerated death benefit provisions or riders that do not require services.

LTC training is not required when transacting accelerated death benefit provisions or riders.

2. Duties of Honor, Good Faith, and Fair Dealing

With regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe their clients a duty of honesty, good faith, and fair dealing. Conduct of an insurer, broker, or agent during the offer and sale of a policy prior to the purchase can be counted in any legal action alleging a breach of these duties.

3. Unnecessary Replacement of LTC Insurance

Insurers, agents, and brokers are not allowed to compel policyholders to replace long-term care insurance policies unnecessarily. It is illegal 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.

According to the Insurance Code, any **third or greater** policy sold to a policyholder within a 12-month period is automatically considered to be **unnecessary**. This rule, however, does not apply to instances in which a policy is replaced solely for the purpose of consolidating policies with a single insurer.

4. Advertisement and Cold Lead Device Disclosure

Every insurer providing long-term care coverage in California must provide a copy of any advertisement intended for use in California to the Commissioner for review at least **30 days** before it is used. The advertisement must also be retained by the insurer for at least **3 years**.

An advertisement designed to produce leads must **prominently disclose** that an insurance agent will contact the consumer if that is the case. An agent, broker, or other person who contacts a consumer as a result of receiving information generated by a cold-lead device must immediately disclose that fact to the consumer.

5. Suitability Standards

All insurers that market long-term care insurance must develop and abide by suitability standards to determine whether the purchase or replacement of LTC insurance is appropriate for the applicant's needs. A copy of the standards must be available for inspection upon a request by the insurance Commissioner. It is the insurer's responsibility to train its agents in the use of the suitability standards.

California regulates the sale of long-term care insurance in order to promote the public interest, promote availability of insurance, and protect consumers from unfair or deceptive sales or enrollment practices. However, when purchasing LTC insurance, the consumer needs to be aware of benefits and limitations to avoid problems in the event of a claim in the future:

- **Benefit limits:** All LTC policies set benefit limits, in terms of how long the benefits are paid and/or how much the dollar benefit will be for any one covered care service. Maximum coverage periods also vary.
- **Elimination period:** This is the period from the inception of a policy during which benefits will not be paid. This period may range from 0 days to 365 days. The longer the elimination period, the lower the premium.
- **Inflation protection:** While California insurers must offer policyholders the option to purchase inflation protection that increases the benefits of the policy to account for anticipated increase in the cost of services, the cost of the increase protection may make the policy unaffordable after a certain period of time.

6. Replacement Coverage

When long-term care coverage is replaced, the sales commission that is paid by the insurer and that represents the percentage of the sale normally paid for first year sales of long-term care policies or certificates will be calculated based on the

difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission will be limited to the percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement is contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured. This rule does not apply to group insurance replacement.

Commission or other compensation includes compensation of any kind (monetary or not) relating to the sale or renewal of the policy or certificate including (but not limited to) bonuses, gifts, prizes, awards, and finder's fees.

K. Chapter Recap

In this chapter, you learned about the important terms, definitions, and policy components of long-term care insurance policies. Let's look over some of the key points:

LONG-TERM CARE	
Policies	• Available as individual policies, group policies, or as riders to life insurance policies • Coverage for individuals who require living assistance at home or in a nursing home facility • Must provide at least 12 months of consecutive coverage in a setting other than an acute care unit of a hospital • Guaranteed renewable, but insurers may increase premiums
Levels of Care	• *Skilled care* - daily nursing and rehabilitative care provided by medical personnel • *Intermediate care* - occasional nursing or rehabilitative care provided for stable conditions that require daily medical assistance on a less frequent basis than skilled nursing care • *Custodial care* - care for a person's activities of daily living provided in an institutional setting or in the patient's home • *Home health care* - provided by registered nurses, licensed practical nurses, licensed vocational nurses, or community-based organizations like hospice in one's home • *Residential care* - provided while the insured resides in a retirement community • Hospice - short term for terminally ill people with a life expectancy of 6 months or less • *Adult day care* - provides for functionally impaired adults on less than a 24-hour basis • *Respite care* - provides relief to the family caregiver; adult day care centers may also provide this type of relief • *Assisted living* - provides help with nonmedical daily activities
Coverage and Benefits	• 12 consecutive months • Elimination period between 0-365 days

	• Longer benefit periods result in higher premium • Trigger: inability to perform 2 ADLs
Required Provisions	• Must be guaranteed renewable • Must offer inflation protection • Must cover Alzheimer's disease • Disclosure requirements - outline of coverage and policy summary