STATE HEALTH INSURANCE COUNSELING (SHIP)
LONG-TERM SERVICES AND SUPPORTS (LTSS)

TRAINING MANUAL 2016

SHIP LTSS TRAINING MANUAL | *Table of Contents*

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Welcome to the 2016 update of the National Long-Term Care Training Manual. It has been 12 years since the original manual was published in 2004, and much has changed even since the 2009 update. This 2016 edition serves as both a supplement and an update to the previous manuals.

To begin, today we talk about Long-Term Services and Supports (LTSS) to more broadly incorporate all aspects of what has historically been called "long-term care." This new vocabulary is important in recognizing the diversity of types of care needs and the nature and types of services and supports that are brought to bear when someone has a functional and/or a cognitive limitation. As people live longer, the need for LTSS will continue to increase. LTSS are needed by people of all ages and, as we'll learn in this manual, encompass a diverse and ever-changing set of needs. The objective of the LTSS National Training Manual is to educate, inform, and support the ability of aging services network professionals, volunteer counselors, and the consumers they serve to better prepare consumers for the critical issues and care needs they will face. The original manual and its current and 2009 updates are based on research informing both consumer and counselor educational needs. In 2003, the U.S. Department of Health and Human Services conducted three comprehensive, multi-day training sessions covering the material in the manual. The trainings were conducted for representatives of each state's State Health Insurance Counseling (SHIP) agency. The training materials, including a manual and videos of the training (to be used to "train the trainers"), were also made available as on-line resources to staff of both SHIP agencies and the Aging & Disability Resource Centers (ADRCs).

The goal of the original and updated manuals is to advise and inform professionals and volunteers working in SHIPS, ADRCs, or other agencies who might be in a position to advise and counsel consumers on LTSS including the most recent developments, options, and issues in this area.

To develop the 2009 edition, focus groups were conducted with users of the 2003 materials as well as LTSS counselors unfamiliar with the previous manual. The project team collected input on the agencies' preferences and needs for training and counseling consumers about LTSS. Interviews were conducted by phone and in person with SHIP Directors and/or SHIP staff from 12 states.

Changes made to the original and subsequent manual to better meet counselor and consumer needs included:

- The creation of easy-to-use Counselor Tip Sheets and Consumer Tip Sheets on the most frequently requested content. These provide an "at a glance" treatment of the topic to supplement information in the manual. These also serve as helpful "leave behind" material for consumers.
- **Education about private options for how to plan ahead and help pay for LTSS when needed was expanded.** While people found the other modules of the training materials helpful, SHIP Program Directors and staff articulated, almost uniformly, a need to raise the level of knowledge among their counselors about the details of long-term care insurance and other private finance options.

- **SHIP counselors expressed the need for different types of training and training materials on private long-term care insurance.** A common request was for training that would give counselors the tools and knowledge needed to sit down with consumers and counsel them on the specific features of a policy, or to compare one policy with another. A second request was for more generic training on long-term care insurance products for all benefit counselors. SHIP counselors also expressed interest in educational material that counselors could give to consumers to take with them after a counseling session to serve as a reminder of the information provided during the session.

Who Should Use this Training Manual?

Anyone who is in a position to educate, inform, or advise consumers about LTSS in general, and insurance specifically, should find this Training Manual to be a helpful resource.

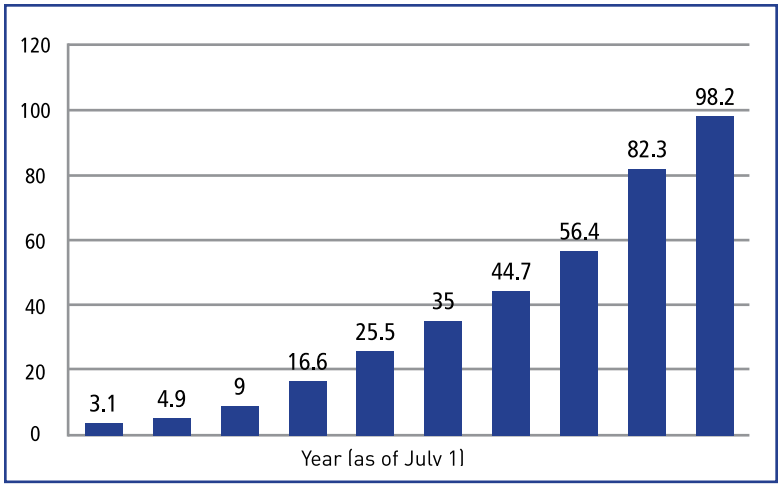
The Importance of LTSS Counseling

Long-term care needs are best met when they are planned for. As a counselor, you play an important role in helping people plan for their LTSS needs. Whether they are just starting to think about these issues or have already taken some steps in the planning process, your role is to provide information and resources to help them understand the options and which options work best in each person's particular situation.

There is, and will continue to be, a growing need for LTSS. This is due to a number of factors, including:

- Population Growth. Older adults comprise a large and growing proportion of the total U.S. population. Persons aged 65 and over account for more than 14 percent of the population today and will represent nearly 22 percent of the population by the year 2040. [Administration on Aging, ACL, www.aoa.acl.gov/aging_statistics. (This compares with 8 percent in 1950.) The group that is most at risk of needing LTSS – people over age 75 – is growing at nearly four times the rate of the general population.
- Living Longer. Advances in medical care and improved nutrition mean more people will live long enough to reach the point where they may need LTSS. These advances impact all ages; as recently as from 1990 to 2007, death rates for the population aged 65 to 84 have decreased. Life expectancy at age 65 has increased by four years since 1960 (compared with only a 2.5 year increase for the period 1900 through 1960).
- Social Changes. Adult children are less likely to live near their aging parents. Women have historically taken care of family members needing care and many continue to do so. However, because more women work outside the home today and may also be raising children, they are less likely to be able to provide the care that family members need. More people who need LTSS will have no choice but to turn, in whole or in part, to paid services (formal care), rather than relying exclusively on family members to provide care (informal care).

Figure 1: Number of Persons 65+, 1900 to 2060 (numbers in millions)



Note: Increments in years uneven.

Source: U.S. Census Bureau, Population Estimates and Projections.

The counselor's role is to provide the most relevant information and help consumers find the best solution for their individual situation. The counselor worksheets and consumer tip sheets described below, as well as other resources such as the National Clearinghouse for Long-Term Care Information (www.longtermcare.gov), can be valuable tools in this process.

Helpful Resources

This LTSS Training Manual includes helpful resources to support you and the consumers you counsel. These include the following pieces of information that are color-coded for easy identification:

Counselor Tip-Sheets (blue banner at the top). These one to two page handouts or worksheets are designed to reinforce and summarize key points from the manual. The Counselor Tip Sheets are easy "cheat sheets" to help counselors easily recall critical information. They can also be used to test your knowledge and train others. Counselor Tip Sheets include:

- **LTSS Planning Worksheet** – Information needed to assess the consumer's situation and determine appropriate options.
- **Long-Term Care Insurance Present Value Worksheet** – To summarize a consumer's existing coverage to see if an upgrade or replacement is necessary or if it will adequately meet today's and tomorrow's LTSS needs.
- **Private LTSS Financing Options: At a Glance** – To summarize financing options other than insurance, and help provide a framework for determining if these other options might be appropriate for a consumer.
- **Partnership Brochure** – A generic brochure about the Long-Term Care Partnership Program. States may also modify this to develop a brochure specific to their state's program requirements.

Consumer Fact Sheets (brown/orange banner at the top). These are intended as worksheets or summaries that the counselor can review with the consumer and give to the consumer for further review and consideration. Each Fact-Sheet pertains to an important topic for considering how to plan for and finance LTSS needs.

Consumer Fact Sheets include the following:

- **LTSS Fact Sheet** – Basic information on long-term care.
- **Who Pays for LTSS** – Summary of how LTSS are typically paid for and the conditions associated with various payment sources.
- **Planning IQ Quiz** – Designed to get consumers thinking about easy steps they can take to begin planning for LTSS.
- **How to Design the Right Policy** – A series of checklists to help consumers understand the key elements in designing a long-term care insurance policy and questions to ask to tailor a policy to their unique circumstances and needs.
- **Policy Comparison Worksheet** – Drawn in part from the NAIC Shoppers' Guide for Long-Term Care Insurance, this worksheet lets consumers compare features of policies they may be considering.
- **Is Long-Term Care Insurance Right for Me?** – A worksheet for consumers to determine whether they should even consider long-term care insurance. It assesses financial and non-financial considerations important to making this decision.
- **How to Be a Smart Shopper** – Offers tips on what to look for and what to avoid in searching for a high-quality, long-term care insurance product.
- **Long-Term Care Insurance Personal Worksheet** – A generic version (not state specific) of the suitability worksheet required in many states and designed to help consumers decide if buying long-term care insurance is right for them. Consumers who decide to apply for long-term care insurance often need to complete and submit this form along with their applications as the insurer is obligated to review the suitability of the sale against its company's standards.
- **Things You Should Know Before You Buy** – A summary of important considerations in buying long-term care insurance.
- **Long-Term Care Partnership Programs: Frequently Asked Questions** – Provides concise and clear answers to important questions about state Long-term Care Partnership Programs. While not state-specific, states can customize it to their own Partnership program provisions.
- **Can Everyone Buy Long-Term Care Insurance?** Helps consumers understand underwriting and the types of conditions that might cause someone to be uninsurable.
- **My Rates Went Up! What Do I Do Now?** A step-by-step guide on how to handle a rate increase if a consumer receives notification of a rate increase.
- **Tax Treatment at a Glance** – A summary of how long-term care insurance premiums and benefits are handled from a tax perspective.
- **Private LTSS Financing Options** – A consumer guide to considerations influencing the choice of private finance options such as stand-alone or combination insurance products, reverse mortgages, annuities and others.

Other Resources in the Manual:

- A Glossary of Terms (glossary terms are also included in a side-bar box on the face page of each chapter where they are introduced).
- A Resource Section with Internet links and other resources, with a brief description of each, listed alphabetically by topic.
- As requested by SHIP counselors, a sample Long-Term Care Insurance Policy annotated to analyze and explain – in plain English – the purpose and meaning of each section of the policy. This sample policy developed for annotation represents a typical long-term care insurance policy sold today by the major insurance companies. Counselors and consumers can compare a specific policy under consideration with the "annotated" version to help better understand key provisions.

CHAPTER 1 | Long-Term Services and Supports (LTSS) Basics

Chapter 1 is an introduction to LTSS. This chapter describes how professionals determine when a person needs LTSS, the different types of care settings, services, and providers and the basics on how these services are paid for.

There are concepts and terminology unique to the topic of LTSS. Beginning here and continuing throughout the training manual, these terms are introduced and defined for you. At the beginning of each chapter, there is a list of keywords for easy reference. Your familiarity with these terms will help you assist consumers in understanding and discussing LTSS as they begin to plan for their own or a loved one's future.

Specifically, this chapter answers the questions:

- What are LTSS?
- When are they needed?
- What are the different types of LTSS?
- Where is care typically provided?
- How long are LTSS received?
- How much does care cost?
- Who pays for LTSS?

Counselor Tip Sheets:
» A Closer Look at Medicaid and LTSS
» A Closer Look at Medicare and LTSS

Consumer Fact Sheets:
» LTSS Facts
» Who Pays for LTSS?

Chapter 1 Key Words & Acronyms:

- Activities of Daily Living (ADLs)
- Assets
- Cognitive Impairment
- Formal Care
- Income
- Informal Care
- Instrumental Activities of Daily Living (IADL)
- Intermediate Care Facility
- Medicaid
- Medicare
- Personal Care
- Skilled Care
- Skilled Care Facility
- Supervisory Care

What does the term Long-Term Services and Supports Encompass?

LTSS describes a wide variety of services and supports to meet the health or personal care needs of people who have a chronic illness or disability. The majority of long-term care is non-skilled assistance with activities of daily living or care and supervision for a person with a Cognitive Impairment.

The six basic Activities of Daily Living are:

Bathing. Getting into and out of the tub or shower; washing oneself in the tub or shower or by sponge or bed bath
Dressing. Getting, putting on, and taking off all necessary clothing, including braces and splints
Toileting. Getting to and from and on and off the toilet; caring for clothing and performing related personal hygiene

Transferring. Moving between a bed and a chair
Continence. Voluntary control of bowel and bladder function or being able to use devices such as a catheter or continence pad and all associated personal hygiene
Eating. Getting food into your body by any means once it has been prepared and made available

Cognitive Impairment is a deterioration or loss of intellectual capacity. Someone who has a cognitive impairment may have problems with memory, reasoning, or may be disoriented about people, place, or time. People with cognitive impairments often require continual supervision to protect themselves or others. The most well-known example of a cognitive impairment is Alzheimer's disease.

Most long-term care is provided in the home but can also be provided in the community, in an assisted living facility, or in a nursing home. The goal of LTSS is to help maximize independence and functioning at a time when an individual is unable to be fully independent.

Types of LTSS

When many people think of LTSS, they think first of nursing home care. But the majority of LTSS is provided in the home and in the community. There are three different types of long-term care:

Skilled Care is medical or nursing care (such as help with medications, monitoring a chronic illness, or caring for bandages and wounds) and therapies (such as occupational, speech, respiratory, and physical therapy). Skilled care is usually delivered by a nurse, therapist, or other trained professional. Most people think of skilled services when they think of LTSS. But in reality less than 15 percent of all people who need LTSS actually need skilled care.

Personal Care is hands-on care or assistance with basic life activities (referred to above as Activities of Daily Living) such as bathing and dressing. Personal care may also include assistance with what are called "instrumental activities of daily living" (IADLs), which often accompany loss of the ability to perform ADLs or the presence of a Cognitive Impairment. IADLs include activities such as grocery shopping, meal preparation, managing money, using the telephone, and performing housework. The goal of personal care is to provide help with activities a person is unable to perform on his or her own. Most people who need LTSS need personal care, not skilled care.

Supervisory Care is monitoring, supervision, and stand-by help with Activities of Daily Living to ensure that individuals do not harm themselves or others. Supervisory care is often needed because of a severe cognitive impairment. In fact, many people who have this type of loss (cognitive), are able to independently perform their ADLs, but may not do so properly or may be a danger to themselves or others due to confusion, disorientation, or similar cognitive deficits.

Table 1.		
Skilled Care	**Personal Care**	**Supervisory Care**
Medical or nursing care; physical, speech, occupational therapies	Help with Activities of Daily Living	Monitoring, supervision, and stand-by help with Activities of Daily Living, because of cognitive impairment

Where are LTSS Provided?

LTSS are provided in many settings. While often associated with nursing homes, the majority of care is provided in the home and in community settings. It is estimated that fewer than 20 percent of all people who require long-term care live in nursing homes. Where care is provided depends on a person's condition, preferences, and family circumstances, the care options available in the community, and the person's ability to afford the different types of care.

Home Care consists of a broad range of services delivered in the home. Home care can be provided by paid professionals (formal care) through home care or home health care agencies, or by family and friends (informal care).

Paid professionals include nurses and therapists providing skilled care (for example, speech or physical therapy or help taking medications) or personal care aides or home health aides helping with personal care, chores, or homemaker services.

About 40 percent of home care is provided by informal caregivers (on a weekly basis). Caregivers provide a vast array of emotional, financial, nursing, social, homemaking, and other services on a daily or intermittent basis. One study estimates caregivers spend on average 19 days per month providing direct personal care, help with personal care, managing medications and housekeeping, meal preparation, and similar tasks. About half (46 percent) of caregivers surveyed in one study reported that they performed a variety of "medical and nursing tasks". More than half of informal caregivers report that they had caregiver responsibility for an average of three years or more. [https://caregiver.org/].

Adult Day Service Centers provide a coordinated program of services for adults in a community-based group setting. These services are designed to provide health, personal care, and social services to adults who need supervised care in a safe place outside the home during the day. They also afford caregivers respite from the demanding responsibilities of daily care-giving. Adult day service centers typically operate during normal business hours five days a week. Some programs offer services in the evenings and on weekends; a few may also offer services at night. Although facilities may differ in terms of features, most provide the following services: personal care, therapeutic activities including supervision and help with medication, meals, transportation, and social and recreational activities.

Nursing Homes care for people who are chronically ill or recuperating from an illness and need regular nursing care and other services, but not hospitalization. They also provide support, supervision, and assistance to people who may not need skilled care but who are cognitively impaired or need help with ADLs.

Nursing homes usually provide basic room and board, personal care (help with ADLs), nursing care, rehabilitation and therapy programs, social activities, and supervision.

There are two basic types of nursing homes:

- **Skilled Care Facilities** that provide both skilled care and personal care.
- **Intermediate Care Facilities** that provide personal/custodial care. Some may also provide a limited number of skilled care services.

Skilled care is the highest level of care and the most expensive; only a small percent of nursing home residents (about 20 percent) ever require skilled care. Sometimes these are also called convalescent care facilities.

Some nursing homes have both skilled care units and personal care units.

Assisted Living Facilities provide an alternative living arrangement for people who do not need nursing home care, but who need more support, assistance, or supervision than is available at home. These facilities are often smaller, more home-like settings. But they can also be larger, campus-like facilities. They generally care for people who are less disabled, and they typically cost less than nursing homes. Most Assisted Living Facilities provide housing, help with personal care, supervision, help with household activities such as meal preparation, help managing medications, social and recreational services, and other services. These facilities are known by a variety of different names including residential care facilities, personal care homes, and board and care home.

How Long Do People Usually Receive LTSS?

People may need LTSS on a short-term or long-term basis, or not at all. The most frequently cited study showed that about one-third of people aged 65 and over will not need care. However, 70 percent of people aged 65 and older will need care and will require it for varying amounts of time. About 20 percent of them will need care for five years or more. *[FN: Kemper, et. al., "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" Inquiry 42: 335-350 (Winter 2005/2006).]*

Table 2. Lifetime Use of Long-Term Care for People Turning Age 56
(includes both paid and unpaid care and includes all persons even those who never need LTC)

Years of Care	All	Male	Female
None	31%	42%	21%
1 year or less	17%	19%	16%
1 year to 2 years	12%	10%	13%
2 years to 5 years	20%	17%	22%
5 years or more	20%	11%	28%

Source: Kemper, et al., "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" Inquiry 42: 335-350 (Winter 2005/2006)

Short-term users typically require post-hospital care for an acute illness or injury. Their need for LTSS ends when they recover, when their condition stabilizes, or if they die. Of the 69 percent of individuals who need some type of LTSS, about 25 percent of are "short-stayers" requiring one year or less of care. At the other extreme, 29 percent of persons are "long-term users" requiring five years or more of care; they tend to have chronic illnesses or cognitive impairments such as Alzheimer's disease that require care for extended periods *[fn: Kemper, Komisar, and Alecxih. "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect." Inquiry, Winter 2005/2006].*

New analysis is currently underway to update these figures. While the risk of eventually needing LTSS may not have changed much in the decade since this 2005 analysis was published, we do know that people are living longer and healthier lives. This may change the probability of ever needing LTSS or it may change the duration of time for which people require care once they do need it. There are factors to suggest that, as people live longer, their risk of eventually needing some type of care may have increased. However, with medical advances that impact longevity come improvements in morbidity; the new data may show a decrease in the number of people who need care or who need care for an extended amount of time.

The Cost of LTSS

Long-term care is expensive. In 2014, the average cost of one year of care in a nursing home was $85,045 for a semi-private room and over $97,400 for a private room. Care in an Assisted Living facility in 2014 cost on average just under $50,100 a year for a one-bedroom unit. Some facilities charge additionally for care-related services while others include services in the rental price. One year of care at home, based on a mix of family and paid care, costs over $35,000. (This estimate is based on national data indicating that those who need long-term care at home typically receive 17 hours of paid home health aide care and 19 hours of paid homemaker care weekly. *[fn: LifePlans, Inc., "A Descriptive Analysis of Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community. U.S. DHHS publication, April 1999.])* Care in an Adult Day Care Center costs about $69/day. [Sources: LTCG, 2014 Cost of Care Study and Genworth 2015 Cost of Care Survey.]

The costs of LTSS vary by state and even local areas within states. It also depends on the type and amount of care provided and the provider. Some care facilities have "all inclusive" fees, while others charge extra for any services beyond the basic room-and-board charge. Home health and home care services are usually provided in two-to-four-hour blocks of time referred to as visits. Evening, weekend, or holiday visits may cost more than weekday visits. Some community programs, such as adult day care, are provided at a per-day rate, and rates may differ based on the type and variety of programs and services offered.

Table 3. Average Long-Term Care Costs in the United States (2009)
$233/day for a semi-private room in a nursing home
$267/day for a private room in a nursing home
$4,245/month for care in an Assisted Living Facility (for a one-bedroom unit)
$79/hour for care from a Registered Nurse (RN)
$62/hour for care from a Licensed Practical Nurse (LPN)
$22/hour for a home health aide (licensed but non-Medicare certified)
$20/hour for homemaker services*
$69/day for care in an Adult Day Health Care Center*

*Source: LTCG, 2014 Cost of Care Study. *Data reflect median rates as reported by Genworth, 2015.*

Table 4. Most Expensive States for Nursing Home Care
(Presented in order based on Private Room Rates)

State	Average Private Room Rate*	Average Semi-Private Room Rate*
Alaska	$466	$474
Connecticut	$453	$421
Massachusetts	$401	$366
Washington DC	$394	$358
New York	$382	$367
New Jersey	$380	$336
Hawaii	$368	$318
Vermont	$354	$307
North Dakota	$342	$334
California	$338	$236
US Average	$267	$233

*Rounded to nearest whole dollar

Table 5. Least Expensive States for Nursing Home Care (Presented in order based on Private Room Rates)		
State	Average Private Room Rate*	Average Semi-Private Room Rate*
Missouri	$183	$160
Arkansas	$187	$167
Louisiana	$187	$161
Oklahoma	$191	$155
Kansas	$201	$182
Iowa	$201	$184
Texas	$205	$151
Georgia	$215	$199
Mississippi	$218	$199
Nebraska	$221	$205
US Average	$267	$233

*Rounded to nearest whole dollar

Table 6. Most Expensive States for Assisted Facility Care	
State	Average 1-Bedroom Monthly Rate*
Washington DC	$8,127
New Jersey	$6,196
Alaska	$6,037
Massachusetts	$5,686
Connecticut	$5,613
Maine	$5,516
Maryland	$5,443
New York	$5,322
Delaware	$5,303
Hawaii	$5,275
US Average	$4,245

*Rounded to nearest whole dollar

Table 7. Least Expensive States for Assisted Facility Care	
State	Average 1-Bedroom Monthly Rate*
Mississippi	$3,038
North Dakota	$3,193
Iowa	$3,484
Louisiana	$3,465
Oklahoma	$3,465
South Dakota	$3,423
Arkansas	$3,556
Minnesota	$3,534
Idaho	$3,508
Wyoming	$3,669
US Average	$4,245

*Rounded to nearest whole dollar

Table 8. Most Expensive States for Home Health Aide	
State	Home Health Aide Average Hourly Rate*
Iowa	$30
North Dakota	$29
Minnesota	$28
Wyoming	$28
Rhode Island	$27
Massachusetts	$27
Alaska	$26
Colorado	$25
California	$25
Hawaii	$25
US Average	$22

*Rounded to nearest whole dollar

Table 9. Least Expensive States for Home Health Aide	
State	Home Health Aide Average Hourly Rate*
West Virginia	$17
Mississippi	$17
Arkansas	$18
Georgia	$19
South Carolina	$19
Alabama	$19
Tennessee	$19
Florida	$19
North Carolina	$19
Idaho	$20
US Average	$22

*Rounded to nearest whole dollar

Consumers will want to know how much LTSS cost where they live or plan to retire. For more information on local LTSS costs, use the interactive map at the Long-Term Care Clearinghouse website:

http://longtermcare.gov/costs-how-to-pay/costs-of-care-in-your-state/

As consumers plan for these care needs, remind them that many people receive care from both family members and from paid providers. Although long-term care provided by family members is often not counted as a "cost," there truly is a cost to family caregivers that should be considered in planning for long-term care needs. The "cost" of family-provided care can include the costs associated with a family member needing to cut back at work, take unpaid leave, quit entirely, or hire additional daycare for children while they attend to a parent's care needs. Caregiver services in 2009 were valued at $450 billion per year. This is a comprehensive figure which includes both direct costs (housing, medicine, food, transportation) and indirect costs such as reduced wages from time away from work. [Source: Valuing the Invaluable: 2011 Update, the Economic Value of Family Caregiving. AARP Public Policy Institute. Updated November 2012.]

The average lifetime expenditure on LTSS, after age 65 (projected to 2015 based on 2005 dollars at 4 percent/year) , is roughly $213,500. For a female, the average lifetime expenditure is higher ($247,000) while for males it is less ($161,000). This is because males generally require long-term care while their spouses are still available to provide unpaid informal care. Males also tend to have a higher mortality rate and are slightly less likely to live to the point of needing long-term care. *[FN: Alecxih, L. The Lewin Group, personal communication, 2008, based on Kemper, et. al., Medical Care, 2005/6)]*

Of course, there are significant variations. Some people have few or no costs, while for others, who need care for a long time and/or do not have family upon whom they can rely, the costs may greatly exceed this average.

Who Pays for LTSS?

For most people, the costs of LTSS are paid out of their income, savings, and assets. There are, however, an increasing number of private payment options that help cover the costs of LTSS. Some people purchase private long-term care insurance or other private financial instruments such as annuities or special types of life insurance policies with a LTC provision to help them pay for LTSS. Reverse mortgages and other ways to use home equity are also options. Some people apply for Medicaid, which will pay for LTSS on behalf of those who qualify as a result of having limited income and assets.

Until a person or a loved one needs care, he or she may not know the following essential facts about LTSS financing:

- **Medicare and Medicare supplemental insurance (Medi-gap) generally do not pay for LTSS.** Many people believe they can rely on Medicare to pay for LTSS. However, Medicare only pays for long-term care related services if a person requires skilled services or recuperative care for a short period of time. Medicare does not pay for what comprises the majority of long-term care services—non-skilled assistance with Activities of Daily Living or supervision because of a condition like Alzheimer's disease.
- **Most forms of employer-sponsored or private health insurance, including Health Maintenance Organizations (HMOs) or managed care, follow the same general rules as Medicare.** If they cover any LTSS, it is typically only for skilled, short-term, medically necessary care.
- **Medicaid only pays for LTSS for people with limited financial means.** Many people qualify for Medicaid only after their LTSS expenses have wiped out virtually all their financial resources.
- **Relying on Medicaid for LTSS reduces a person's options.** The choice of where to live, from whom to receive care, and according to what schedule, are more limited with Medicaid.
- **Other Federal programs such as the Older Americans Act and Veterans Affairs (VA) pay for some LTSS, but only for specific populations and in specific circumstances.** While there are no specific financial eligibility criteria for Older Americans Act services, they are generally targeted for low-income, frail seniors over age 60, and minority elders and seniors living in rural areas. The VA provides LTSS to veterans who meet established disability criteria, or who need care because of service-related disabilities. The VA may also cover those who do not have service-related disabilities, but who are unable to pay for necessary care. Middle-class veterans needing long-term care for non-service-related conditions may find it difficult to access VA benefits for LTSS.

Review the handouts, **A Closer Look at Medicare and LTSS and A Closer Look at Medicaid and LTSS**, for a more detailed look at when and how these public programs cover long-term care services.

Summary

Chapter 1 has provided a basic overview of LTSS. At the conclusion of this chapter you should be able to:

- Define when a person might need LTSS;
- List several types of formal and informal LTSS;
- List at least three settings where a person might receive LTSS; and
- Provide an overview of how these types of services are typically paid.

Chapter 2, *Planning for LTSS*, explains the benefits of planning for long-term care needs and why people often don't plan ahead. Case studies and some real-life stories of people who have planned are included to help consumers understand the benefits of planning.

CHAPTER 2 | Planning for Long-Term Services and Supports (LTSS)

In Chapter 1 you learned about LTSS — what they are, what they cost, and where care is provided. Chapter 2 provides facts about the risk of needing LTSS, insights into the reasons why people don't plan, and examples of how some people did plan. In addition, this chapter provides an overview of how factors such as age and health influence risk and planning. This chapter will help you frame discussions with consumers and provide information to help them best meet their needs. Various options for financing future LTSS needs are introduced. However, more detailed information about these financing options is presented in chapters 3, 4, and 5.

This chapter covers:

- The risk of needing LTSS
- Helping consumers plan
- Planning options as you age
- Variables that affect financing options
- Examples of people who have planned

Counselor Tip Sheets:

» Planning Options at a Glance
» Planning Worksheet

Consumer Fact Sheets:

» Planning Facts
» Test Your Planning IQ
» Planning and Options throughout the Lifecycle

Chapter 2 Key Words & Acronyms:

- Accelerated Death Benefit
- Advance Directive
- Annuity
- Continuing Care Retirement Community
- Financial Planner
- Life Settlement
- Life/LTC Hybrids
- Long-Term Care Insurance
- Partnership Policy
- Private Care Managers
- Reverse Mortgage
- Self-pay
- Viatical Settlement

The Risk of Needing LTSS

Most people will need some form of LTSS at some time in their lives. The type and amount of care may be different for each person and may change with time:

- Almost seven out of ten people turning age 65 today will, at some point in their lives, need LTSS.
- While most people who need LTSS are in their 70s and 80s, young people can also require care. Younger people may need LTSS because of an accident, heart attack, stroke, cognitive impairment, or another reason. Nearly 40 percent of those currently receiving LTSS are between the ages of 18 and 64.

Factors that increase the risk of needing LTSS are:

- Age—The risk of needing care increases as you get older.
- Marital Status—Single people are more likely to need care from a paid provider.
- Gender—Women are at a higher risk than men, primarily because they tend to live longer.
- Lifestyle—Poor diet and exercise habits can increase risk.
- Family history and health may increase risk.

While many people need LTSS for only a short time, some require care for many years. As you recall from Chapter 1, 20 percent of people receive care from two to five years, and another 20 percent need care for over five years. This includes all types of care — care provided by family or friends, as well as paid services such as home health care from a nurse or personal care aid or care in a nursing home or assisted living facility.

So why don't people plan? Reasons include:

- **A tendency to avoid thinking about becoming dependent on others for care.** Most people don't like to think about getting older, developing a disability, becoming less independent, or needing help with personal care.
- **Misinformation about coverage for LTSS**. Many people believe – incorrectly – that if they need LTSS, these will be covered by Medicare or their private health insurance. Consumer surveys show that many individuals don't realize that health insurance, Medicare, and/or disability coverage do not pay for most long-term care services. Many people don't realize that Medicaid only pays for LTSS for people with limited income and financial resources.
- **Financial barriers.** People with fixed or limited incomes may feel that they cannot afford to plan ahead for LTSS.
- **Lack of knowledge about planning options.** Many people realize it's important to plan, but don't have the information needed to put a plan in place.

Helping Consumers Plan

What does it mean to plan for someday needing LTSS? It means thinking about the future, articulating feelings and preferences, and taking action to ensure that the necessary documents, financial arrangements, and communications are in place so that things go the way the person wants them to go.

It also means understanding – both for the consumer and counselor – where the consumer is relative to optimum planning strategies. Age and health, as well as family support, are some of the important considerations for personal and financial planning decisions for LTSS.

While no one can know for certain if he or she will need long-term care, assessing risk factors can help a consumer understand whether he or she is at a higher or lower risk. Reviewing the five basic risks – age, marital status, gender, lifestyle, and health and family history – is a good way to start. Encourage the consumer to talk with his or her doctor about risks based on medical and family history or lifestyle choices. Not only will the consumer gain a better understanding of the risks associated with needing LTSS, but the doctor may be able to help the consumer decrease risk through better medical management of existing conditions and better lifestyle choices.

Thinking about Where to Receive Care

Ask the consumer to consider the following question: If you were to need care for an extended period, where would you want to receive it? Review the available options: home, community-based care, assisted living facility, nursing home. Allow the person to consider each of these options and whether it is a realistic one for him or her given his or her particular situation.

Housing Considerations

Home modifications can help consumers stay in their homes longer. Most people prefer to remain in their own homes and consider alternatives only if their care needs cannot be met at home. Modifying the home is an option that can improve safety and help someone perform ADLs, such as bathing and cooking. Home modifications range from grab bars in the bathroom and improved lighting to handrails and wider doorways for wheel-chair access, or even adding a bathroom on the first floor of a two-story home for someone no longer able to climb stairs.

Some state and local governments have programs to provide loans and grants to help pay for home modifications.

Talking with Family or Friends

Does the consumer have family or friends who would want to or be able to care for him or her if he or she became ill or disabled for a long time? Ask the consumer to consider how he or she would feel about relying on help from friends or family members?

Planning Considerations for Different Age Groups

You may work with consumers of many different ages. Many people don't plan for LTSS because they don't know where to begin. Similarly many people don't know when to begin planning or they wait until they are close to the time when they may need care, at which point some options may no longer be available. While each person's situation is different, here are some basic guidelines for long-term care planning for different age groups. Encourage consumers to take the following steps based on their current age.

Between the ages of 40 and 60…

- **Learn about LTSS.** Suggest that the person talk to friends and relatives who are currently facing these issues themselves or on behalf of a loved one. Everyone's experience is different, but one can learn a lot from talking to people who have direct experience.
- **Learn more about the risks of lifestyle behaviors and their effects on healthy aging.** Encourage consumers to talk to their primary care physicians or check some of the "Healthy Aging" resources in this guide.
- **Learn about the financial risks of needing LTSS and the various financial options for planning ahead.** Help the consumer learn what LTSS cost. One way is to suggest he or she ask friends and relatives about their experiences and plans. Have any of them purchased long-term care insurance or considered reverse mortgages? Since long-term care insurance is less expensive when purchased at a younger age, it is useful to assess whether long-term care insurance is a good option at this stage. Suggest that consumers investigate whether their

employers offer long-term care insurance as a voluntary benefit. Many states and the federal government offer a long-term care insurance program to employees and family members (usually one that the employee pays for on their own with after-tax dollars.)

- **Get legal affairs in order.** Counsel consumers to establish an Advance Directive that expresses their desires for medical treatment in the event that they are not capable of making decisions on their own.

Between the ages of 60 and 70…

- **Talk to family members about plans for retirement and old age.** Ask the consumer to consider if family will be nearby and able to help if she needs care and how she feels about relying on family care?
- **Assess finances.** Encourage consumers to consider their ability to pay for future LTSS, as well as living expenses for retirement years. A financial planner may be helpful to get professional advice.
- **Think about living arrangements.** Encourage consumers to think about whether they want to stay in their current home and to begin thinking about home modifications that may allow them to stay at home longer.
- **Review financing options including long-term care insurance, reverse mortgages and other options.** Long-term care insurance may still be a good option for consumers between 60 and 70 years old if they are in reasonably good health and can qualify. Reverse mortgages become a possible option for consumers who are at least 62 years of age.
- **Increase personal savings.** Regardless of what financial option the consumer has or is considering, most consumers should be encouraged, if they can, to increase the percentage of income allocated to savings. Surveys show that most people are not saving enough for their older years.

Over 70 years of age…

- **Consumer is most likely retired.** At this stage, consumers should have an LTSS plan in place. Family members should be aware of the consumer's plans and preferences.
- **LTSS financing options.** Purchasing a long-term care insurance policy at age 70 may be too expensive. Or an individual may no longer qualify on the basis of their current health condition or other risk factors. However, new Partnership Policies may offer an opportunity to craft less expensive policies for smaller amounts of coverage. (Partnership Policies are explained in Chapter 3.) There are other private financing options that consumers may wish to consider — for example a reverse mortgage or annuity that may not exclude someone based on their current health status. (These options are discussed in Chapter 5.) A financial expert may be helpful to evaluate the consumer's situation and assess whether he or she has adequate financial reserves. Consumers may need to reduce monthly living expenses and save more for later.
- **Stay active, physically and mentally.** Encourage consumers to walk more, drive less, participate in local community programs, or join a gym to get regular exercise.
- **Have legal documents in place.** By age 70, consumers should have legal documents in place that reflect their wishes regarding medical treatment in case of a disability or loss of the ability to make their own decisions. Advance care planning documents are important to have completed with copies stored with a family member, friend, health care provider, or legal counselor.

- **Housing plans.** Consumers should determine whether they wish to remain in their current homes or plan alternative living arrangements should they need long-term care services.
- **Private care managers.** Suggest learning about private care management services available in the area. These are agencies/professionals that help identify and coordinate services. Even if the person is in no immediate need of services, a care manager can be helpful in planning for future needs.

Financial Planning

Which financial option is best for the consumer depends on many factors including health status, age, risk of needing long-term care, and personal financial situation. The following charts provide a quick look at how financing options relate to these variables. The ***Private Financing Options Worksheet*** condenses the information to help you narrow down the options.

Table 10. Consumer Health Status: Which Financing Options Are Most Suitable?

Relatively Good Health	Poor Health or Terminally Ill	Health Considerations are Not Important
• Long-Term Care Insurance • Continuing Care Retirement Community • Life Insurance with a LTC Benefit	• Accelerated Death Benefits • Viatical Settlements	• Some Annuity/LTC hybrids • Using home equity to fund long-term care services • Life Settlement

Some private payment options are good choices for older people; others make more sense for a younger person.

Table 11. Consumer Age: Which Financing Options Are Most Suitable?

Better Option for Younger Person	Better Option for Older Person
• Long-Term Care Insurance • Self-Pay (Save on your own)	• Annuity/LTC and Life/LTC Hybrids • Sell home options • Reverse Mortgage • Life Settlement • Continuing Care Retirement Community

Detailed information about each of these options is provided in Chapters 3, 4, and 5.

The following section provides examples of people who have done some planning for their long-term care needs. These help illustrate the concepts presented in this chapter about how age, health, and family situation influence the type of long-term care planning and the options that make sense for different consumers.

Examples of People Who Planned

While these are fictional illustrations, they represent a variety of real-life situations. The people described are composites drawn from real-life; they illustrate the range of personal circumstances people might find themselves in and the different forms that planning for LTSS might take. *There is no one-size-fits-all plan.*

Mrs. F is 81. She has osteoporosis, arthritis, and high blood pressure. Otherwise she is basically healthy, but frail. She lives on a limited, fixed income and does not have significant assets to draw upon to help her meet her LTSS needs. She has been living in a modest one-bedroom rental unit, but is finding it difficult to maintain her apartment on her own.

Plan:

- Pay for modifications to daughter's home (outfit spare bedroom and second bathroom for Mrs. F).
- Move in with daughter.
- Establish Advance Directive and create Durable Power of Attorney.

Mrs. W is 78. Since having a stroke several years ago, she depends on a wheelchair to get around. She and her husband live in the three-bedroom house they bought when they were first married. The home's value has increased dramatically since they bought it and they paid off the mortgage a few years ago. The upkeep of such a large home is taking a toll on both her and her husband.

Plan:

- Sell home and use the resulting proceeds to move to a Continuing Care Retirement Community when she and her husband turned 75.
- With no children, the Ws decided to establish a Charitable Remainder Trust to pay for their care and willed the remainder of the trust after they both passed away to the California Horticultural Society.

At 46, Ms. S had the opportunity to purchase long-term care insurance as a federal employee. She has chosen coverage that will allow her to be cared for at home, in an Assisted Living Facility, or in a nursing home if necessary. She bought the policy now since the cost is based on her age when she buys it. Waiting would only mean higher premiums and the possibility that she might develop a health condition that would cause her to be declined for the insurance. Through the federal program, she was also able to also buy coverage for her spouse. To keep their plans affordable, they bought a slightly less comprehensive plan for her husband since Ms. S is likely to be able to provide some of his care needs as he is more likely to need care first, or to not need as much care as she might need. She does not want to have to rely on her family to pay for or provide care for her if and when she needs it. She likes being independent and having peace of mind that comes from planning ahead.

Plan:

- Purchase long-term care insurance, which she pays for through an automatic deduction from her bi-weekly paycheck.
- Prepare a living will so that her family will know her preferences and wishes for care and life support if she becomes unable to communicate or carry out her preferences on her own.
- Speak with daughter and niece and specify her preferences for care.

Mr. C is an 82 year old widower. He lives in the modest home in which he raised his children. He has prostate cancer and has had a pacemaker for the past two years. At this point he is still able to take care of all his physical needs and he is very keen on remaining at home to receive the care he needs, because of all the wonderful family memories it holds for him. However his income and assets may not be enough to pay for the care he needs at home.

Plan:

- Stay at home and receive care there if necessary.
- Pay for care with a combination of savings and a reverse mortgage.
- Son and daughter coordinate care and repay the reverse mortgage loan amount when it is due (upon Mr. C's death or when and if he needs to permanently move out of the home). His children can keep the house in the family if they wish, after paying off the loan amount from other financial resources they or Mr. C have, or they can sell the home and use the proceeds to pay off the loan amount. They are allowed to keep any additional funds from the sale of the home that exceed the loan amount to be repaid.

Summary

Chapter 2 discussed different factors that contribute to the risk of needing LTSS. Various options for financing LTSS were mentioned in this chapter.

At the conclusion of this chapter you should be able to:

- Discuss factors that contribute to the risk of needing LTSS;
- Understand why people often don't plan for these types of future care needs;
- Define different planning strategies for individuals in three ages groups: 40 to 60, 60 to 70, and over 70; and
- Identify financing options that may be more or less appropriate for individuals at different ages or with specific health status.

The next chapters provide detailed information about each of these financing options to help you counsel consumers on the range of financial options and help them determine which of these might best suit each individual's situation. Chapters 3 and 4 provide an in-depth look at long-term care insurance. Chapter 5 provides information on other financing options including reserve mortgages and annuities.

Advance Care Planning

Advance care planning is the process of discussing, determining, and executing treatment directives — such as Living Wills or appointing a health care proxy decision maker for care in the event that a person is not able to make medical decisions for him or herself. These documents can make a critical difference in a person's life and the lives of friends and family.

To be most effective, advance care planning needs to be a comprehensive, ongoing process that includes a person's family and friends, proxy decision maker, and care providers. Planning should reflect the person's personal values and beliefs.

Many different professionals can assist in creating advance directives, including lawyers, social workers and members of the clergy. Some counselors and social workers, especially those who work for hospice services, are also qualified to offer guidance at all stages of the advance care planning process.

Advance Planning Documents

Health care proxy. A health care proxy is a surrogate decision-maker. The proxy needs to be able to make decisions based on understanding and respecting a person's values and beliefs about care. The proxy needs to understand and agree to carry out the person's wishes even if they include denying life-sustaining treatments.

Advance Directive. Advance Directive describes two types of documents — living will and medical power of attorney. These planning documents allow a person to communicate the type of care he wants if he cannot speak for himself, including the extent to which he wants life-sustaining medical treatments, and who should make those decisions if he cannot.

Living Will. Sometimes called medical directive, a living will is written instructions for care in the event that a person is not able to make medical decisions for him or herself. Currently, 47 states and the District of Columbia have laws authorizing living wills. State law, however, can vary on signing requirements and other aspects of a living will. Check your state's requirements regarding living wills.

Medical Power of Attorney. Sometimes called health care or durable power of attorney, medical POA is a document that appoints a particular person as a health care proxy or health care agent to make health care decisions in the event that a person is unable to do so for him or herself (not just during a terminal illness). A health care proxy is a substitute decision-maker. All 50 states and the District of Columbia have laws recognizing health care powers of attorney. Some specify the types of decisions that health care proxies can make.

Do Not Resuscitate (DNR). A physician's order that is written in a person's medical record indicating that health care providers should not attempt life-saving measures such as cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest (commonly known as a heart attack) or respiratory arrest. A request for a DNR can be included in planning documents. Most health care facilities have a Do Not Resuscitate order policy and forms that a hospital professional can help with if someone chooses this option after being admitted to a hospital.

It's important for people to discuss their wishes with family and other important people in their lives so they understand those wishes and what is included in any advance directive documents. It is particularly important to discuss these decisions with the individual who will be the health care proxy to be sure he/she is comfortable with the role and will be available to carry out those wishes.

Advise consumers to keep planning documents easily accessible and in multiple places. Giving copies to family members, friends, a physician, and/or attorney is appropriate. It is critical that the health care proxy has a copy or can access a copy quickly if there is an unexpected emergency. The consumer should also be counseled to review the plans periodically to be sure they are still appropriate and that the health proxy is still able and willing to be responsible for carrying out the plans.

The Additional Resources Appendix contains resources for help with Advance Care Planning.

CHAPTER 3 | Long-Term Care Insurance

In Chapter 2, you learned that there are various options for financing LTSS. You will help consumers consider these options based on their age, health status, and financial resources. As you may recall from Chapter 2, long-term care insurance may be a good option for consumers in relatively good health and under the age of 70.

This chapter provides an introduction to Long-Term Care Insurance. Chapter 4 continues the discussion with specific issues you may encounter when counseling consumers about Long-Term Care Insurance. Chapter 5 considers other financing options.

Specifically, this chapter covers the following:

- Overview of Product Basics and Policy Features
- To Buy or Not to Buy
- Helping People Decide
- Policy and Benefit Choices
- Services Long-Term Care Insurance Typically Covers
- Understanding Long-Term Care Insurance Underwriting
- When are Long-Term Care Benefits Paid
- Paying for Long-Term Care Insurance
- Consumer Protections
- Where to Buy Long-Term Care Insurance
- Helping a Consumer Design the Right Policy

Counselor Tip Sheets:

» Long-Term Care Insurance FAQ
» Long-Term Care Insurance Policy Comparison Worksheet
» How to Design the Right Policy
» Annotated Long-Term Care Insurance Policy

Consumer Fact Sheets:

» Sample Insurance Company *Suitability Personal Worksheet*
» Sample Insurance Company *Things You Should Know Before You Buy*
» How to Design the Right Policy
» Should I Buy Long-Term Care Insurance?
» How to Be a Smart Shopper
» Long-Term Care Insurance Policy Comparison Worksheet

Chapter 3 Key Words & Acronyms:

- Attending Physician Statement (APS)
- Benefit period
- Benefit trigger
- Care coordinator
- Compound inflation protection
- Comprehensive policy
- Covered services
- Daily benefit
- Daily/maximum benefit
- Dementia
- Diabetes
- Disability method
- Elimination period
- Group policy/individual policy
- Home electronic monitoring systems
- Indemnity method
- Inflation protection
- Instrumental activities of daily living
- Lifetime benefit maximum
- Lifetime coverage
- Medical Underwriting
- Motor vehicle no-fault law
- Premium
- Reimbursement method
- Respite care
- Rider
- Simple inflation protection
- Single pay option
- Third party designee
- Transient Ischemic Attack (TIA)
- Unlimited coverage
- Voluntary benefit
- Workers' compensation

Overview of Product Basics and Policy Features

Long-term care insurance is a type of insurance developed specifically to cover the costs of long-term care services, most of which are not covered by traditional health insurance or Medicare. These include services provided at home, such as assistance with Activities of Daily Living, as well as care in a variety of facility and community settings.

Long-term care insurance has been available for over 30 years, but it is only in the last 10 to 15 years that the market has matured in terms of both sales and policy features. As of December 2014, there were an estimated 7.1 million policies in force.

There is a great deal of choice and flexibility in long-term care insurance policies. Consumers can select a range of care options and benefits that cover the cost of services in the settings of their choice. Many policies offer benefits in a variety of settings, such as home, an adult day service center, an assisted living community, or a nursing home. The cost of the policy is based on the type and amount of services covered, how old the person is when he or she buys the policy, and any optional benefits he or she chooses.

With long-term care insurance, the consumer pays premiums, and the policy pays for the long-term care when the consumer needs it—up to the coverage limits selected by the consumer when they purchased the policy. Typically premiums are waived during the time the consumer is receiving benefits.

Sometimes the premium may vary based on one's health – either providing a "good health" discount or an additional premium charge for someone who wants coverage but is not a standard risk due to a current health condition. Companies commonly offer a good health discount of about 10 percent or 15 percent. Consumers in poor health or already receiving long-term care services may not qualify for long-term care insurance. Some companies will issue coverage to someone who presents with certain high risk health conditions but at an additional premium charge on average of from 20 percent to 60 percent depending on the health condition and the insurance company offering the coverage. Another approach that is sometimes used is for an insurance company to approve coverage for someone with known health risk conditions at the "standard" premium, but to limit the type and amount of coverage they can buy.

Newer policies also may have gender-distinct rates; that means that the premium will differ for two people of the exact same age making the exact same coverage selections if one of them is male and one is female. Because they face a higher risk of needing LTSS, the premium is generally higher for women, all else being equal. Some insurance companies offer the buyer a choice of a product with gender-distinct (male vs. female) rates or one that offers a unisex or blended rates. A few states prohibit using gender as a basis for setting different LTC insurance premiums.

Long-term care insurance policies usually have either a benefit period or, more typically, a lifetime benefit maximum, which is the total amount of time or total amount of dollars up to which benefits will be paid. Common benefit periods for long-term care policies are two, three, four, and five years, and lifetime or unlimited coverage. Other options between five years and lifetime/unlimited coverage are also available from many companies. Most policies translate these time periods into dollar amounts and do not actually limit the number of days for which they will pay for care — just the dollar amount that the policy will pay.

To Buy or Not to Buy?

Long-term care insurance is not right for everyone. Individuals who already need long-term care probably will not qualify for insurance. It also may not be an appropriate purchase for individuals with little income or few assets.

There is no easy rule to guide consumers in deciding whether or not long-term care insurance is right for them. While some facts are important to consider — such as income, assets, age, and health — many intangibles are also important to the decision:

- How important is it to the consumer to receive care at home?
- Does the consumer have family or friends he or she can rely on to provide care even at some unknown date in the future? Is he or she comfortable doing so?
- Does the consumer have assets to protect and preserve for heirs?
- How important is it to the consumer to be able to choose the type and amount of services he or she receives?
- How "risk averse" is the consumer?

Generally, individuals should consider buying long-term care insurance if they:

- **Have assets to protect.** While there is no hard and fast number, some financial experts recommend considering insurance if you have $50,000 or more in non-housing assets. Even people with significant wealth who could afford to pay for care on their own often choose to buy insurance so they can protect more of their assets.
- **Are not eligible or close to qualifying for Medicaid.**
- **Can afford the premiums for the type and amount of coverage they believe best suits their needs.** Some financial experts recommend that premium costs not exceed seven percent of a person's income. Individuals should take into account whether their current income is expected to increase, decrease, or remain the same. Also, some people use the interest from assets, rather than other income, to pay the premium, so it is important to think about other ways to make the premium affordable.
- **Are in reasonably good health to qualify for insurance.**
- **Are concerned with the possibility of someday needing LTSS.** Someone with a family history of longevity and/or chronic health conditions may feel more at risk of needing care in the future. Similarly someone who does not want to or can't rely on family or friends for care may believe it is more important to have insurance to cover the costs of paid care.

Affordability means different things to different people. People are willing to spend varying amounts on long-term care insurance, based on how important the purchase is to them. Today, about two-thirds of people who buy long-term care insurance use some portion of their savings to pay for insurance, so an affordability index based solely on income is not realistic.

Real-life data on how much income people allocate to pay for long-term care insurance shows a range from as little as one percent to eight percent or more. In 2010, almost one-fourth of all people buying long-term care insurance spent six percent or more on the purchase; 16 percent spent more than eight percent of their income on the purchase. The largest group of buyers (58 percent), however, spend from one percent to three percent of their income on premiums.

Why People Buy Long-Term Care Insurance

People buy insurance for a variety of reasons — to avoid relying on others, to help pay for needed care, to preserve assets, and protect their family's quality of life (see Table 12).

Table 12. Why People Buy Long-Term Care Insurance

Why People Buy LTC Insurance	Percent Citing as Very Important Reason
Protect Assets and/or Leave an Estate	33%
Avoid Dependence on Others	19%
Protect Quality of Life/Living Standards	18%
Guarantee Affordability of Care	13%
One of the other reasons (e.g., government won't pay for care; maintain adequate income for a spouse; freedom of choice for care needs; avoid Medicaid)	17%

Why People Do Not Buy Long-Term Care Insurance

People cite different reasons for not buying long-term care insurance (see Table 13). Since part of the counselor's role is to help consumers overcome the denial, confusion, or misinformation that may be a barrier to planning ahead for LTSS needs, it helps to understand these reasons and discuss them with consumers as needed.

Table 13. Reasons People Don't Buy LTC Insurance

Reasons People Don't Buy LTC Insurance	Percentage Responding, 2010
Too costly	56%
Waiting for Better Policies	21%
Don't believe insurers' promises	19%
Choosing a policy is confusing	14%

Cost is the most frequently cited reason people do not buy long-term care insurance. Confusion about coverage features or types of policies is another. Some consumers are "waiting for better policies," and others are uncertain whether they can trust insurance companies to provide the coverage they promise.

When consumers cite "it costs too much" as a reason for not buying coverage, it actually may mean they do not perceive the value of coverage relative to the price or that they are considering coverage options

that cost more than what they believe they can afford. You can help consumers understand the value of long-term care insurance and help them identify less costly coverage options that still provide adequate coverage appropriate to the individual's needs. One helpful framework is to compare the cost of buying coverage with the costs of paying for care on one's own as described below by one real-life buyer:

> *"I bought a policy that will pay for seven years' worth of care (at whatever the going rate is at the time I need it.). At age 45, my premium was $1,500 a year and I haven't had any rate increase since I bought my plan. By the time I'm age 80 – and might need care – I will have paid in $52,500 in premiums. But by the time I'm age 80, even one day of care in a nursing home will cost about $450. So the amount I've paid in premium by then would only last for just over three months of nursing home care; but my policy will pay for at least seven years' worth of care. And I never would have had the discipline to save that much each year on my own. So while I hope I never need LTC, if I do, I feel I'm really getting my money's worth out of that premium investment."*

Buyers vs. Non-Buyers

Several studies have identified key differences between buyers and non-buyers. These studies identify motivators as well as barriers to planning ahead.

In the individual market, buyers tend to be younger than non-buyers (age 59 vs. age 67) Buyers are also more likely to be married (69 percent vs. 57 percent), to have higher incomes, greater assets, and high levels of education. They are also more likely to have someone in the household who is still employed (69 percent vs. 37 percent).

While demographic differences between buyers and non-buyers exist, attitudes more consistently differentiate buying behavior (see Table 14). Buyers say it is important to plan ahead for long-term care needs that they would otherwise pay on their own. Buyers are also more likely to see themselves at risk of needing long-term care.

Table 14. Attitudes of Buyers vs. Non-Buyers

Attitudes	Buyers	Non-Buyers
Think they will pay on their own	59%	37%
Think they are likely to need nursing home care	62%	58%
Think they are likely to need care at home	70%	66%
Think it is important to plan ahead	62%	41%

Source: America's Health Insurance Plans [AHIP], March 2012

People's attitudes influence their interest in planning for long-term care needs. Asking consumers about their personal/family experience with LTSS can help illustrate the realities of long-term care risks, costs and who pays, and the potential benefits of long-term care insurance and other financing options.

Helping People Decide

While people have many different reasons for buying or not buying insurance, you can help a consumer frame the decision by asking about personal situations and preferences.

A good place to begin is with two key criteria — is the consumer in reasonably good health and likely to be insurable, and are the premiums affordable? The handout ***Can Everyone Buy Long-Term Care Insurance?*** provides guidelines for helping people determine whether they might qualify for insurance. Consumers who already need LTSS or already have a chronic degenerative condition, such as Parkinson's or Alzheimer's disease, would not qualify for insurance.

Financial considerations are another good place to begin. Many states require that insurance companies use a *Suitability Personal Worksheet* and give the consumer a document called *Things You Should Know Before You Buy*. Both documents are intended to help the consumer assess the appropriateness of the sale and help people decide whether long-term care insurance makes sense for them. All tax-qualified long-term care plans are required to determine the financial suitability of a sale before the insurer can accept an application. (See Chapter 4 for a detailed discussion of tax-qualified plans.) Copies of these documents can be found in Appendix 3.

Keep in mind the other reasons people buy insurance:

- Greater control over care choices
- Being able to receive care at home rather than in a facility
- To relieve the stress of extended or complex LTSS needs on the financial and emotional health of the family
- Lack of family living nearby who would be willing and able to provide care

Help the consumer understand that the insurance company will try to help him or her assess whether long-term care insurance is appropriate, based on income and assets. However, insurance companies cannot refuse to sell based on any of the consumer's answers on the *Suitability Personal Worksheet*. Consumers also have the right to refuse to provide the financial information requested on the worksheet. Make sure consumers are informed that an application for insurance cannot be refused simply because they elect not to provide financial information to the insurer.

Policy and Benefit Choices

Policy and benefit choices typically include:

Daily benefit amount. This represents how much of the expenses for care the policy will pay. Most policies offer a choice from $50/day to as much as $500/day. Some policies express this in terms of weekly or monthly benefits, rather than in terms of daily benefits. For example, a policy that pays $100/day covers monthly expenses up to about $3,000/month. Choosing a weekly or monthly benefit amount (if that option is available to the consumer) gives more flexibility, since it is often typical to have more expenses on some days and fewer on other days, especially when thinking about receiving

care at home. Uneven expenses day to day are typical, especially if a consumer has unpaid family care available on some days (for example, weekends) and not on others.

Home care or facility-based care. Often the consumer can choose whether he or she wants the policy to pay the same daily or monthly benefit amount for care in all settings, or whether he or she wants the policy to pay less for care in less costly settings, such as home care. Common choices include a home care benefit of either 50 or 75 percent of the facility care benefit amount. Fewer policies sold today offer these choices, but where they are available, these are a good option for someone who wants to purchase a more affordable plan. Make sure the consumer understands what care costs at home or in a facility when they are considering what benefits amounts to purchase.

Maximum benefit. Policies often have a choice of a Maximum Lifetime Benefit or total lifetime amount. Policies typically offer a choice of lifetime dollar amounts — for example, $100,000 or $300,000. The dollar amounts may also correspond to a period of time. For example, a three-year policy at $100/day of benefits would provide $109,500 worth of care. Some insurers also sell "lifetime" or "unlimited" coverage that has no dollar limit; the insured person receives benefits as long as he or she continues to need long-term care and receives covered services. However, many insurers no longer offer lifetime/unlimited coverage; instead they might offer a high lifetime benefit amount such as $1,000,000, or an optional rider that the consumer can buy to provide "catastrophic" or high dollar value coverage for an additional premium. Having a choice of lifetime coverage amounts helps the consumer tailor coverage to their needs, preferences, and ability to pay. Some people want to purchase coverage sufficient for the "average" risk while others want to be highly certain that care needs will be covered even if they end up needing more care than average.

Comprehensive or facility care only. Comprehensive coverage pays for care in all long-term care settings, including care at home (from providers such as home health aides, homemakers, nurses, and therapists), community-based care such as adult day services, or care in a nursing home or assisted living facility. Most policies offered and purchased today are comprehensive policies.

Some people prefer to buy Facility Care Only policies. These pay for care in a nursing home or assisted living facility, but not for care at home or in the community. These policies may still include hospice or respite care. Facility Care Only policies cost less than comprehensive policies, and if people have family or friends to provide care at home, they may only have the policy to reimburse them for paid care in a facility if and when they need it.

Additional optional benefits or "riders" allow buyers to customize the coverage. One important option is Inflation Protection, which helps protect the consumer from the rising cost of care over time. It works the same way that an inflation clause on homeowners' insurance works: as the cost of replacing the home increases, so does the amount of insurance coverage maintained on the home. There are many different types of Inflation Protection in long-term care insurance.

To help consumers understand how the Inflation Protection options work in any policy they are considering, work through the following five questions with the consumer:

1. At what rate do benefits increase?
2. Are the increases on a compound or simple basis?
3. Do the increases take place every year or only every few years?
4. What, if anything, would cause the increases to cease?
5. Does the premium increase along with and because of the inflation protection or is the premium intended to remain level while it pays for an increasing amount of coverage? [NOTE: It is important not to confuse the "level premium" aspect of certain types of Inflation Protection (where the automatic coverage increases are "built into" the starting premium which doesn't change) with the limited right that insurance companies have to raise premiums overall. Insurance companies have a limited right to increase premiums on a group or class basis if it is justified by actuarial data and approved by state regulatory authorities, but they cannot single anyone out for a rate increase based on age, health or need for care.]

The table below compares three different typical types of Inflation Protection based on these five key questions:

Table 15.

Attribute	Compound Inflation Protection	Simple Inflation Protection	Benefit Increase Offer or Future Purchase Option
At what rate do benefits increase?	Usually a choice of amount from 1% to 5%, selected by the consumer at time of purchase.	Usually a choice of amount from 1% to 5%, selected by the consumer at time of purchase.	May be pre-defined amount as with other types of Inflation Protection or may vary based on the amount made available by the insurer.
Are the increases on a Compound or Simple Basis?	Compound	Simple	Varies
Are increases annually or less often?	Annually	Annually	Can be yearly or every two to three years.
What causes the increases to stop?	Usually they continue for the life of the policy	Usually they continue for the life of the policy	The increase offers are not usually made once someone has declined two prior upgrade offers or when they begin to need care.

Table 15.			
Attribute	**Compound Inflation Protection**	**Simple Inflation Protection**	**Benefit Increase Offer or Future Purchase Option**
Are premiums intended to remain level even though benefits "inflate" automatically?	Yes	Yes	No. The additional amount of coverage the consumer wants is purchased based on the rate for that amount of new coverage and their age at the time they accept the upgrade.

The ***Long-Term Care Insurance Policy Comparison Worksheet*** is helpful for consumers to compare how well different policies might meet their needs.

Services Long-Term Care Insurance Typically Covers

The majority of policies sold today are comprehensive policies. They typically cover care and services in a variety of long-term care settings:

- Home care, including skilled nursing care; occupational, speech, physical, and rehabilitation therapy; help with personal care, such as bathing and dressing. Some policies also cover some homemaker services, such as meal preparation or housekeeping, when these services are provided in conjunction with other covered services;
- Adult day service centers;
- Hospice care, which provides personal care and support to someone who is terminally ill;
- Assisted living facilities (also called residential care facilities or alternate care facilities);
- Alzheimer's special care facilities; and
- Nursing homes.

Many comprehensive policies also pay for a variety of other services and devices to support people living at home:

- Equipment, such as in-home electronic monitoring systems;
- Home modifications, such as grab rails and ramps;
- Transportation to medical appointments;
- Training for a friend or relative to learn to provide personal care safely and appropriately;
- Respite care to pay for formal care for a short time (for example, two weeks) to give time off to family or friends who care for someone.

Some policies provide some payment for family members or friends who help care for someone, but may do so on a limited basis or only in relation to the costs that the family member incurs.

Many policies provide a care coordinator, usually a nurse or social worker in the community. The care coordinator is available to meet with the consumer to discuss the consumer's specific situation and help arrange for and monitor care needs on an ongoing basis, if requested to do so.

Understanding Long-Term Care Insurance Underwriting

Most long-term care insurance is medically underwritten, meaning that an individual has to qualify medically to purchase the insurance. This doesn't mean they have to be in perfect shape or health, but it does mean they must be in reasonably good health with no disabling conditions or cognitive impairments already existing. The insurance company will examine the applicant's current and recent health history and ask about regular physical and mental activity.

The insurance company generally gathers information about an applicant from four major sources.

- **Insurance Application.** It is important to answer all questions on the application fully and accurately. Medical information left out (intentionally or not) about a medication, hospitalization, or medical condition may be grounds for the insurance company to later deny benefits or actually rescind the policy. However, after two years the insurer can only do this if the omission is clearly found to be fraudulent and germane to the cause of the claim.
- **Attending Physician Statement (APS).** In many cases the insurance company will ask for copies of the consumer's medical records with the doctors' notes from office visits and copies of medical tests. Occasionally the insurance company will request specialists' records. The insurance company is responsible for obtaining this information at no expense to the consumer.
- **Telephone or face-to-face interview.** A nurse, social worker, or paramedical professional will interview the consumer. In a telephone interview the applicant may be asked to clarify portions of the medical history provided on the insurance application. The interviewer may even conduct a short-term memory test in person or over the phone. The in-person interview may also include height, weight, blood pressure, a memory test, and further clarification of information from the application.
- **Additional information** may be gathered from pharmacy or medical insurance databases.

What Might Cause the Long-Term Care Insurance Company to Deny Coverage?

Long-term care insurance companies are likely to deny coverage to individuals who already need long-term care services or who have a condition or combination of conditions that are strong predictors of the need for services in the near term. This includes documented evidence of mental confusion or memory loss as cognitive impairment is one of the major causes of lengthy, and therefore expensive, long-term care claims. Some examples of conditions that might cause coverage to be declined include:

- Currently receiving LTSS
- Osteoporosis with fractures (especially of the spine and hip)
- Diabetes with complications or combined with smoking or a Transient Ischemic Attack (TIA)
- Progressive neurological conditions, such as Parkinson's Disease or Multiple Sclerosis
- Alzheimer's Disease or other dementia

Applying for long-term care insurance at a younger age can help consumers get insurance in place before any health conditions develop that make them uninsurable or only insurable at a higher rate. Typical acceptance rates by age are shown below but experience varies significantly from one company to another. Also very few companies today will offer coverage to persons ages 80 and over.

Table 16.

Age	Percent Declined
30-39	4%
40-49	12%
50-59	15%
60-64	22%
65-69	30%
70-74	41%
75-79	48%
80+	54%

Source: 2013 Long-term Care Insurance Survey. Broker World. July 2013.

Some insurance companies accept people for coverage on a pass/fail basis; others offer coverage to those with some health conditions or minor impairments but at a higher premium or with less coverage than the individual requested. The insurance company prices the coverage to cover the higher risk. Many carriers also offer coverage to very healthy people at a significant discount — often as high as 10 percent to 20 percent.

The consumer handout ***Can Everyone Buy Long-Term Care Insurance?*** can help consumers understand how medical underwriting may affect their ability to purchase long-term care insurance.

Services Long-Term Care Insurance Does Not Cover

Like all insurance, long-term care policies have exclusions. These are listed in the policy. States regulate what exclusions are allowed. Even if a consumer meets all the other requirements of the policy, long-term care policies typically exclude (will not reimburse or pay benefits for) the following:

- Care or services provided by a family member, unless the family member is a regular employee of an organization providing the treatment, service or care; and the organization they work for receives the payment for the treatment, service or care; and the family members receives no compensation other than the normal compensation for employees in that job category;
- Care or services for which no charge is made in the absence of insurance;
- Care or services provided outside the United States of America, its territories or possessions. However, a growing number of policies now have an international care benefit that can provide care outside the United States;
- Care or services that result from war or act of war, whether declared or not;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Care or services for alcoholism or drug addiction (except for an addiction to a prescription medication administered in accordance with the advice of the consumer's physician);
- Treatment provided in a government facility (unless otherwise required by law); and
- Services for which benefits are available under Medicare or another government program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.

While many policies do not pay for care provided by a family member, friend, or other individual who is not a paid caregiver (or may only pay for family care on a limited basis), some policies do have benefits that pay a cash payment for each day the consumer needs and receives care, regardless of who provides that care including family members. Also, some policies pay a cash benefit each day that someone needs care, whether they receive any care or not. Most policies do pay for training and support for informal caregivers.

Most policies require that the facility, agency, or individual providing care meet certain minimum standards with respect to quality, safety, and training. For example, a nursing home that is not licensed, but operates in a state that requires licensure would likely not be covered. Some policies pay for home care only when it is received from a licensed home health care agency, while other policies pay for care provided by an appropriately trained and credentialed "independent provider," who could be a home health aide, nurse, or therapist working on his or her own, rather than as an agency employee.

Most policies do not pay for assistance with housekeeping, meals, laundry, or transportation (activities referred to as Instrumental Activities of Daily Living or IADLs). However, these may be covered if they are provided in conjunction with assistance with Activities of Daily Living from a formal care provider.

Finally, long-term care policies do not pay for items solely for comfort or convenience, for example, the costs for cable television service or the hair salon visit while in a care facility.

When Are Long-Term Care Benefits Paid?

Policies specify two types of objective measures that must be met before benefits are paid for long-term care services. These include "benefit triggers" and an "elimination period." The "benefit triggers" start the clock. Most policies use Activities of Daily Living and level of Cognitive Impairment as the independent triggers for benefits. Generally, if a person needs help with two or more of the six Activities of Daily Living (which is expected to last at least 90 days), and/or if they have a severe Cognitive Impairment, the policy pays benefits after the individual has satisfied the "elimination period", if one is required.

There are two types of elimination periods. Depending on the policy, there is what is called a "Service Day" or a "Calendar Day" elimination period. This is a specified amount of time between certification of the individual having met the benefit trigger and when the long-term care insurance payments begin. Consumers may sometimes be able to choose the type of elimination period if the company from which they are buying offers both types.

The elimination period is like the deductible on a car insurance policy, except it is usually specified as a period of time rather than a dollar amount. During the elimination period, the person may be responsible for paying for any services received. Sometimes other insurance, such as Medicare, may pay for some of the care during this time. With a Service Day Elimination Period, each day that qualifying services are received is a day counted toward satisfying the elimination period. A Calendar Day Elimination Period is a specific number of days between certification of the benefit trigger and when the policy will reimburse services – regardless of any services received. The individual is not required to receive qualifying services as long as they meet the benefit trigger. However, as with the Service Day Elimination Period, if the individual receives formal paid care, he or she would have to pay on his or her own for the services received, if they were not covered by any other insurance including Medicare.

For example, let's assume Alice has a policy with a 30 Service Day Elimination Period. She must first "trigger" the benefit by needing help with two or more ADLs or being cognitively impaired. If Alice receives home care five days a week, it would take her six weeks (which represents 30 service days but 42 calendar days) to satisfy the Service Day Elimination Period. If Alice had a Calendar Day Elimination Period, she would have satisfied the elimination period 12 days earlier - in 30 calendar days. Most Calendar Day Elimination Period policies start counting the days toward satisfying the elimination period with no requirement for any care to be received. These only require satisfaction of a benefit trigger in order to "start the clock" counting the days. (A few "Calendar Day Elimination Period" policies require a single day of service be received in addition to meeting the benefit trigger before starting the calendar day clock on the elimination period.) Also, some policies with a Service Day Elimination Period give the consumer "extra credit" and count all 7 days of the week as long the individual received at least one qualifying service during that week.

How Are Benefits Paid?

There are typically three ways that long-term care insurance policies pay benefits: a reimbursement approach, an indemnity approach, and a disability approach.

Reimbursement Method. This is the most common approach and it is also the least costly for the consumer. This type of policy typically pays 100 percent of covered expenses up to the pre-set amount the individual selected when the coverage was purchased. If the policy specifies a nursing home daily benefit of $150 and the consumer receives care in a nursing home that costs $120, the policy pays the consumer (or pays the facility directly) $120. If the nursing home costs $180/day, the policy pays $150 and the consumer is responsible for the $30 difference. Some policies keep premiums lower by specifying the benefit payment in terms of a percentage. They may specify a payment of less than 100 percent of the cost of care, for example, 80 percent, in an effort to keep premium cost lower. This approach has less consumer appeal as most people want their expenses covered in full if at all possible.

Indemnity Method. Some policies pay a set amount per day for care, based on the amount of coverage chosen when the policy was purchased. With this approach, the amount paid does not vary even if the costs of care vary. If the consumer is in a nursing home that costs $120/day and has an indemnity policy paying $150/day, the consumer would receive the full $150/day. If the nursing home cost $180/day, the consumer would still only receive the set amount of $150.

Disability Method. A small number of policies offer a "cash disability" approach. This is the most expensive model to purchase. In this approach, the policy makes a cash payment for each day that an individual needs help with two or more Activities of Daily Living or has a cognitive impairment, whether or not the individual receives any paid long-term care services on that day. The cash can be used to pay for traditional long-term care services, as well as for non-licensed or family caregivers or anything the individual wants. While this approach allows more flexibility to use the benefit payment any way the individual desires, it also costs more. Typically policies that offer this approach cost about 40 percent more than those using the reimbursement approach.

Paying for Long-Term Care Insurance

Premiums are based on the consumer's age when the policy is purchased, so the younger someone is when she buys, the less she'll pay. Insurers have a limited right to increase premiums only for like classes or groups of policyholders. Buying at a younger age is a good idea since the initial premium is lower than it would be at a future age and is intended to remain the same throughout the time the policy is in force. Even if there is a rate increase in the future, someone who bought at age 65 would continue to pay the rate associated with a 65-year old buyer, even when they are age 75 or 80. As long as they don't voluntarily choose to increase some aspect of their coverage, the age on which their rate is based never changes.

Policy costs vary greatly based on age at the time of purchase, the type of policy, and the coverage selected. The average annual premium cost for a policy purchased in 2001, across all ages of buyers and all types of policies in the individual market was just under $2,300 This represents a comprehensive

policy providing an average of 4.8 years worth of benefits, with a daily benefit amount of $153. Nearly 75 percent of the policies purchased in the individual market in 2010 also included some form of automatic inflation protection. A more recent study shows that the average premium for people buying individual LTC coverage in 2014 was $2,409. For buyers in the group market (where the average purchase age is younger), the average premiums for 2014 was $1,070. Table 17 shows the long-term care insurance average premium for all individual policies purchased by age group in 2010.

Table 17. Average Long-Term Care Insurance Premiums: Buying at a Younger Age Results in Lower Premiums

Age	Average Annual Premium Purchased in 2010
All ages	$2,283
Under age 55	$1,831
Age 55 to 64	$2,261
Age 65 to 69	$2,781
Age 70 to 74	$3,421
75 and older	$4,123

How Do Different Options and Coverage Choices Affect Premium?

Consumers can customize long-term care insurance coverage to match the amount they feel they can pay. Table 18 illustrates how different long-term care insurance options and coverage choices — all from the same program — result in different monthly premium costs. The illustration only changes one coverage element at a time. The price associated with some changes varies by age; for other types of changes age is not a factor. The premiums shown below are monthly premiums which are paid until a insured goes into benefit (premium payments are not required while you are receiving benefits).

The basic coverage design in Sample Plan A:

- Comprehensive Coverage (facility, at-home, and community care)
- Facility care daily benefit of $150/day
- Home Health Care Benefit of $112/day (75 percent of the facility care amount)
- Elimination period of 90 days
- Lifetime coverage maximum equivalent to five years (or just under $275,000 for a policy paying $150/day)
- Automatic Compound Annual Inflation Protection at 5 percent for the life of the coverage

Table 18. How Different Coverage Choices Influence Premium Cost					
Age at Purchase	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 5**
40	$107	$71	$72	$87	$24
45	$128	$86	$90	$104	$31
50	$154	$103	$112	$125	$42
55	$189	$126	$143	$153	$58
60	$231	$154	$183	$187	$81
65	$293	$195	$242	$238	$117
70	$306	$204	$263	$248	$173
75	$487	$325	$437	$393	$313

Note: Premiums shown here are based on one long-term care program's rates. Premiums for the same coverage from a different company will vary from the rates shown here. These premiums are based on the Federal Long-term Care Insurance Program (www.ltcfeds.com). This website has a premium calculator to show how other types of coverage changes might affect the rates, or to explore sample rates for other ages.

Plans B through E show different ways to reduce premium costs compared to the coverage described in Plan A. Examine how the premium changes for Plans B through Plans E compared with Plan A.

Plan B: Same as Plan A, except pays benefits at $100/day for facility care and $75/day for Home Health Care Benefit.

Plan C: Same as Plan A, except the automatic inflation protection is compounded at 4 percent instead of 5 percent.

Plan D: Same as Plan A, except the lifetime maximum is equal to three years (just under $165,000).

Plan E: Same as Plan A, except does not include Compound Annual Inflation Protection. Instead, each year the purchaser can elect to increase coverage by a set amount (typically 5 percent of the prior year's benefit amount) and the consumer pays for the additional amount at the time it is elected.

Another way to buy more affordable long-term care insurance is to consider a special type of long-term care insurance program called a Partnership Policy. Chapter 4 describes the Partnership Program in detail. If your state offers a Partnership Program, consumers can save money by buying a Partnership Policy with a smaller total dollar amount of coverage while taking advantage of the Medicaid Asset Disregard these policies offer.

Premium Payment Options

Policies may offer different payment options:

- Paying premiums as long as the policy is in effect unless benefits are being received
- Paying premiums for a specified period of time
- Paying the entire premium in a single payment

Paying premium as long as the policy is in effect. With most policies, the purchaser selects the payment schedule: monthly, quarterly, semi-annually, or annually. Many companies also make it possible to have the premium automatically withdrawn from a bank account, pension check, or paycheck (if coverage is through an employer). Some insurers now offer payment by credit card. Typically purchasers pay premiums until they begin to receive benefits. Premium payments are typically not required as long as the person continues to receive benefits. In the event that the person no longer needs care and stops receiving benefits, premium payments are resumed.

Paying premium for a specified period. Some policies specify that premium will be paid for a specific number of years, most often 10, 15, or 20 years. For example, with the 20-year option, the monthly premium is paid for 20 years and then the coverage is fully paid up. If the consumer begins to receive benefits before the 20-year pay period is over, premium payments stop while benefits are being received. If the person recovers and has not yet paid in for all 20 years, he or she must resume paying premiums. Some policies require that premiums be paid only until age 65. These policies cost more than those that require continued premium payments over one's lifetime (or until benefits are received).

Paying premium in a single payment. A few companies offer a "single pay" option, in which the insurance is paid for in one lump sum payment. These policies are typically much more expensive than traditional long-term care insurance, but the advantage is that the single lump sum payment is the only premium required. These policies typically pay for long-term care expenses and also offer the option to include a death benefit for heirs. Some states do not allow single-pay policies.

Consumer Protections

Today's long-term care insurance policies include many important consumer protection features. The following rules apply to all long-term care insurance policies:

- Coverage cannot be cancelled or not renewed as long as the consumer continues to pay premiums as they are due and has not used up the maximum policy benefits.
- Purchasers have 30 days after receiving the policy to return it for a full refund. The agent who sold the policy typically delivers it and gets a delivery receipt showing the date the policy was received by the consumer. The person then has 30 days from that date to examine the policy and has the option to return it for a full refund of any premium paid.
- The consumer has the right to designate another person (a "third party designee") to receive notice of premiums due and payments missed so he or she won't accidentally miss a payment.

- The consumer has up to 65 days after the date a premium payment is due to make payment. Coverage cannot be cancelled for non-payment until after this grace period and until the third party designee has also been notified.
- If coverage lapses for non-payment because the consumer was disabled at the time, he or she can restore coverage within five months of the missed premium due date.
- Consumers who purchase a group policy through an employer or other association can continue that coverage, unchanged, if they leave the group but want to maintain the coverage.
- A spouse insured through an employer group plan may maintain coverage even after a divorce.
- An individual cannot be singled out for a rate increase. Premiums are designed to remain level over the lifetime of coverage, and are based on the age when the consumer first bought the policy. The insurer can change rates on a group or class basis, but has only a limited right to do so, and the change must apply to an entire group or class.
- In most states, rate increases must be filed with and approved by the state's department of insurance. Many states have adopted regulations that make it very difficult for an insurer to obtain approval for a rate increase.
- If there is a rate increase of a "significant" amount, the insured can refuse to accept the rate increase and instead receive (at no cost) a Contingent Nonforfeiture Benefit. This provides only a limited amount of coverage to help transition care needs and is a good option for someone who would otherwise need to cancel their coverage altogether if they are unable to afford the rate increase. The limited coverage amount is equal to roughly 30 days of care.
- Also, if there is a rate increase, consumers can elect a decrease in coverage to avoid the change in premium so that they aren't forced to either pay more or drop their coverage.
- Most plans include an independent third party review of claim denials as an option for consumers who wish to appeal a claim denial. This is typically a last step in the reconsidering and appeals process which also has internal steps for reviewing a claim denial that the consumer feels should have been approved.

Where to Buy Long-Term Care Insurance

Most people buy long-term care insurance directly from an insurance agent, financial planner, or broker. States regulate which companies can sell long-term care insurance and the products they can sell. There are over 100 companies who have over the years been offering long-term care insurance. Some of those companies are still selling coverage and others have "closed" their sales but still maintain the coverage of those who already have policies with them. As a result, only about 15 companies account for the vast majority of policies in force and of sales today. The best way to find out which insurance companies offer coverage in your state is to contact your state's department of insurance.

Some people have the option to buy long-term care insurance through their employer. Many private and public employers, including the federal government, offer group long-term care programs as a voluntary benefit. Employers typically do not contribute to the premium cost (as they do with health insurance), but they often negotiate a favorable group rate. Some employers might pay a portion of the premium or buy a minimal coverage plan and allow employees to enhance that coverage with additional amounts. This is more likely to be done within small employers (e.g., doctor offices or law firms) or for executives only within a company.

If a consumer is currently employed, it may be easier to qualify for long-term care insurance through his or her employer than purchasing a policy on his or her own. Counsel working consumers and retirees to check with their company's benefit or pension office to see if the employer offers long-term care insurance.

Employees, retirees, or annuitants of the federal government or eligible family members of any of these people, may be able to buy long-term care insurance through the federal Long-Term Care Insurance Program. More information on this is available at www.ltcfeds.com.

Many states also offer long-term care insurance to state employees, retirees, and their spouses, parents, and sometimes grandparents. Keep in mind that the list of states offering such programs is likely to change over time, so it pays to check periodically with your state employee personnel office. Check with the state employee personnel office to see if long-term care insurance is offered to employees and their families.

Market Overview

While many insurance companies have sold LTC insurance over the years, about 15 companies currently dominant the market. Most policies are sold in the individual market. That refers to the typical "one-on-one" sale where an insurance agent or broker meets with an individual or couple, explains the coverage choices available, asks them about their insurance needs, and works with them to design a plan. Agents that represent multiple insurance companies are called independent agents; agents that work for only one company are called captive agents.

Long-term care insurance policies offered at the workplace are a smaller but important market segment. The employer sponsors the plan and makes payment through payroll deduction possible, but does not typically contribute to the premium cost.

In 2014 one-third of the policies in force were group policies, costing an average of $1,070 per year; two-thirds of policies were individual policies with an average annual cost of $2,409.

Table 19 summarizes where people today buy their long-term care insurance.

Table 19. Where Do People Buy Long-Term Care Insurance?

Source	Percent
Agent or broker	58%
Work	21%
Direct (mail, insurance company main office, Internet)	11%
Association	7%
Other	3%

The chart below shows the number of LTC insurance companies and the number of policies currently in force for the companies with the most policies as of 2011.

Table 20.

Insurer	Policies in Force	Insurer	Policies in Force
Genworth	1,245, 470	New York Life	137,538
UNUM	950,507	State Farm	132,316
John Hancock	901,779	RiverSource	132,316
Metropolitan Life	525,746	Allianz	126,713
C.N.A.	431,614	Thrivent	125, 271
Bankers	283,161	Mutual of Omaha	120,894
FLTCIP	271,150	SHIPs	89,431

Table 20.			
Insurer	**Policies in Force**	**Insurer**	**Policies in Force**
Transamerica	255,062	Mass Mutual	81,071
Prudential	251,143	MedAmerica	57,886
Northwestern	197,951	Lincoln Benefit	53,727
CalPERS LTC	138,626	Aetna	52,100

Helping a Consumer Design the Right Policy

Consumers need good information to help them choose the right long-term care insurance plan for their particular situation. Long-term care insurance is not as simple as some other insurance. For example, in choosing a term life insurance policy, a person is most concerned about choosing the right amount of death benefit to take care of surviving dependents. In choosing long-term care insurance, there are several critical choices that affect the amount of benefits the consumer eventually will be able to access. The choices affecting the structure or design of the policy include:

1. Type of policy
2. Benefit length
3. Inflation protection
4. Daily/monthly maximum
5. Elimination period

Type of Policy. Does the consumer want coverage for all types of care — a comprehensive policy — or only for facility care? If the consumer has ready, willing, and able informal caregivers to provide care at home or wants to go to an assisted living facility as soon as care is needed, he or she may be able to save premium dollars by choosing facility-only coverage. Be aware that in some states, long-term care carriers may only offer comprehensive policies, in which case the consumer has no choice.

Benefit Length. How long does the consumer think he or she might need services? Ask the consumer to consider his or her current and expected health status based on risk factors such as diet, exercise and family history. Are there any recurring health conditions in the family? One example might be several relatives who were diagnosed with Alzheimer's disease at a relatively young age. Are family members particularly long-lived? Were they impaired in their later years? Answers to these questions will help the consumer design a policy with a benefit length or amount that makes the most sense given his or her potential or perceived risk. It is often best to choose the longest amount of coverage you can afford since you can always reduce coverage in the future if affordability is a concern or if your needs change, but it is more difficult and sometimes not possible to increase coverage.

Inflation Protection. Knowing the longevity in the consumer's family and the consumer's current age and health will help in estimate what might be a reasonable life span for which to plan and might help the consumer determine which type of inflation protection and the policy benefit length best meets their needs.

If the choice is between a 5 percent compounding inflator and a 5 percent simple inflator, there won't be a significant difference in the amount added to the daily/monthly maximum until after the twelfth year. For example, a male, 65 years old, might choose a 5 percent simple inflator. But if his relatives all lived into their late 90s, he might wish to re-think that choice and opt for the compounding inflator. On the other hand, if the consumer does not have longevity in his or her family and does not anticipate living into his or her 80s or beyond, a simple inflator or even a Future Purchase Option Inflation Protection may make more sense. A policy that adjusts for inflation based on a specific index of inflation rate for LTSS (the LTC-CPI) makes sense because in reality there are times of higher and lower inflation so one that automatically adjusts to the environment in the long run is more cost effective. Keep in mind that the rate of inflation in LTSS is not as high as typically thought of for medical care. Whatever a consumer chooses, the most important message you can give your consumer is to make some plan for inflation.

Daily/Monthly Maximum. Choosing the daily or monthly maximum on the policy is probably the most important choice the consumer will make. The consumer needs enough coverage to pay for the type and quality of services he or she desires. However, this does not mean that he or she needs to insure the full cost of care.

Help the consumer investigate what long-term care actually costs in his or her area or in the area where he or she expects to live later in life. You might call local providers such as home care agencies, assisted living facilities, and nursing homes to get an idea of costs in the area. You can also use the map of long-term care costs on the National Clearinghouse website (http://longtermcare.gov/costs-how-to-pay/costs-of-care-in-your-state/) to help the consumer identify the average cost of care for different types of providers in her state or elsewhere.

The consumer should also understand what care might cost in the future. This will help determine how much he or she might be able to afford to pay for care out of pocket, based on his or her expected retirement income. The cost savings calculator on the Clearinghouse website can help the consumer see the expected future cost of care in his or her area based on the average amount of care typically needed. With this information, he or she can choose a daily/monthly maximum amount that works best for his or her situation.

Elimination Period. Look carefully at the premium differences between longer and shorter elimination periods. In policies with a service day elimination period, paid services must be incurred for a specified number of days before benefits start. During this elimination period, the consumer is responsible for paying those costs (unless they are covered by Medicare or other insurance). Consequently, it is useful for the consumer to consider what these costs might be when deciding on how long an elimination period to choose. For example, if the elimination period is 100 days and she needs nursing home care, in current dollars, that 100 days might cost $18,000. But 14 years from now that cost could be over $36,000 (5 percent compounding factor) and 28 years from now it could be over $72,000. A Calendar Day Elimination Period, unlike a Service Day Elimination Period, does not require the individual to incur any out-of-pocket expenses, but the individual still may require paid care if family or friends can't provide care during the elimination period. It is difficult to estimate what the costs associated with a Calendar Day Elimination Period are. Although a Calendar Day Elimination Period may result in lower cost for the consumer during the elimination period, there is a higher premium cost for this option and the individual may still have some out-of-pocket costs if he or she requires care that cannot be provided by unpaid caregivers.

With some new policies, the elimination period for home care is set at zero (or can be through a rider called the waiver of home care elimination period). In this case, days that are covered for home care also count toward the elimination period for a future stay in an assisted living facility or nursing home. This feature makes a 90- or 100-day elimination period more attractive. Here an elimination period applies only if the consumer goes directly to a facility with little or no home care. Home care received for the entire span of the elimination period would satisfy this requirement. This makes assuming the risk of the longer elimination period more affordable.

Summary

Chapter 3 has presented basic information about long-term care insurance. This included definitions of different long-term care insurance policy types, considerations in applying for coverage, services that may or may not be covered by the insurance, and how the insurance actually works when a policy holder needs care. Review the Annotated Long-Term Care Insurance Policy included with this chapter to familiarize yourself with the layout and the language of a typical long-term care insurance policy. Refer to the Counselor Tip Sheets and the Consumer Fact Sheets for targeted information on the specific areas each covers.

After completing this chapter you should be able to:

- Explain the concept behind long-term care insurance;
- Help consumers assess whether long-term care insurance is an option that makes sense in light of their goals, age, health, and financial resources;
- Explain common benefit periods/benefit maximums;
- Explain the difference between comprehensive coverage and facility-only coverage;
- Differentiate between services that are typically covered or not covered by long-term care insurance;
- Explain how and when long-term care insurance coverage pays for services;
- Discuss consumer protections; and
- Assist consumers in finding more information about long-term care insurance in your state.

With the basics under your belt, you are now ready to proceed to Chapter 4 to learn about special counseling issues you may encounter when discussing Long-Term Care insurance with your consumers.

Helping a Consumer Compare Long-Term Care Policies

Helping a consumer compare long-term care policies poses some challenges, because features may work slightly differently from one policy to another. For example, in one policy, days that count to satisfy the elimination period may be calendar days on which the consumer is impaired (according to the policy's benefit "triggers"); in another policy, it may be days on which the consumer is **both** impaired and receiving care that would have been paid for by the policy except for the elimination period. Clearly the former method of counting days is more generous but it also costs more. It is not possible in all situations to have a simple checklist of policy elements. More weight will need to be given to certain benefits in some policies even though, on the surface, things might appear to be equal.

The first level of comparison is broad. What are the insurance companies? How are they rated by the insurance rating services? How big are they in terms of assets? How about the agent(s)? Have they been selling long-term care insurance for a long time? Were they referred or recommended by someone the consumer respects? Is long-term care insurance the agent's specialty or does he sell all types of insurance? Look for experience especially from the insurance company, but also from the agent.

Make sure the consumer understands exactly what is being compared when two policies are looked at: a facility-only and a comprehensive policy? An older policy with fewer bells and whistles and a new comprehensive policy with everything added? How important are the new features? Are they worth the higher premium?

When comparing an old policy to a new policy, significant benefit differences will probably be found and/or premiums may also be considerably different. Comparing an older policy to a newer one is helpful in determining whether or not to replace existing coverage. The older policy may have been the "top of the line" when it was issued years ago, but today may be found lacking compared to a newer model. The older policy shouldn't be discarded just because it is older— the consumer's current age and health cannot affect it or the premium. The older policy may be more than sufficient and the newer features may not be worth paying two or three times as much to get.

Comparing newer policies requires detective work to see just how the various elements in the policy work. Use the ***Policy Comparison Worksheet*** to help guide the discussion.

How much is the consumer willing to pay to upgrade and are the missing features that important? Have the consumer use the ***Long-Term Care Insurance Present Value Worksheet*** for assistance with this exercise. Be sure to remind consumers **NEVER** to drop an existing policy until they apply for and are approved for coverage under a new plan, should they decide to upgrade. Sometimes, a consumer can upgrade to a newer policy with the same insurer and receive a premium credit for their past insured status. This is likely to be more affordable than buying a completely new policy at their current age.

CHAPTER 4 | Special Topics in Long-Term Care Insurance

In Chapter 3, the basics of long-term care insurance were presented. This chapter introduces some of the special issues you may need to understand as you counsel consumers who are contemplating purchasing insurance or who have long-term care insurance in place, but have questions related to their existing policies.

The items discussed in Chapter 4 represent some of the most common questions and issues counselors encounter in the field. Use the Counselor Tip Sheets and Consumer Handouts to help consumers sort things out when they come in with questions or problems in these specific areas. Refer back to Chapter 3 for information on basic policy issues to help with questions on topics such as elimination period, premium payment, application procedures, and consumer protections.

The chapter focuses on:

- Handling a claim denial
- Handling a long-term care insurance rate increase
- Long-term care insurance tax issues
- Long-term care and health savings accounts
- The Long-Term Care Partnership Program

Chapter 4 Key Words & Acronyms:

- Asset disregard
- Class basis
- Deficit Reduction Act
- Durable Power of Attorney
- Flexible Savings Account (FSA)
- Guaranteed renewable insurance
- Health Insurance Portability and Accountability Act (HIPAA)
- Health Savings Account (HSA)
- High Deductible Health Plan
- Non-cancelable insurance
- Partnership-Qualified Policy (PQ)
- Tax-qualified Policy (TQ)

Counselor Tip Sheets:

» Special Topics in Long-Term Care Insurance FAQ
» Long-Term Care Partnership FAQ
» Long-Term Care Insurance Present Value Worksheet
» Sample of Partnership-Qualified Policy Notice
» Sample State-Specific Partnership-Qualified Certification Form

Consumer Fact Sheets:

» Partnership Program Brochure
» Long-Term Care Insurance: Tax Treatment at a Glance
» Can Everyone Buy Long-Term Care Insurance?
» My Rates Went Up! What Are My Options?

Handling a Claim Denial

Having a claim denied at any time and with any insurance is frustrating. It may be even more frustrating with long-term care insurance, because there is often a long period of time between purchase and use of the policy. In many cases problems at claim time might not even turn out to be denials — a consumer may need help getting the claim process started.

A few of the most common reasons for claim problems are simple to fix. Seven examples of common claims problems follow:

Example 1: The insurance company has not been contacted, and a claim has not been initiated. Many individuals are used to having claims filed for them, perhaps by their doctor, as is often the case with health insurance and Medicare, so they may not have contacted the claims department to initiate the claim.

Because of HIPAA (Health Insurance Portability and Accountability Act) privacy rules, the consumer, consumer's agent or Power of Attorney must be the one to call the insurance company. A provider or spouse may not make the call on the consumer's behalf unless they have been legally given the right to do so. This is an example of why it is important to have a durable power of attorney in place. Durable power of attorney is a document in which a consumer gives another person legal authorization to act on the consumer's behalf. Without legal authorization, insurance companies are not allowed to discuss a consumer's claim with anyone but the consumer. However the claim department is used to getting this type of call and can help the family members understand the process and obtain the documents they need to get started.

The insurance company's claim department typically takes the information and sends out claim forms to be filled out by the consumer or the consumer's agent, the consumer's doctor, and the care provider. With some insurers, the consumer may be able to initiate a claim simply with a phone call or letter. The insurer may make an appointment for a nurse or social worker to visit and complete an assessment report (more likely if someone is not in a care facility and/or hasn't had a precipitating medical event). The whole process can take several days. If care is needed immediately, counsel the consumer to arrange for services while the claims process gets underway. Help the consumer understand and plan for what care expenses he or she may have to pay for out of pocket – either because the elimination period needs to be satisfied that way or because the services are not covered under his or her policy. The consumer should look into whether some of the care needed during the elimination period might be covered under other insurance or Medicare, thus reducing what he or she has to pay on her own. The insurance company's care coordinator can usually assist with this. Even if it takes some time for the insurance company to approve the claim, expenses that are eligible to be reimbursed are often covered retroactively. Most insurance companies use the "earliest possible date" they can accurately verify as the claim start date even if that date has already passed.

Example 2: Benefits have not been "triggered." Many people forget that there are specific benefit triggers for these policies and that these need to be verified by the insurance carrier. For example, the consumer may not realize that tax-qualified plans require certification of an anticipated need for help with two or more ADLs that is expected to last at least 90 days, or for care or supervision due to a cognitive impairment.

In some instances, a care manager may have visited the consumer and done an assessment. Perhaps the claim was denied because the care manager's assessment (using a standardized tool for making such determinations) found that the benefit trigger was not satisfied. Keep in mind that care managers do not make the benefit decision; they simply collect information on the consumer's condition for the insurance company. If the consumer's condition has changed or he or she feels that the initial assessment did not accurately capture the nature and degree of his or her loss, the consumer may request that a second assessment be performed. She may need your assistance to request this second assessment. In addition, investigate whether the insurance company would accept a doctor's report.

Finally, don't forget the requirement to anticipate if help with activities of daily living is expected to be needed for 90 days or more if the consumer has a tax-qualified plan. There only needs to be the expectation that care needs last at least 90 days. If the consumer recovers sooner, the insurance company will still cover the claim, assuming it had been approved at the outset. Some people misunderstand the 90-day requirement and think that the claim won't be paid if the claim is expected to last 90 days, but the individual recovers more quickly than anticipated.

Example 3: Elimination period has not been met. One of the most frequent reasons claims are initially denied (but then subsequently approved) is because people request benefits before the elimination period has been met. A long elimination period may be confusing to calculate, particularly if is extended because it is a service day elimination period.

Remember that the benefit trigger also has to be met for the days to count toward the elimination period. An assessment may have to be done for the days to count toward the satisfaction of this period. Advise the consumer that it is better to initiate a claim and get an assessment done (if needed) even if the claim is denied. It is harder to prove an impairment existed without having an assessment on record and a claim form filed.

Sometimes the consumer has met the required benefit trigger (for example, needing help with two or more ADLs), but has not satisfied a requirement to receive covered services for a certain amount of time during the elimination period. Many but not all policies require the consumer to both satisfy the benefit trigger and receive covered services (Service Day Elimination Period). This means that the days in an acute care hospital recovering from a stroke, for example, would not count, but once the consumer is discharged to home and begins receiving home health care, the elimination period counting process will begin.

Help the consumer understand and plan for satisfying the elimination period. Consult the policy and explain how the elimination period is counted – calendar days? Service days? Consecutive days?

Make sure that whatever care is being delivered is documented and meets the policy's requirements. This may include saving and submitting detailed bills from providers. Make sure the consumer or his agent does not wait to submit these bills to the insurance company. It is better to submit copies of bills too early than too late.

Example 4: The type of care is not covered. Occasionally you'll find a claim denied because the policy does not cover the type of care being delivered. For example, a facility-only policy will not cover home health care, and a home health care-only policy will not cover nursing home care.

Sometimes in much older policies, you may find the type of care covered, but only after a set period of time in another care venue. For example, home care might be covered for two years after a 15-day stay in a nursing facility. The only remedy here would be to arrange for the type of care covered, as long as it's appropriate, or to follow the requirements in the insurance contract to access the desired care.

If the consumer purchased a Facility-Only Policy and his claim for home care was denied, make sure the consumer met the benefit trigger requirements and then see if assisted living facilities are acceptable to the consumer and acceptable to the insurance company. If not, find out what type of facility would be acceptable to the consumer and meet the insurance company's requirements. Help the consumer consider other financing options that might pay for the type of care needed if it is not covered under the insurance policy.

Example 5: The particular site of the care or the provider is not covered. Most insurance policies require that providers meet certain requirements, usually in terms of how they are staffed, licensed, or certified. This is intended to help ensure that the consumer receives safe and appropriate care. Help the consumer review the policy to find out what these requirements are, or help place a call to the insurance company claims department to find out whether a specific provider meets these requirements. The company may request that the provider fax them a copy of its license or certification.

Even when care is paid for by the consumer (e.g. during the elimination period), it is still important to determine as soon as possible whether or not the provider will be covered and whether or not the care provided will count toward the satisfaction of the elimination period. The same provider requirements apply both to when benefits are paid and toward counting a day toward satisfaction of the elimination period. If a service or provider would not be covered under the policy, then receiving that service or getting care from that provider also won't satisfy the service day elimination period requirement.

Example 6: Care was needed outside the United States. Accidents can happen on vacation, for example, and care might be required before the consumer returns home. Some policies will cover care outside the United States and others will not. Check the policy's contract language regarding care outside the United States or its territories.

Example 7: Care was covered and now it's not. There may be several reasons for care that was covered in the past suddenly to be denied:

1. First check to see if the policy benefit limit or the limit on specific services has been reached.
2. Check to see if there has been a change of providers. For example, was the insured moved from one nursing facility to another? The claim department may require additional paperwork to cover the new provider or the consumer may have decided to use a type of service not covered under the policy.

3. Was there an interruption of care — a period during which care wasn't needed? Does this particular policy require a new elimination period to be satisfied? While most policies sold today have a "once per lifetime" elimination period, older policies may require the consumer to satisfy a new elimination period if more than a specified amount of time elapses since the last episode of care.
4. Check to see if the insurance company is still receiving required bills or other documentation they require. If not, why not? Who was sending these materials before? Sometime, an interruption in required billing information is responsible for denial of claims.
5. Check to make sure the consumer is still in need of the level and type of assistance with personal care or supervision for cognitive loss that qualifies his or her for benefits. Some people initially meet these benefit triggers and might even move into an assisted living facility, but after time passes, their condition improves to the point where they no longer need the covered level of care. The long-term care insurance policy will only continue to pay for the assisted living facility if the consumer continues to satisfy the basic requirements for needing LTSS. People may not realize that there is more recovery from long-term care needs than people might otherwise assume. Approximately 30 percent of all LTC insurance claims end in recovery. Less than half of those who do recover (and go off claim) will eventually re-claim.
6. Some consumers may not realize that their benefits will end as a result of their recovery. This is most common with someone in an assisted living facility; they are still living in the facility but are functioning independently and no longer need the personal care or supervision they were receiving. Consumers are surprised when their insurance benefits end since their facility "rent" continues. The LTC insurance is meant to cover facility costs when care is provided and not when someone has recovered and isn't receiving covered care.

If none of these examples applies and there seems to be no rational explanation for the cessation of benefits, talk to the claims department and attempt to walk through the sequence of events logically to understand why claims are now being denied. Stay on the phone with the claim department until:

- You understand the reason for the claim denial and how to address it, if possible; OR
- The claim department understands that the claim seems to be valid and states what steps it will take to either verify the need for care/impairment, or begin benefits; OR
- Both sides agree that the claim is not valid.

Keep in mind that most insurance policies have a procedure outlined in the policy for how to appeal or request reconsideration of claim denial. Once internal protocols for appealing a claim denial are exhausted, most policies allow the consumer to take the matter to a third party, such as an administrative law judge or an independent third-party review entity. In fact, many states require that a policy include an appeal option with an independent third-party review.

In closing, be aware that claim denials and problems obtaining benefits are rare. Some findings from recent studies of LTC insurance claims processing:

- Roughly 95 percent of all claims are paid.
- Among those on claim:
  - 94 percent had no disagreement with the insurer and 3% had a disagreement that was satisfactorily resolved

- Insurance covers between 72 percent and 98 percent of care costs
- Most claimants say their policy benefits meet care needs — 90 percent feel their policy provides flexibility in service choice
- In absence of insurance, half the claimants felt they would have to seek facility care or not be able to afford care
- Most (77 percent) do not find it difficult to file a claim

Handling a Rate Increase

Only a very few policies (issued as "non-cancelable") guarantee premiums to be fixed forever. With most long-term care insurance, the insurance company has a limited right to increase premiums on a class basis in the state where the policy is filed. In the industry this is called being "guaranteed renewable." The vast majority of long-term care insurance policies are guaranteed renewable. The insurance carrier must file with the state for a rate increase and provide evidence of its need for this increase. The state where the policy is filed reviews and either approves, denies, or alters the requested premium increase. Only after the insurer obtains approval for the rate increase would the consumer receive notice of it. Individuals generally receive notice 45 to 60 days in advance of the effective date of the rate increase. The insurer's limited right to increase premiums is printed on the front of the insurance policy in bold letters.

Unfortunately, a growing number of companies have requested and received approval for rate increases in the last few years. A number of factors underlie this trend. One is the sustained recession which means that the reserves the insurance company had accumulated from the outset to pay current and future claims has not grown as expected. Health care advances also mean that people are living longer and experiencing more disability as they age than was the case decades ago when many of these policies were priced.

Several lines of questioning are helpful when working with consumers handling a rate increase:

Can the consumer afford the rate increase? If the consumer can afford the increase and he or she values the insurance coverage as it stands — with no changes in the benefit levels — then it is probably in his best interest to keep the policy as is and pay the new premiums. In many cases, this is less costly than changing to another insurance policy (assuming the consumer is still insurable) or going without coverage.

If the consumer cannot afford the rate increase or does not wish to pay the higher premium, you can offer two sets of options for consideration, depending on whether or not he is insurable:

If the consumer is not healthy or currently needs long-term care services, he is most likely not still insurable. In this case, the following options are:

- Keep the existing policy and accept the price increase;
- Change the policy structure to lower the premium to an affordable level; or
- Cancel the coverage. This option makes little sense if the consumer needs long-term care.

Counseling Consumers about Benefit Changes to Lower Premiums

Be careful when you advise consumers on making benefit changes. Make sure they understand the implications of these changes.

Often, the best place to start when looking to lower the premium is a shorter benefit length. This is a straightforward change — it only changes the policy by decreasing the length of time for which the consumer has coverage (or the total dollar amount of that coverage).

Similarly, changing to a longer elimination period or a lower benefit level are straightforward ways to reduce premium costs. Changing a policy's inflation protection option is more complicated. Make sure the consumer understands that if he decides to drop automatic inflation protection, the benefit level will most typically remain at its current (inflated) level but in some cases it might revert back to where it was on the original issue date of the policy. If it drops back to its original level, the consumer will lose all the inflation protection he paid for from the beginning. This might not be the best way to save money on premiums.

If the consumer wishes to maintain coverage, but at a lower level to reduce the cost, he or she needs to contact the insurance company to learn what reduced coverage options are available that would produce an affordable premium. Most likely, the insurance company has sent information about how to do this along with the rate increase notice. Consumers always have the right to reduce their coverage in light of a rate increase rather than forcing them to either accept the rate increase or drop their coverage! The coverage is "guaranteed renewable" so only the consumer can cancel the policy. The consumer's current health is not a problem if he is asking to reduce his coverage. It is only a factor if he wishes to increase his benefits.

Insurance companies usually allow people to reduce their coverage without any medical underwriting required since it lowers the insurance company's risk. The consumer should ask the insurance company for options to reduce the premiums. The insurance company may offer options such as:

- shorter benefit length;
- longer elimination period;
- lower daily benefit level; or
- different inflation protection option.

The consumer may be able to choose a combination of these changes.

For example, the consumer might shorten the benefit period from a six-year benefit length to a five-year benefit length, and he might lengthen the elimination period from 30 days to 60 or 90 days. The choices depend on what the insurance carrier makes available. Advise the consumer to ask the insurer to quote new prices based on the changes offered. If the consumer decides to make changes, the insurance company needs the change request in writing — either on a signed and dated form it provides or in a letter from the consumer. In most cases, the cost of reducing coverage is still based on the consumer's age at the time he or she originally purchased the insurance, not on his or her current age.

If the consumer is insurable, he or she may have more options. He or she can either keep the current policy as-is and pay the higher premium, change the policy structure to lower the premium (as described above), or shop around to see what other carriers would charge for similar coverage. Depending on the length of time since he or she purchased his or her current policy, he or she might find that purchasing a new policy from a different carrier could have a higher premium than his or her current premium with the rate increase. This is because 1) he or she is older than when he or she first purchased the existing policy,

and policy prices are higher for older individuals since they are based on the age at purchase; 2) also, he or she will have to purchase a higher daily benefit amount to equal what the current benefit amount may have inflated to, and 3) if his or her health and/or marital status have changed, significant discounts may be lost on a new policy. Nevertheless, finding out what similar coverage would cost at today's premiums will help him make the best decision.

If a new policy is discovered that looks attractive both in its benefits and its pricing, counsel the consumer NOT to cancel the old policy until he is sure the new policy has been approved and is in force.

Tax Treatment of Long-Term Care Insurance

Federal Taxes

Most long-term care insurance policies sold today are federally tax-qualified or TQ policies. The Health Insurance Portability Act of 1996 (HIPAA) clarified favorable tax treatment for long-term care insurance plans that meet certain requirements. If a long-term care insurance policy provides certain basic consumer protections — most of which are routinely included in today's policies — it qualifies for TQ status. Over 98 percent of the policies sold today are federally tax-qualified.

How to Tell if a Policy is Federally Tax-Qualified (TQ)

The long-term care insurance policy will state that it is tax-qualified directly on the face page of the policy. An example is below. Policies issued prior to January 1, 1997 are automatically granted TQ status, even though they may not meet the current requirements for TQ policies. These older policies will not have the "tax disclosure" notice on the face page, but are considered TQ by virtue of having been purchased prior to the effective date of the new tax clarification.

Sample Long-Term Care Insurance Policy: Tax Qualified Status Disclosure Notice

IMPORTANT NOTICE: This Policy is intended to be a tax qualified long-term care insurance contracted under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191.

- With a tax-qualified long-term care contract, the benefit payments are tax-free, and premiums may be tax-deductible under certain circumstances. Specifically, the cost of premiums can be combined with other itemized medical expenses, including any out-of-pocket long-term care expenses. If these itemized medical expenses exceed 10 percent of the consumer's adjusted gross income, a portion of the long-term care insurance premium can be deducted. (Until 2017, this figure is 7.5 percent if you are over age 65 and in a nursing home or assisted living facility).

The amount of premium that can be deducted depends on the consumer's age. Each year, the IRS specifies by age group the maximum premium amount that can be deducted by people who qualify for the deduction. These amounts are shown in Table 21 for the years 2014 and 2015.

Table 21. Maximum Deduction for Qualified Long-Term Care Insurance Premiums Under Code § 213(d)(10)		
Age Before Close of Year	**2014**	**2015**
40 or Less	$370	$380
More Than 40 But No More Than 50	$700	$710
More Than 50 But No More Than 60	$1,400	$1,430
More Than 60 But No More Than 70	$3,720	$3,800
More Than 70	$4,660	$4,750

These dollar limits are indexed to increases in the Consumer Price Index (CPI) and change each year.

Most people do not qualify for the medical expense deduction, because their total health and medical expenses do not exceed 10 percent of their income. However, someone with a lower income and/or extremely high medical expenses may qualify for this tax deduction. For example, someone undergoing costly experimental treatments for cancer and taking unpaid leave from her job might well incur extreme medical costs at the same time that her income is reduced. For that year, she may qualify for the medical expense deduction. If so, she could include the cost of her long-term care insurance as well. Some married couples file separately if one of them has extreme medical expenses that would qualify them for the deduction if they did not file jointly.

Some additional facts about tax benefit amounts and limitations:

- Self-employed individuals are allowed to deduct 100 percent of the premiums for tax-qualified long-term care plans, up to the age-specific amounts.
- Employees cannot pay for long-term care insurance premiums with pre-tax dollars as part of Section 125 cafeteria plans and other similar arrangements.
- Unlike medical, dental, and pharmacy expenses, premiums paid for long-term care insurance cannot be counted against amounts set aside for a health care Federal Savings Account (FSA). This is also true of the premium amounts paid for health insurance.
- Policies that pay a cash benefit (without regard to whether or not the insured receives long-term care services or incurs any long-term care expense) also receive a portion of that cash benefit on a tax-free basis, up to a certain amount. In 2014 and 2015 the amount is $330. If an individual receives a cash benefit in excess of that per diem limit, the excess amount may be subject to taxes. However, if the consumer can document that all or a portion of that excess amount was spent on long-term care services, the excess may be deemed tax-free. Consumers should always check with a tax accountant or attorney to be sure how to handle a cash benefit amount that exceeds the specified tax-free maximum.

State Taxes

Over half the states offer either a tax deduction or a tax credit for long-term care insurance. Some states offer this only for the first year in which the policy is purchased, but most states allow it as long as the policy is in effect and the consumer is paying premium. Some states only give the state tax break if the individual doesn't take the federal tax break. And some states may have other tax credits or deductions for long-term care expenses or expenses associated with being a caregiver. Each state specifies its own rules and procedures for receiving the tax deduction or tax credit.

Because rules are always in flux, consumers should check with a CPA or tax advisor. The following states have offered some sort of tax advantage specific to long-term care insurance: Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, West Virginia and Wisconsin.

Because more states are likely to offer tax breaks for long-term care insurance and because the rules differ by state and are likely to change over time, always counsel consumers to consult their tax accountants or attorneys or their State Insurance Division for specific information about both state and federal tax advantages for long-term care.

Long-Term Care and Health Savings Accounts

Health Savings Accounts (HSAs) are a relatively new approach to providing employees with choice and flexibility in obtaining and paying for health care insurance. A small but growing number of employers offer an HSA option to their employees. To qualify to have an HSA, an individual has to choose what is known as a High Deductible Health Plan. Furthermore, the person cannot be covered by other health insurance that is not a High Deductible Health Plan. A "high deductible health plan" is one that has at least a $1,300 deductible for a single person or a $2,600 deductible for a family. The amount that can be contributed to the HSA depends on the consumer's age and the type of High Deductible Health Plan. However, long-term care insurance is allowed, along with automobile, dental, vision and disability insurance, as examples of other insurance you can have and still be eligible for an HSA.

HSAs allow consumers to save annually up to $3,350 for a single person or $6,650 for someone with family coverage in an HSA account and exclude this amount in that year's taxable income (as of 2015). Employees contribute pre-tax income up to these limits, and some employers may even make a small additional contribution to their employees' HSA accounts. The funds in the account accumulate tax-free interest and can be carried over in the account from year to year (unlike the more traditional Flexible Spending Account (FSAs) that must be used annually). The amount of income put into an HSA is an allowable "above the line" tax deduction from federal income taxes. The allowable amounts are adjusted annually by the IRS.

The money in the HSA account may be used for qualified medical expenses, such as doctor and hospital bills, prescription drugs, mental health care, alternative care treatments, over-the-counter medications, and insurance premiums for TQ long-term care policies. Withdrawals made from an

Advantages of Health Savings Accounts

- Qualified consumers contribute pre-tax income to the HSA, thereby lowering their taxable income.
- HSAs accumulate tax-free interest.
- Consumers can make tax-free withdrawals to pay for qualified medical expenses, such as doctor and hospital bills, prescription drugs, mental health care, alternative care treatments, over-the-counter medications, and insurance premiums for TQ long-term care policies.

HSA for these qualified medical expenses are tax-free. Long-term care insurance premiums can be paid for from funds in your HSA, thus allowing consumers to pay those premiums on a pre-tax basis as well. However, the long-term care insurance premium limits described in Table 21 also apply as limits for the amount that can be withdrawn from an HSA tax-free to pay for long-term care insurance.

In theory a person could make sizable contributions every year and let the account grow, and if they began years before retirement, this would produce a considerable amount that could be spent on LTC. Or one could use HSA funds each year to pay part of an LTCI premium. But in reality, people with high-deductible health plans usually need funds from their HSAs to pay out-of-pocket medical costs, and rollover amounts are typically not large. The rollover amount is the amount left over at the end of the year after the funds are used for qualifying expenses. (As of 2011, one-third of HSAs had rollover amounts of less than $500, and only one-fourth had $2,000 or more.) To sum up: those covered by a high-deductible health plan have the opportunity to use an HSA to pay for LTC or LTCI premiums on a tax-free basis, but it is unlikely that many people will be able to do so.

While on average HSA account balances are limited, older persons tend to have considerably more money in their accounts than do younger HSA users. Consumers ages 55-64 had an average of just under $3800 and those 65 or older had an average account balance of $4,460.

Individuals who are enrolled in Medicare are NOT eligible for an HSA.

Long-Term Care Partnership Programs

A Long-Term Care Partnership Program is the collaboration between a state government and the private insurance companies selling long-term care insurance in that state. Partnership policies offer a special feature known as an Asset Disregard. This allows a consumer to keep additional assets if, after using their long-term care insurance policy coverage, they need to rely on Medicaid for continued long-term care services. With a Partnership policy, the consumer can retain assets of equal value to the amount of their long-term care insurance coverage used, over and above the maximum asset amounts that the state's Medicaid program generally allows people to keep.

Someone without a Partnership policy who uses up his or her long-term care policy benefits, but still requires care, would have to "spend down" his or her assets to the state-mandated level to be eligible for Medicaid. For a single person, Medicaid only allows $2,000 in assets; married couples can retain more than that in most states.

With a Partnership-Qualified policy, the consumer is allowed to keep $1 of additional assets for every $1 she receives in benefits from her long-term care insurance policy. For example, if the consumer purchases and uses a Partnership-Qualified long-term care insurance policy that pays $200,000 in benefits, the consumer can retain an additional $200,000 over and above the asset threshold Medicaid requires. Moreover, these assets are also exempt, after death, from Medicaid estate recovery and are preserved for the consumer's heirs.

Each state determines if and when it wants to offer a long-term care Partnership Program. A Partnership-Qualified policy is a long-term care insurance policy that has been certified by a state as qualified for its Partnership Program. Each state determines the requirements for its own Partnership Program. States also specify the types of notices and disclosures they require insurers to send so that consumers know whether or not that have bought a Partnership-Qualified policy. The typical Partnership Program has the following characteristics:

- State mandated levels of and type of inflation protection based on the consumer's age at the time of purchase.
- All Partnership policies must also be federally tax-qualified (TQ) policies.

Policies issued prior to a state's Partnership Program effective date are not considered Partnership-Qualified. However, there are circumstances under which a consumer can exchange a previously purchased policy for one that is Partnership-Qualified.

Partnership policies offer advantages to consumers that may be of particular value to those who are unable to afford a large amount of long-term care insurance but who have assets they want to protect from Medicaid spend-down should their care needs extend beyond the amount of private insurance they have purchased.

An individual can tailor the lifetime maximum of the insurance policy to the amount of assets he wants to protect from Medicaid spend-down. For example, if he wants to protect $150,000, he buys a Partnership policy with a $150,000 lifetime maximum. In this way, Partnership policies offer an incentive to those of more modest means to buy at least a small lifetime amount of long-term care insurance. Keep in mind that a consumer buying a $100,000 policy today might well receive a larger benefit payout when care is needed, due to the inflation protection included in the policy. If the consumer has that policy for 14 years without having yet filed a claim, his or her lifetime maximum would now be about $200,000 if he or she included an automatic 5 percent compound inflation protection provision in his or her coverage.

How Can You Tell the Difference between Partnership Policies (PQ) and Non-Partnership Policies?

A partnership policy may not differ from a non-partnership-qualified policy sold on the same policy form from the same insurance company. If Company A obtains Partnership certification for its "Secure Independence" long-term care policy form, the non-partnership-qualified version of that policy form will be identical to the partnership-qualified version. **What makes the policy partnership-qualified is whether the individual buying it has purchased the required level and type of inflation protection and received the required disclosures and notices from the insurer.** Otherwise, the benefits and coverage in the two policies are the same. Most states require that the PQ policy be delivered with a disclosure form indicating its PQ status.

Still there are some important caveats consumers should understand:

- Eligibility for Medicaid is not automatic. Even with a Partnership-Qualified long-term care insurance policy, the consumer would still need to satisfy other Medicaid eligibility requirements pertaining to health, income, home value, and other criteria.
- Services received under Medicaid may differ from services covered under the Partnership-Qualified long-term care insurance policy, and what Medicaid covers may change over time.
- Partnership policies protect a specified amount of assets from counting against eligibility for Medicaid, but they do not protect income. The consumer must still satisfy the state's income criteria to become eligible for Medicaid.

Reciprocity Agreements

All but two states (New York and California) have agreed to offer reciprocity to individuals with a LTC Partnership-Qualified policy. This means that a resident can buy a partnership policy in one state, move to the other state, and receive dollar-for-dollar spend-down protection if he or she uses up his or her benefit and applies for Medicaid. Without reciprocity, a consumer with a Partnership-qualified policy would be entitled to Medicaid spend-down protection only in the state where he or she bought the policy. While the Partnership policy is in force, however, the consumer can receive benefits under it in any state, regardless of whether they have a Partnership program or offer reciprocity.

Reciprocity. Counsel consumers to think about where they may be living at the time that they need care. Not every state has a Partnership program. But for all but two states that do offer Partnership LTC programs, reciprocity is allowed (New York and California do not have reciprocity with other Partnership states). In all other states that have a Partnership program and that provide reciprocity, the purchasers of Partnership policies can be less concerned about moving to another state and potentially losing one of the main advantages of the policy — Medicaid spend-down protection. Broad reciprocity makes Partnership policies much more attractive to consumers, increasing the number of people who buy them. (States can elect not to provide reciprocity but to date all state Partnership programs are providing it. States are automatically deemed to be included in reciprocity unless they specifically opt out.)

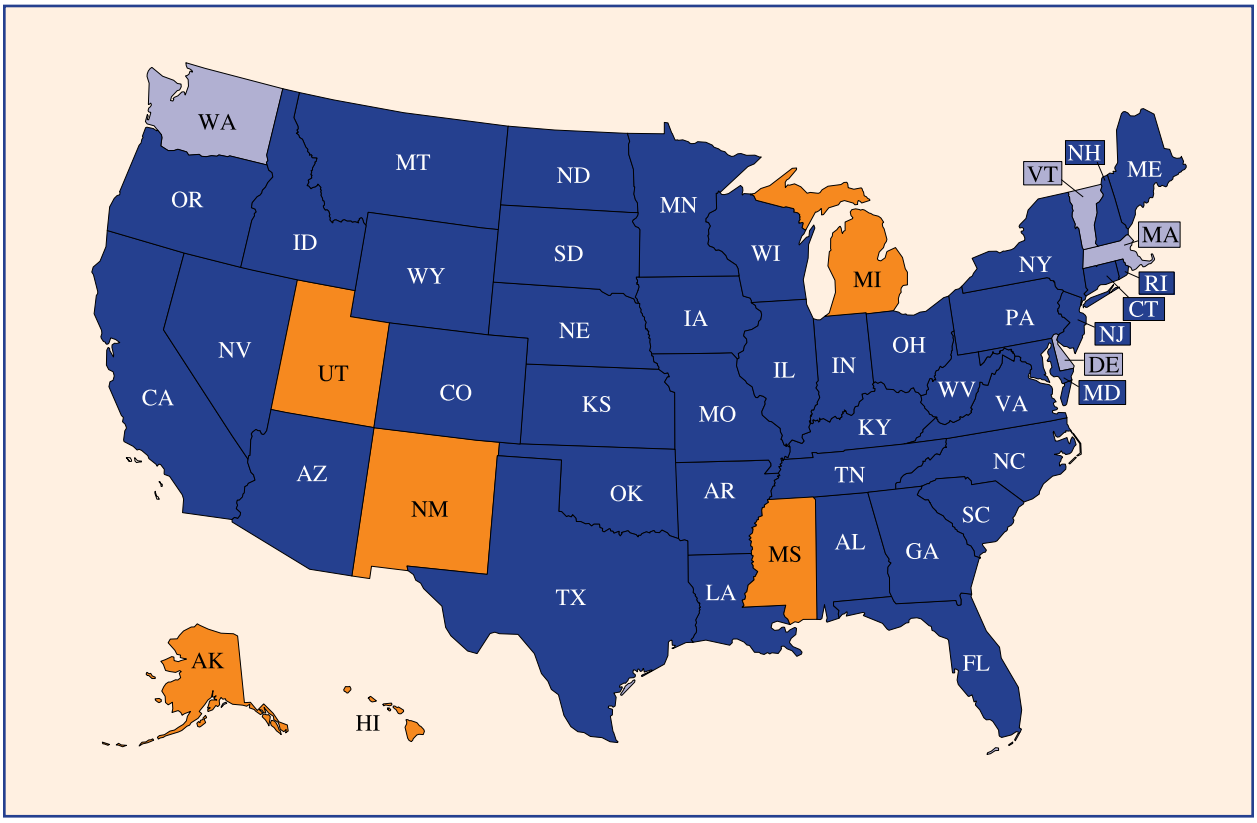
In short, under new federal legislation, each state can establish its own Partnership program under its own rules, but with a certain amount of uniformity in programs and policies from state to state and with reciprocity among states greatly encouraged.

Status of State Activity on Partnership Programs (as of November 2013)

Many states have embraced implementation of the new long-term care insurance Partnership Initiative. As of December 2013, insurers have received certification for Partnership-Qualified policies and these policies are now available for sale in all but the following ten states: Alaska, Hawaii, Illinois, Massachusetts, Michigan, Mississippi, New Mexico, Utah, Vermont, and Washington. There is a fair amount of uniformity with regard to procedures and policy provisions for Partnership coverage in these states; however, different types and amounts of inflation protection may be required based on the buyer's age. Also, keep in mind that the four original Partnership states (California, Connecticut, Indiana, and New York) operate on different rules than those described above.

Other states are likely to follow as many have filed enabling legislation to move forward with a state Partnership program. Figure 2 shows the status of Partnership Programs as of 2013.

Figure 2: State Implementation Status as of October 2013



MAP KEY: Policies for Sale; Approved State Plan Amendment (SPA); SPA Submitted; State Enabling Legislation or other Documents Available

Partnership Program Specifics

The key features of Partnership Programs are explained in more detail below.

Inflation Protection. Partnership-Qualified long-term care insurance policies are required to include certain types of inflation protection depending upon the age of the buyer, specifically:

- Individuals purchasing a policy at age 60 or younger must buy a plan with annual compound inflation protection;
- Individuals buying at ages 61 to 75 must have some type of inflation protection. This need not be automatic annual compound increases; it could be simple rate increases, a guaranteed future purchase option, or some other form of protection;
- Individuals aged 76 or older must be offered an inflation protection option, but they are not required to purchase that option.

All Partnership-Qualified policies must also be federally tax-qualified, which means that those policies are required to offer 5 percent compound annual inflation protection to all purchasers regardless of age. However, the individual has the right to decline this offer. Individuals who decline this offer are required to sign a statement indicating that they were aware they received the offer and elected not to purchase it.

- Some states adopted the Deficit Reduction Act language verbatim; others adopted variations on the language that provides more specific guidance as to the various types of inflation protection that may be allowed. The major differences pertain to the requirements for individuals age 60 or younger, since there are many variations that would satisfy the broad requirement for "annual compound" inflation protection. For example, some states allow a CPI-based inflation index and also allow inflation amounts as low as 1 percent in some cases. Some states allow for a "graded" inflation protection benefit which means that both benefits and premiums increase by a modest set amount per year (e.g., 3% or 5%). A few states allow a Future Purchase Option for these youngest buyers, but with some rules around how that is implemented. Some states have not specified their position on FPO, while some states have clearly said that it is not allowed to satisfy the requirement for a purchaser under age 61.

- Most states have not addressed the issue of whether or not an insured person could lose his policy's Partnership-Qualified status if he elects to downgrade to a different form of inflation protection than the one originally purchased as they "age into" the next level of required inflation protection. For example, if someone bought a Partnership-Qualified policy with 5% compound annual inflation protection at age 55 and then decided at age 77 to drop the inflation protection (perhaps to be able to afford to retain coverage in more income-limited retirement years), would this change the policy to one that is no longer Partnership-Qualified?

Policy Exchanges. There are currently over 8 million long-term care policies in force. Many policies already in consumers' hands have all the required components that would make them Partnership-Qualified, but they were purchased before the Partnership Program was in place in their state. Additionally, many consumers with long-term care insurance policies only need to add inflation protection to have coverage that satisfies all the requirements of a Partnership-Qualified policy. Since Partnership-Qualified policies have the advantage of Medicaid Asset Disregard, there is an incentive to exchange the non-Partnership-Qualified policy for a Partnership-Qualified policy.

Some states require insurers to notify consumers of the right to exchange their existing long-term care insurance policies for Partnership-Qualified policies and specify how far back insurers have to go in offering the exchange. Other states indicate they will allow insurers to offer or accept requests for policy exchanges but leave the details up to the insurer.

Certification Requirements. The Deficit Reduction Act outlined both general requirements and specific consumer protections that every Partnership-Qualified policy must include. These provisions are included in many long-term care policies sold today and are drawn from the NAIC Long-Term Care Insurance Model Acts and Regulations, which more than half of the states have adopted in whole or in part. The requirements address issues such as allowable exclusions and limitations in coverage, renewability, disclosure of past rate increases, protection against unintentional lapse, and ensuring suitability of the sale.

As a result, states have had to identify a mechanism to certify long-term care insurance policies that satisfy the Partnership-Qualified requirements. Most states are opting for an approach where they provide a state-specific Partnership-Qualified certification form for insurers to complete. This identifies the insurance policy form to receive Partnership-Qualified certification and documents that all relevant provisions have been met.

Notification Requirements to Policyholders and Claimants. Consumers need to know whether they are purchasing or have purchased a Partnership-Qualified policy. They should understand the special Medicaid Asset Disregard provision, especially if they are near to or have exhausted benefits and are about to apply for Medicaid assistance. States have addressed the first issue — making clear to purchasers whether the policy they have is Partnership-Qualified or not; the second issue is still a work in progress.

Most states with Partnership Programs specify a consumer notice that must be provided to the insured at the time of purchase to indicate clearly that the policy is Partnership-Qualified. One state also requires a similar notice be included in non-Partnership-Qualified policies. It also addresses some of the circumstances that might cause a policy to lose its Partnership-Qualified status:

- If the consumer moves to a state that does not have a Partnership Program;
- If the consumer makes a disqualifying change to his or her coverage; or
- If the state discontinues its Partnership Program.

States are also exploring options for providing notification that a consumer is about to exhaust his or her benefits so that she or a legal representative will be aware of the Asset Disregard the Partnership-Qualified policy affords. Examples of approaches under consideration include:

- Requiring insurers to send a letter to claimants they believe have only 90 days of benefits remaining;
- Using the annual IRS 1099 form claimants receive to track the total benefits received to date so that the consumer knows how much Asset Disregard has accumulated;
- Requiring insurers to provide, upon request, a written statement to claimants of benefits earned to date and their policy's current Partnership-Qualified or Non-Partnership-Qualified status;
- A statement on the monthly Explanation of Benefits (EOB) form that claimants get while they are receiving benefits.

Asset Disregard Policies. The Deficit Reduction Act provides structure and guidance on the rules regarding Asset Disregard. Consumers with a Partnership-Qualified policy are allowed to retain an additional amount of assets equal to the total amount they have received in benefits under their Partnership-Qualified policy. The Asset Disregard applies both at the time of application to Medicaid as well as upon estate recovery.

One issue that states are determining on their own is whether or not to require "exhaustion of benefits" under an individual's Partnership-Qualified long-term care insurance policy before they are allowed to apply for Medicaid. To date, no state requires exhaustion of benefits before an individual can apply for Medicaid.

Another issue to be resolved on a state-by-state basis is how to treat additional assets that Medicaid recipients may attain should their initial asset base fall short of the amount of Asset Disregard to which they are entitled based on the amount of benefits they received under their Partnership-Qualified policy. For example: An individual with a Partnership-Qualified policy applies for and becomes eligible for Medicaid, having earned $150,000 in Asset Disregard. The individual only has $100,000 in assets at the time he or she applies. Will he or she be able to continue to accrue Asset Disregard for the interest earned on the protected assets, up to the total amount he or she received in benefits under the Partnership-Qualified policy? That is as yet unresolved, and is up to each state to determine.

Use the appropriate handouts to clarify and reinforce the discussions you have with consumers on these special topics. The handouts may be helpful during your discussion to anchor the conversation and to reinforce main points for the consumer to consider after a counseling session about long-term care insurance.

Summary

Chapter 4 has provided information about specific issues you may encounter when counseling consumers about long-term care insurance. The first half of the chapter addressed some of the most common questions consumers have about long-term care insurance claims, how to help consumers handle notification of an insurance rate increase, and tax issues associated with long-term care insurance.

The rest of Chapter 4 was devoted to a discussion of the state Long-term Care Partnership Programs.

After completing this chapter you should be able to:

- Offer insights and advice to consumers who have received a claims denial or have experienced difficulties initiating a long-term care insurance claim;
- Discuss options for handling a long-term care insurance premium rate increase;
- Explain some of the federal and state tax treatments associated with long-term care insurance and direct consumers to resources for more information on related tax issues;
- Understand the state Long-Term Care Partnership Program and where to find more information on your state's status with regard to this initiative; and
- Assist consumers the advantages and disadvantages of various policy options.

For some consumers, however, it will become apparent that long-term care insurance is not a viable option. Chapter 5 focuses on other options for long-term care planning that you will be able to discuss with consumers as they consider what makes the most sense for their particular situations.

CHAPTER 5 | Other Private Options for Financing LTSS

In Chapter 2 you learned about the range of financial options for helping consumers to plan and pay for LTSS. The option that works best for the consumer depends on his or her age, health, life situation and other factors. In Chapters 3 and 4, you learned about Long-Term Care Insurance — one financial tool for covering long-term care. This option may be a good solution for some consumers, but may not be suitable for others. A consumer may have health issues that render her uninsurable or there may be financial issues that would make even a modest long-term care insurance policy an unwise financial purchase. For these consumers, there are other private financing options that may be appropriate. These include reverse mortgages, other uses of home equity, annuities, and viatical settlements.

In most cases, these financing options reconfigure existing assets to make them available, liquid, and more suitable for financing LTSS. This chapter presents five private financing options:

- Using the equity in a home to pay for LTSS or purchase long-term care insurance
- Using life insurance to pay for long-term care
- Hybrid products – combination products that bundle a LTSS benefit with either a life insurance policy or an annuity
- Continuing Care Retirement Communities (CCRCs)
- Paying directly for care

Chapter 5 Key Words & Acronyms:

- Accelerated death benefit
- Annuity
- A.M. Best rating
- Cash value life insurance policy
- Federal Housing Administration (FHA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Home Equity
- Home Equity Conversion Mortgage (HECM)
- Lien
- Life Estate
- Life Settlement
- Reverse Mortgage
- Reverse Mortgage Annuity
- Supplemental Security Income (SSI)
- Trust
- Viatical

Counselor Tip Sheets:

» Private Financing Options Worksheet
» Quick Facts about Reverse Mortgages

Consumer Fact Sheets:

» Private Financing Options Overview
» Comparing Options for Using the Equity in Your Home to Fund Your LTSS Needs

An overview of each of the five financing options follows.

Using Home Equity to Fund Long-Term Care Needs

In many cases, the largest single financial asset an individual has is the built-up equity in his or her residence. There are several ways an individual can turn this intangible value into dollars to pay for long-term care. This is known as "equity conversion". Some methods of equity conversion make more sense for older, retired individuals than others. This depends on the consumer's immediate needs and future goals. Options include:

- Sell the house and move
- Sell the house and lease it back
- Home Equity Loan
- Reverse Mortgage
- Reverse Mortgage Annuity

Sell the House and Move. Some consumers may think that selling their home and using the proceeds to pay for LTSS expenses or to generate income with which to buy insurance is a good way to fund their LTSS needs, particularly if they are interested in downsizing, moving to a new area, or to a retirement community. Besides the personal issues of selling what may have been their family/primary residence of many years, there are a number of other considerations:

- Is this a good time to sell to maximize the cash they would receive? Have they consulted a realtor or other housing professional for an estimate about the amount of cash they could expect for their home?
- Would the proceeds from the sale be enough to cover the new housing situation and still provide income to pay for care expenses?
- What are the tax benefits and liabilities?
- Would investing the proceeds from the sale create enough of a reserve fund or stream of income to pay for long-term care insurance or help pay for LTSS when needed?
- If the consumer is interested in purchasing an Immediate Annuity, it is best to refer him or her to an annuity specialist to help determine what type of income stream would be generated by the proceeds from the sale of the house.
- Are there other options, such as a reverse mortgage, that might be more appropriate?

Sell the House and Lease it back. With this option, the house is sold but the consumer retains the right to continue to live in the house for a period of time. Sale and leaseback can be arranged through a long-term lease or the creation of a life estate. Because both a life estate and a long-term lease have economic value, the sale of the house may occur at a discount to the market.

Sale and leaseback considerations include:

- If the sale at discounted value is to family, the consumer gets to keep the house in the family in a way that works well for both parties.
- The consumer's life may be simplified since responsibility for taxes and home maintenance shift to the new owner.
- Will the proceeds from the sale of the house provide enough funding for financing long-term care?
- How comfortable is the consumer with the new owner regarding issues such as maintenance and upkeep of the house and the consumer's ability to stay in the home?

Help the consumer with the financial decision by talking through these considerations. In some cases, it may be best to refer the consumer to the appropriate professionals for specific financial and market advice. For example, an annuity specialist can provide annuity information and compare the amount of income generated from the sale proceeds and the amount saved in property taxes and home and grounds maintenance, with the new requirement to pay rent and/or substantially discount the house sale.

Home Equity Loan. With a home equity loan, the consumer accesses a portion of his home equity, usually borrowing up to 80 percent of the value of the equity built up in the home. This money can be used to pay for LTSS or to purchase long-term care insurance. However, this type of loan requires a monthly repayment. So in addition to other budgeted items, the homeowner adds a home equity loan payment to his or her budget. Considerations for a Home Equity Loan include:

- Is the additional monthly expense of an equity loan affordable?
- How does this compare to other options such as reverse mortgage, e.g. borrowing fees may be lower for an equity loan?
- How does the amount of income available with this and other options compare?

Reverse Mortgage. A reverse mortgage is a loan that uses the home as collateral, but requires no repayment as long as at least one of the eligible home owners remains in the home. This type of loan solves the problem created by using a home equity loan — namely, it eliminates the need to make monthly loan re-payments. It is generally available to consumers who are aged 62 and older. The house must be free of any other liens or have only a small amount still owed that can be paid off with the proceeds of the reverse mortgage.

The amount that can be borrowed is based on the age of the youngest homeowner (who must be at least age 62), location of the home, value of the home, the current interest rate, and the type of reverse mortgage the consumer chooses. The terms of the loan vary depending on whether it is an FHA-insured loan (Federal Housing Authority), known as a Home Equity Conversion Mortgage (HECM), a lender-insured loan, or an uninsured loan. Some banks offer reverse mortgage products where the loan amounts are generally higher than would be available under the HECM programs, but it is important to compare pay-out amounts and options as well as interest and other borrowing fees.

Always caution consumers to fully research any reverse mortgage they are considering so that they understand the related tax issues, loan repayment requirements, and monthly payment promises. Offer to set up a follow-up meeting when they are further along in their research or refer out to a fee-based financial planner for an impartial assessment of the options being offered.

Table 22 shows the differences between a reverse mortgage and a conventional mortgage,

Table 22. How Does a Reverse Mortgage Compare with a Conventional Mortgage?		
	Conventional Mortgage	**Reverse Mortgage**
Purpose	Purchase a home	Get cash from equity
At the time of closing:	You owe a lot and have little equity in the home	You owe little and have lots of equity in the home
During the loan:	• You *make* monthly payments • The loan balance decreases • Your equity grows	• You *receive* payments (either as a lump sum, monthly payments, or line of credit) • The loan balance rises • Your equity decreases
At the end of the loan:	• You owe nothing • You have substantial equity in the home	• You may owe a large amount • You may have little or no equity in the home
Closing costs	• Based on the amount of the loan • Can be financed as part of loan	• Based on appraised value of home • Can be financed as part of loan
In short...	• Falling debt • Rising equity	• Rising debt • Falling equity

As Table 22 illustrates, a reverse mortgage is the opposite of a traditional mortgage. There is one point to keep in mind with a reverse mortgage. While it is possible in a declining real estate market to end up with no equity left in the home at the end of the loan, it is also possible in a rising real estate market to end up with more equity than when the loan started. In either case, the amount owed will rise over time as more money is borrowed and/or as interest on the loan accrues. The amount owed is based on the amount of money borrowed and interest on the loan, not on increases in the home's value after the loan is granted, should that occur.

There are three types of reverse mortgages:

- **Home Equity Conversion Mortgage (HECM)** — This program is offered by the Department of Housing and Urban Development (HUD) and is insured by the FHA. HECMs are the most popular reverse mortgages, representing about 90% of the market.
- **Fannie Mae Home Keeper Loan** — Borrowers may receive more cash from these loans than with a HECM because the limit for these loans is higher.
- **Financial Freedom Cash Account Loans** — These loans are designed for seniors who own expensive homes because the amount of funds that you can borrow are higher than the limits that are set (despite the home's value) in the other reverse mortgage programs. Generally, the other programs limit the loan amount to a set percent of the home's value (or a county-wide

limit) that may be equal to about 50 percent of the home's value; but private lending vehicles typically allow a higher loan amount.

The only type of reverse mortgage that is federally insured by the FHA is the Home Equity Conversion Mortgage. The HECM requires borrowers to receive counseling prior to taking out the loan. This helps to ensure that all options have been explored, the total costs of the loan examined, the cash advance options considered, the timing of the cash advances discussed, and the advantages of the growing HECM credit line fully understood.

Most people get a reverse mortgage through a mortgage lender. Some credit unions and banks, along with state and local housing agencies, may also offer these loans.

Some different features of reverse mortgages include the following:

1. **Age requirement.** To get a reverse mortgage, all individuals on the title/deed of the home must be at least 62 years of age.
2. **Home Ownership.** With a reverse mortgage, the consumer remains the owner of the home. He or she does not turn over the title of the home to the lender. Generally, as a condition of the loan, the owner is responsible for keeping the home in good repair, keeping it adequately insured and paying property taxes. At the end of the loan, either the consumer or his or her heirs can keep the home by paying off the amount borrowed plus any accrued interest. This can be done by selling the home and using the proceeds to pay off the loan. But it can also be done by obtaining a conventional or forward mortgage or using other assets to obtain the needed cash.
3. **What if the consumer still owes money on the home?** In most cases, the reverse mortgage must be the only mortgage - with no other mortgages or liens against the home. If there is an existing mortgage, to secure a reverse mortgage, one can either pay off the existing conventional mortgage on the home before getting the reverse mortgage, or use some of the money from the reverse mortgage to pay off the old debt.
4. **What if the consumer can't afford the financing fees?** The fees associated with a reverse mortgage can be substantial. You don't have to pay these fees before "closing" on the reverse mortgage. You can request that these fees be included in the loan amount. These are then paid back, with interest, when the loan is over. This is often called "financing" the fees.
5. **How much cash can a reverse mortgage make available?** This depends on the type of reverse mortgage plan and whether or not the loan fees are financed as part of the loan. If the fees are financed, there will be less cash available to borrow against the home. Another factor in determining the amount available is the type of cash advances received. Also, the amount of cash available depends on the consumer's age and the home's value. The older the borrower and the more the home is worth, the more cash is available. The loan amount will also vary depending upon government imposed lending limits. Finally, the amount will depend on the prevailing interest rates and the closing costs on loans in your area. The following show "cash available" amounts for a HECM reverse mortgage with various interest rates and provisions.

Table 23. Home value $300,000 with no outstanding mortgage balance.			
Factor	HECM A	HECM ZERO	HECM C
Age 62	$157,200	$105,900	$157,200
Age 72	$177,300	$127,500	$177,300
Age 82	$202,200	$155,700	$202,200

Note: The terms of the loans shown above vary with respect to interest rate type and amount.

6. **How does the consumer receive reverse mortgage payments?** Funds are usually available as a lump sum, a stream of payments, a line of credit, or some combination of the three. Consumers can usually choose the payout method they prefer. If the consumer is interested in a stream of payments, it may be wise to choose the HECM since the government insures the continuing stream of payments should the lender default.

7. **What if the home's value declines and the amount owed on the reverse mortgage is greater than the home's value?** With a HECM loan, the amount owed can never be more than the home's value. The amount owed on a reverse mortgage is equal to all the cash payments, any financing fees and old debt pay-off, plus all the interest that has accrued on these amounts. The reverse mortgage is a "non-recourse" loan. This means that it is secured only by the home and not by any other assets. Therefore, even if the total owed grows to a point where it exceeds the home's value at the end of the loan, the consumer can never owe more than the home is worth. The lender cannot look to the consumer or her heirs for any further repayment from income or other assets.

8. **When does the loan have to be paid off?** When the last surviving borrower dies, sells the home or permanently moves out of the house, the reverse mortgage becomes due and payable. There are also certain conditions of default that would cause the loan to become due and payable. These include failing to maintain the home, failing to keep the home insured, failing to pay property taxes, declaring bankruptcy, and several other acts or conditions. The loan could also be "accelerated," which means that it would become due and payable if the consumer rented out part of the home, added a new owner to the title or took out a new loan against the home.

9. **What if you change your mind about taking out a reverse mortgage after closing?** Generally consumers have three business days after closing on a reverse mortgage to exercise the right of rescission (canceling the agreement). This must be done in writing. One cannot cancel by telephone or by showing up in person. The lender provides specific forms to exercise the right of rescission at the closing. Counsel consumers to read all the documents and follow the instructions carefully if they decide to cancel the loan within this time period.

Selecting a reverse mortgage lender should be done carefully. The consumer needs to consider the lender's reputation and experience, costs and fees, the nature and type of loans available from each vendor, and loan servicing. Some lenders are members of the National Reverse Mortgage Lenders Association (NRMLA)

and follow "best practices" developed collaboratively. The Better Business Bureau in your community may also have ratings and reviews for the various lenders a consumer is considering.

More information about reverse mortgages is available on AARP's website at www.aarp.org/reversemortgage and on the federal government's National Clearinghouse for Long-Term Care Information at http://longtermcare.gov/costs-how-to-pay/paying-privately/reverse-mortgages/.

To summarize:

The advantages of reverse mortgages include:

- The reverse mortgage converts some of the equity in the house into cash, while the owner continues to own and live in the house.
- Repayment of principal, service fees, and accrued interest does not have to be made until the last borrower dies, sells the home, or moves out permanently.
- An individual can never owe more than the home's value, even if the home declines in value. Any equity left over after loan repayment on the sale of the house goes to the owner or the owner's heirs.
- The heirs can decide to repay the loan by getting a conventional mortgage or paying cash to keep the home.
- The consumer can never be forced to leave his home as long as he continues to pay real estate taxes and keeps the property maintained and insured.
- Payments received from a reverse mortgage are not taxable and do not affect Medicare or Social Security benefits or count as income for Medicaid eligibility purposes.
- There is no need for a credit check to secure the reverse mortgage.
- The consumer does not need to prove he or she is healthy or insurable.
- There is no restriction on the use of funds received from a reverse mortgage. Funds can be used to pay for services such as home repairs and transportation, life or long-term care insurance, long-term care services, annuities, or anything else the consumer wants to purchase.

The potential disadvantages of a reverse mortgage include:

- Up-front costs are considerable. If it is unclear how long the consumer can remain in his or her home, for example because of health problems, a conventional home equity loan might be a better idea.
- Because interest does not have to be paid currently but accrues on the loan, the total amount due on the loan increases over time.
- The homeowner remains responsible for paying real estate taxes and keeping the property maintained and insured.
- Reverse mortgage funds must first be used to pay off any remaining mortgage or debt on the house and make any needed repairs. Remaining funds are then released to the homeowner to fund long-term care. Consequently, funds could be considerably less than expected.
- If the consumer is the sole owner and leaves his or her home for care in an assisted living facility or nursing home for more than one year, the loan becomes due and payable.
- Generally, individuals, including children or grandchildren, can't be added to the title to the home. This changes the basis of the contract, and could result in the default or cancellation of the mortgage.

- A reverse mortgage decreases the amount of equity in the home, consequently, there is less equity in the home, should the consumer later decide to sell the home and move elsewhere.
- If a lump-sum amount is used to purchase an immediate annuity, while the reverse mortgage sum is not considered taxable, portions of the annuity payments over time may be considered taxable income.

Reverse Mortgage Annuity

This option is available to homeowners who wish to convert the equity in their homes into a stream of income payments over a defined period of time (e.g., 5 or 10 years).

Like a reverse mortgage, homeowners must be at least 62 years old. In the case of a couple, the loan can support care needs within or outside of the home as long as their spouse is a joint property owner and remains in the home. The loan funds can be used for care, adaptive home modifications, or to pay for LTC insurance premiums. Prescription drugs and catastrophic medical expenses can also be covered. Like a Reverse Mortgage, the property must be free of any mortgage or lien although the RAM loan can help pay those costs off up to certain amounts.

Specifically, the loan provides up to 70 percent of the appraisal value. Some amounts can be received as a lump-sum at the time the loan is approved, along with tax-free monthly payments over a five or ten-year term. The monthly amounts increase annually to keep pace with inflation. Full loan repayment is only required when the home is sold, not at the end of the loan term.

> Sometimes the term "reverse annuity mortgage" (RAM) is used to refer to reverse mortgages with a monthly income option. Be sure your consumers know this is different from using a Reverse Mortgage to purchase an Annuity from a separate insurance company as described here.

A Reverse Mortgage Annuity may be a good option when:

- The borrower is concerned about having a guaranteed stream of income, even if he or she needs to move to an assisted living residence, nursing home, or to the home of friends or family.

The potential disadvantages of a Reverse Mortgage Annuity include:

- Some portion of the annuity payments may be taxable.
- Annuity payments may affect eligibility for Medicaid or Supplemental Security Income (SSI).

Table 24. Example of a RAM (through the Connecticut Home Finance Authority's program): Ten Year Payment Period				
Appraised Home Value	Maximum Loan Amount (70%)	Year One Monthly Payment: $0 lump sum	Year One Monthly Payment: $5,000 lump sum	Year One Monthly Payment: $25,000 lump sum
$200,000	$140,000	$702	$650	$444
$250,000	$175,000	$881	$830	$624
$476,700	$333,700	$1,695	$1,643	$1,439
$595,700 or higher	$417,000	$2,122	$2,070	$1,865

Table 25. Example of a RAM (through the Connecticut Home Finance Authority's program): Five Year Payment Period				
Appraised Home Value	Maximum Loan Amount (70%)	Year One Monthly Payment: $0 lump sum	Year One Monthly Payment: $5,000 lump sum	Year One Monthly Payment: $25,000 lump sum
$200,000	$140,000	$1,821	$1,727	$1,353
$250,000	$175,000	$2,283	$2,190	$1,815
$476,700	$333,700	$4,379	$4,624	$3,914
$595,700 or higher	$417,000	$5,480	$5,386	$5,013

Source: www.chfa.org

Using Life Insurance to Finance Long-Term Care

Whether life insurance is being purchased for the first time or has been in place for an extended period, there are several ways life insurance can help finance LTSS. The most common options for using life insurance for LTSS are listed below. Because of the different requirements of these options, evaluate each option carefully with the consumer. Some may turn out be inappropriate for the consumer.

- Loans, Withdrawals, or Policy Surrenders
- Accelerated Death Benefits
- Viatical Settlements
- Life Settlements

Permanent Life: Life insurance that provides coverage for an individual's whole life, rather than a specified term. Permanent life policies have a cash value that builds over time. Whole life is the most basic form of cash value life insurance.

Loans, Withdrawals or Policy Surrenders. Life insurance policies that have a cash value are typically called Permanent Life Insurance Policies and include whole life policies, universal life, and variable universal life policies. Most of these allow for loans, withdrawals, or complete policy surrenders for a cash value. There are, however, limitations to the value these bring in the event of a sudden need for LTSS.

The chief advantage of accessing funds with a loan, withdrawal, or complete policy surrender from an existing life insurance policy is that it does not require any medical underwriting.

The potential disadvantages of life insurance loans, withdrawals, or policy surrenders:

- The funds generated by most policies typically do not provide enough money to cover LTSS needs for any prolonged period of time.
- The original goal of having the life insurance policy may not be met, since the loan, withdrawal, or policy surrender decreases the death benefit or eliminates it altogether.

Accelerated Death Benefits. An accelerated death benefit is the earlier distribution of funds that would have been paid upon the death of the insured to, instead, cover the insured's LTSS needs. The amount of the accelerated death benefit is usually expressed as a percentage of the underlying life insurance coverage. It may range anywhere from 25 percent to 100 percent of the death benefit. There may also be a cap placed on the amount available, which might be as low as $25,000 or as high as $500,000.

The proceeds, which are usually distributed as monthly payments, incrementally reduce the cash value and the death benefit of the life insurance policy each month. Upon the death of the insured, any amount of death benefit not previously paid out in the accelerated benefit is paid to the beneficiaries. Many life insurance policies issued today come with this feature already built in. Even in policies without this specific provision, the consumer and family should contact the insurance company to see if the carrier will allow this arrangement.

Accelerated benefits may be accessed under certain conditions, such as:

- Diagnosis of a terminal condition, where death is likely to occur in 12 to 24 months or less
- Diagnosis of a specified illness that requires extraordinary medical treatments and results in a limited life expectancy
- Permanent placement in a nursing home or permanent need for LTSS (remember that 30 percent of individuals who have a LTSS care need experience recovery and thus would not qualify for a permanent-need product.)

Some newer policies offer this benefit for LTSS needs that arise from an inability to perform certain ADLs or in the event of a cognitive impairment.

There are several advantages to funding long-term care services with an accelerated death benefit:

- Benefits received are tax-free when received by a terminally ill patient (certified by a health care professional as likely to die within 24 months of certification). Freedom from taxation applies even if the insured dies after the 24-month period.

- If the policy meets the Health Insurance Portability and Accountability Act (HIPAA) requirements for tax-qualified policies and the benefits are paid to a chronically ill individual for qualified long-term care services, the benefits are free from taxation.

The potential disadvantages of accelerated death benefits include:

- Many people in need of LTSS will not qualify if the benefit trigger is primarily terminal illness.
- The death benefit is reduced or eliminated, meaning that the policy's beneficiaries will receive little or no benefit upon the consumer's death.
- The amount of money available from the accelerated death benefit may not be enough to pay for LTSS expenses. This is especially true with older policies, since these benefit riders and the underlying death benefit on which they depend do not usually contain inflation protection.

Viatical Settlements. A viatical settlement is an arrangement where the owner of a life insurance policy, who is terminally ill, sells the life insurance policy to a third party (usually a viatical company) for a portion of the death benefit to raise funds to pay for end-of-life or LTSS expenses. It may be possible to sell a portion of the policy, if the policy is large enough.

Check to see if your state regulates viatical settlement companies and their business and what the requirements are. When counseling a consumer about a specific viatical settlement company, verify that the company is registered to do business in the state.

The third party becomes the owner and beneficiary of the policy. The original beneficiary signs a waiver, acknowledging this change. The viatical company maintains the policy by paying the premiums, and collects the death benefit when the insured dies.

The amount of the settlement depends on several factors:

- Life expectancy (Medical records are needed for verification.)
- The life insurance policy's face value
- How long the consumer has owned the policy
- Whether there are any outstanding loans against the policy
- The amount of the premiums

Viatical Company: A company that purchases all or a portion of a consumer's life insurance policy, providing the insured (also called the "viator") with cash to pay for end-of-life expenses or long-term care needs.

Other considerations:

- The rating of the insurance company also affects the proceeds of the settlement. A lower amount is offered if the insurer has a A.M. Best rating of B+ or lower.
- Proceeds from a viatical settlement are usually income and capital gains tax-free.
- Higher settlements may be offered if the life insurance policy has a waiver of premium triggered by disability. In this case, if the insured is deemed disabled, the viatical company would not need to make premium payments, and might therefore increase the size of the settlement offered.

Viatical settlements are regulated by some states, but not all. These laws, when they exist, regulate who can own viatical companies or solicit such transactions. The regulations may also provide rescission rights, giving the consumer a limited time period to change his mind. Some states also regulate the minimum proceeds that a policy owner can receive from a viatical settlement. Table 26 shows the National Association of Insurance Commissioner's guidelines for viatical payments.

Table 26. National Association of Insurance Commissioner's Guidelines for Viatical Payments

Life Expectancy	Percent of Death Benefit Paid
1-6 Months	80%
6-12 Months	70%
12-18 Months	65%
18-24 Months	60%
Over 24 Months	50%

A viatical settlement may make sense if:

- The consumer no longer needs life insurance (e.g., children are grown and educated; house is paid off; no spouse to provide for after consumer's death).
- The insured has a life expectancy of two years or less. The shorter the life expectancy the higher the amount of the settlement.
- The insured has had the policy for more than two years, and there is no language in the policy prohibiting a viatical settlement.

The potential disadvantages and issues with viatical settlements include:

- The insured person must also be the owner of the policy to sell it to a viatical company.
- Most individuals needing LTSS are not terminally ill, which is a requirement for a viatical settlement.
- The funds generated may not be sufficient to pay for LTSS for the length of time needed.

Always counsel consumers to check first to see if an accelerated death benefit would yield as much or more than a viatical settlement.

Life Settlements. Life Settlements are similar to viatical settlements in that they involve the sale of a life insurance policy to a third party. The difference between the two financial tools, however, is substantial.

One need not be dying or in poor health to take advantage of a life settlement. No health screening is required. The Life Settlement option is typically available to women over 74 and men over 70. The individual need not be in poor health, just older. If the individual no longer needs the death benefit,

a life settlement can generate extra money to pay for LTSS or to purchase long-term care insurance. The chief advantage of a Life Settlement is that the use of the proceeds is unrestricted. However, if it is simply a matter of needing cash now, the consumer might be better off looking into a policy loan or withdrawal, rather than selling the entire policy.

The potential disadvantages of life settlements include:

- Unlike a viatical settlement, which gives the proceeds free of taxation to a terminally ill person, there may be tax liabilities on the proceeds of the sale. The difference between the settlement proceeds and the cash surrender value will be taxed as a capital gain. The difference between the cash surrender value and the premiums paid will be taxed as ordinary income. Consumers considering a life settlement should consult a tax professional.
- The proceeds from the life settlement may not be enough to pay for long-term care services.
- Little or no death benefit may be left for the consumer's survivors/heirs.

Hybrid or Combination Products

In 2015, there is renewed enthusiasm and a more robust market for "combination" products that can be used to pay for LTSS care needs. Hybrid products combine elements of two or more financial tools that seek to take advantage of the benefits of both products and to overcome objections to any one of the individual products (e.g., life insurance with a LTSS rider or an annuity with a rider or provision to pay out for LTSS needs).

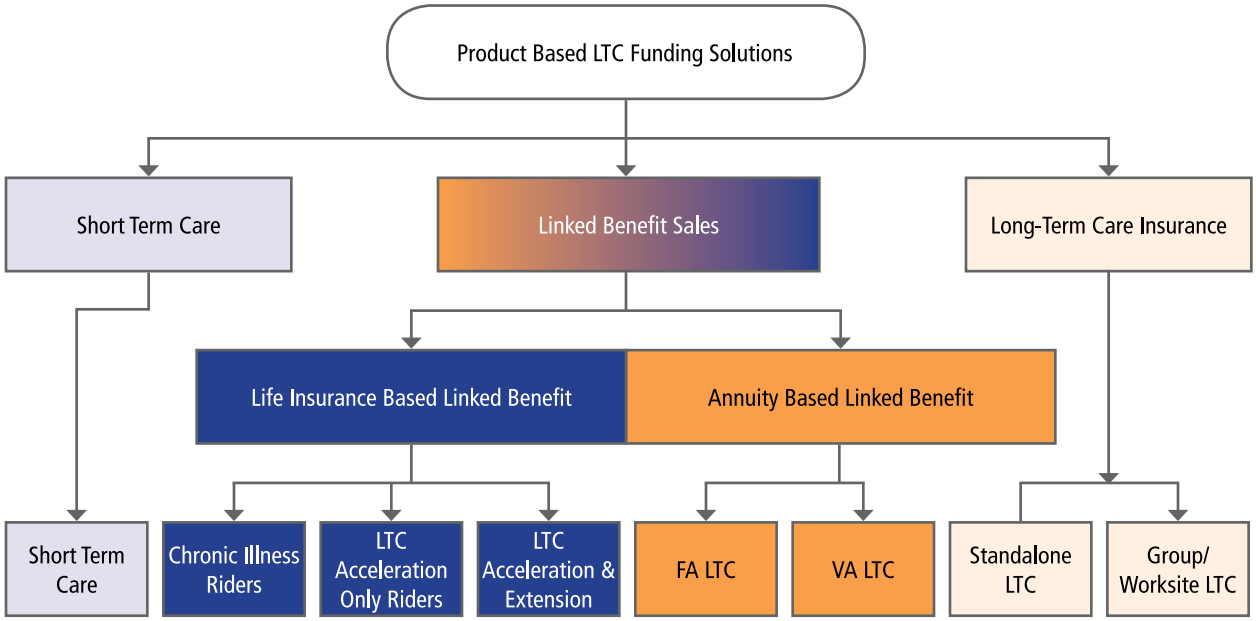
For example, many people feel they should receive something for all the years they pay into a long-term care insurance policy. With a hybrid product, buyers may feel that premiums build up to something that will eventually "pay off" even if they don't need long-term care. In most cases, the hybrid combines long-term care insurance with a product that will grow in value and/or pay off at death. The LTSS risk is funded totally or in part by a portion of the earnings on the "partner" product. In other words, the cost of long-term care insurance coverage is reduced inside a product that has some capability of increasing in value.

Hybrid Long-Term Care products may not be available in all states. Be sure to check whether they are available in your state so your advice to consumers is accurate for your area.

Refer consumers who are interested in hybrid products to trusted advisors who specialize in these products. These are complex planning options, but they may be of interest to some consumers.

The two major types of hybrid products, Life Insurance Hybrids and Annuity Hybrids, are discussed in detail below. Figure 3 shows the variety of combination products – sometimes also called "linked benefits."

Figure 3: Product Based LTC Funding Solutions



Source: Lincoln Financial Group, as presented at Society of Actuaries Health Meeting, Atlanta, June 2015.

Newer options, currently with a smaller but growing share of the market than stand-alone LTC insurance, are the so-called "combo" or "hybrid" products, which combine LTC benefits with either life insurance or an annuity. These products can pay out for one or both reasons—if LTSS is needed, benefits are paid, but if not, there is a death benefit or annuity payout. (Or, if the amount paid for LTSS does not exhaust the product value, the remaining funds can go to a death benefit or annuity payout.) This is one of the principal appeals of combo products—if LTSS is never needed, there is still a return on the money invested.

Like other LTC insurance, the combo products are subject to various types of health underwriting. Life/LTC hybrids are underwritten for both mortality and LTC risk; annuity/LTC hybrids often have more limited underwriting along with limited benefits.

Combo products are commonly designed with a single premium—the buyer pays only a large lump sum at the time of purchase. In 2011 the average single premium for a life/LTC hybrid was $70,000, for a face amount of roughly $146,000 (about two years of LTC benefits). Some life products have regular premiums, and the average annual amount is almost $5,500, for a face amount of $278,000. These amounts are beyond many people's means, but unless the initial investment is significant, the product may not be adequate for LTC needs.

The flexibility offered by these combo products is attractive, but it also makes them complicated, and some consumers find them difficult to understand. And some do not like the fact that LTC benefits, should they be used, deplete the death benefit or annuity pay-out, the main reason most people buy life insurance or an annuity.

Originally a niche market, combination products (both life/LTC and annuity/LTC) seem to be increasing in popularity. In 2009, there were nearly 280,000 of these products sold. Just four years

later, the number of sales for these combination products has risen to just over 480,000 at a time when the sale of stand-alone LTC insurance has remained virtually flat.

Purchaser demographics for hybrid products are similar to those for stand-alone LTC insurance – that is, a more educated and affluent buyer. And while these products hold some appeal because the buyer is likely to get at least one type of payout, consumers have the same objections to buying these products as the traditional single purpose insurance product: denial of the need for LTSS, distrust of insurance companies, and cost.

Life Insurance Hybrids. This option typically combines a single premium cash value life insurance policy with long-term care benefits. Because most of these are single premium policies and require a substantial deposit to gain any significant life insurance and long-term care insurance coverage, they may only be attractive to older consumers. The desire to leave an estate for one's heirs and the need to protect already accumulated assets combine in this product, but the final protection obtained may be less than ideal for either of the risks.

Looking more closely at how these products work, life insurance/LTC hybrids pay for LTSS expenses by accelerating payment of the death benefit—that is, if the insured needs LTC, benefits are paid out of the death benefit (up to maximum monthly amounts), and any amount remaining is paid when the insured dies. Some insurers offer an option, at extra cost, which extends LTC benefits after the death benefit is depleted. The amount of long-term care coverage is a factor of the amount of deposit made and life insurance purchased. Consider two scenarios:

1. If death occurs before LTSS are needed, the death benefit is paid out in full. In this case, pure life insurance without long-term care insurance included might have been cheaper; conversely, more life insurance might have been purchased with the same dollar premium.
2. If LTSS needs arise first and payments are made, the death benefit may be reduced or even eliminated. Because such a large single premium would be required to adequately cover both risks, a more affordable hybrid product may not actually provide sufficient funding to cover long-term care costs. Long-term care insurance purchased separately may give a higher long-term care benefit for the dollars consumed.

Since life insurance hybrids insure against two risks, the consumer needs to be concerned with whether both risks are optimally covered. For some, the "combination" of products is a "best of both worlds" solution while other consumers may see it as a partial or "second best" solution.

When counseling a consumer about life insurance hybrid products:

- Make sure the consumer knows why he wants both parts of the product — the life insurance and the long-term care insurance.
- Make sure the consumer understands exactly how much protection he or she's getting for each risk and the potential for little or no pay off on the death benefit if there are payouts made for LTSS under the long-term care insurance portion of the product.
- Have the life insurance and long-term care insurance priced separately and help the consumer compare the value of the hybrid product with value and cost of buying each of

these insurance products separately. Ask the consumer: Is one risk more important to cover than the other? Would it be better to insure each separately to gain the necessary amount of protection for each?

Again, these are complex products to understand and explain. Refer to a specialist when a consumer is interested in a life insurance hybrid product.

Annuity Hybrids. An annuity/LTC combination adds an LTC rider to an annuity (usually fixed or indexed, rarely variable). If LTSS is needed, benefits are first paid out of the existing policy value, and if that is exhausted, benefits derive from the LTC rider, which typically pays up to three times the amount paid under the account value. For both types of combo products, the buyer selects the amount and period of time for which LTC benefits can be paid (typically 24 to 48 months).

This combination of products takes a lump sum deposit and creates either:

- One account for an annuity and another account for LTSS; or
- One account with a long-term care insurance rider with a benefit based on the amount of the annuity deposit.

Annuity hybrids often require only minimal or no medical underwriting. If there is no underwriting required, there is usually a waiting period of several years before the consumer can access the LTSS benefits. When the LTSS benefits are in a separate insurance rider, the benefits received from the insurance rider do not reduce the annuity value. Often the annuity can also be tapped to supplement the LTSS benefits received from the insurance company.

In another variation of annuity hybrid, any money paid out for LTSS reduces the annuity first and then pays from the separate "extended benefits" LTSS account. This may leave nothing for any beneficiaries at the insured's death. Consumers can buy an annuity with just the first type of arrangement (LTSS pay outs reduce the annuity amount up to a defined limit), or they can buy the combination product with an extension of the LTSS benefits available so that if additional LTSS are needed, there is more adequate coverage for those care needs.

There are many variations of annuity hybrids. It is important to understand exactly how a particular product works before explaining it to a consumer.

Potential advantages of annuity hybrid type products include:

- If a consumer is uninsurable for traditional long-term care insurance because of existing health conditions, but it may be several years before any care might be needed, the annuity with an LTSS benefit rider might be a valuable option. However, the consumer needs significant assets available to make the single premium deposit required to create an LTSS benefit large enough to make a difference.
- While the money is invested in the annuity, it accumulates interest on a tax-deferred basis. Whereas proceeds from a regular life or annuity product are considered taxable income, when the proceeds are used for LTSS, they are not taxable.

The potential disadvantages of annuity hybrid products include:

- The rate of return the money will earn inside the annuity may be less than with other investment options.
- The money in the annuity will be placed in this fund for an indefinite period of time. Withdrawing the money for any purpose other than LTSS destroys the purpose of obtaining the annuity in the first place.
- If the money is needed soon after purchase, cancellation penalty charges may apply.
- If there is a required waiting period before funds may be used to pay for LTSS, the consumer should have a plan for funding care during the waiting period.

President Bush signed the Pension Protection Act of 2006 into law on August 17, 2006. This Act contains a section that made federal law, particularly individual tax law, friendlier to hybrid products involving long-term care insurance, annuities, and life insurance. Under this law moving money around between an annuity or a life insurance policy and long-term care insurance coverage will not result in a distribution out of the annuity or the life insurance policy that would count as taxable income.

Annuity hybrids are complex products. It might be best to refer to a specialist or fee-based planner when you encounter a consumer with a serious interest in hybrid products. Counsel consumers to check with their tax advisors to determine the tax status of any distributions from these hybrids.

Other Long-Term Care Planning Methods

Continuing Care Retirement Communities (CCRCs) offer a combination of independent housing, long-term care and medical options, and living amenities such as housekeeping, social and recreational activities, and local transportation. These services are provided all together on one campus or in one building. A CCRC enables a person to stay in one setting for the rest of his life, moving from independent living quarters to assisted living and/or to the on-site nursing home, as needed.

There are many different types of CCRCs. The traditional, original model was called a Type A or Life Care Community. In this model, the entrance fee and the monthly fees covered all service costs including the cost of all long-term care. The individual may not pay any more (or may only pay a slightly higher cost) to move to the assisted living facility or nursing home.

Other models have emerged. There are full fee-for-service CCRCs, where individuals pay for each level of care they receive. They pay more when they move to assisted living and, while they have enhanced access to nursing home care, they would pay those costs fully on their own. Some communities with this approach offer or require residents to obtain a private long-term care insurance policy specifically to cover these costs. In this way the fee-for-service CCRC "mimics" the Type A Life Care Community approach, but does so with the help of an outside insurance policy.

Usually CCRC residents pay a large entrance fee and ongoing monthly fees. The entrance fee may be nonrefundable, partially refundable, or totally refundable. In some cases, the nonrefundable amount of

the entrance fee increases the longer the resident stays there. For example, 10 percent of the entrance fee may be nonrefundable when the resident moves in, with an additional 2 percent added each month thereafter until the entrance fee is totally nonrefundable. Refundable entrance fees are often higher than nonrefundable entrance fees and are typically refunded when the living unit is sold to a new consumer (either because the prior occupants moved to the assisted living or nursing care facility, died or decided to move out of the CCRC). Facilities that cover all the long-term care costs for the life of the resident usually have the highest entrance fees.

Fees may vary based on the size of the independent living unit the consumer chooses. Small studio units often have a smaller entrance fee than two-bedroom units. The entrance fees, refundable or not, generate income for the facility.

Monthly fees typically pay for housekeeping services, upkeep of the grounds, and usually at least one meal a day in a common dining room. Make sure that consumers understand that fees may increase over the years.

Traditional Continuing Care Retirement Communities include LTSS such as care in an assisted living facility or in an on-site or contracted nursing home in their contracts. Some communities, however, provide, but only partially pay for LTSS and some facilities completely unbundle the cost of LTSS from the residency agreement. Some communities will provide care at home, in the consumer's independent living unit, but many are reluctant to do so and would transfer the individual to the assisted living wing should daily care become necessary. The spouse, if there is one, could remain in the independent living unit while the other member of the couple moves to assisted living.

When LTSS are paid for as part of the community contract, residents usually have to pass a health exam to enter the Continuing Care Retirement Community. This is similar to the medical underwriting that occurs when a person applies for long-term care insurance. In a full-service CCRC, people must be able to live independently when they first arrive. Table 27 describes the three basic types of Continuing Care Retirement Community fee structures.

Table 27. Traditional Continuing Care Retirement Communities

	All Inclusive	Fee for Service	Modified
Covered by Entrance Fee & Monthly Payments	• Housing, social and recreational services • Most LTSS are covered under the entrance and monthly fees.	• Housing, social and recreational services • Access to LTSS for an additional fee	• Housing, social services, and physical assistance • Specified amount of nursing home care for an additional fee
Not Included/ Incremental	• Medical services (usually covered by Medicare or supplemental health insurance)	• Medical services (usually covered by Medicare or supplemental health insurance) • Long-term care services	• Access to additional LTSS for a fee

With entrance fees for these facilities often equaling or exceeding the cost of a large home, many

people want an equity ownership in the unit they choose. Today many Continuing Care Retirement Communities have unbundled the health care and LTSS from the contract and sell the units on a fee simple basis. This gives residents the ability to sell the unit or bequeath the unit to heirs, and the initial cost of the unit can be recouped, depending on the real estate market in the area. With this arrangement, payment for any LTSS is the resident's responsibility.

All-inclusive "lifecare" Continuing Care Retirement Communities are becoming scarce. Since there are now many different types of CCRCs, there are also many different contracts. It is important that the consumer reads and understands everything in the contract before signing. Check to see if there is a rescission clause specifying a time period after signing the contract in which the consumer can change her mind without losing any money she may have put down. It's also a good idea to have the consumer check the history of monthly rate increases at the facility.

Considerations for a Continuing Care Retirement Community include the following:

- CCRCs often provide great peace of mind for residents particularly if they are all inclusive facilities or ones that automatically provide long-term care insurance as part of their fee structure. Consumers may feel they will be cared for no matter what happens with no additional costs.
- If the consumer has existing long-term care insurance, he or she should check if the facility will reduce any fees because of the coverage. He or she might also consider keeping the insurance at some level to finance home care as it may not be included in his or her unit. Be sure to check whether the facility's care providers are covered by any private long-term care insurance the consumer may already have purchased or whether he or she would be allowed to bring in his or her own care providers.
- If the CCRC does not cover all long-term care costs, other financing options may have to be considered.
- Make sure the consumer understands what the entrance fee is buying and whether or not it is refundable, in part or totally. Is it refundable immediately upon transfer to another care level, when the resident dies, or only after the unit is resold?
- Make sure consumers read the Residency Agreement so they understand exactly what services are covered and what circumstances may require or enable them to move from their unit into the assisted living or nursing care units. Find out if a move to assisted living or nursing care is guaranteed when the need presents itself, or if someone in independent living might still face a waiting list that would impose a care burden on them.

Continuing Care Retirement Communities may not be appropriate for everyone:

- Large fees put this option out of reach for many people.
- If a resident is unhappy at the community, he may lose a significant amount of money (all or a portion of the entrance fee) if he decides to move out of the community. Consumers should spend time at the community or talk to existing residents to be sure that the life style the community offers is appealing to them. Often, "word of mouth" or knowing someone who already lives there is the best way to learn about a community. Some CCRCs have visitor units in which you might stay to "try it out" for a short visit.
- Some facilities have long waiting lists. Consumers may want to have a back-up plan since a

future health event may make them unacceptable for an all-inclusive community before they have been screened and accepted.
- Large entrance fees may lower the consumer's income by removing a sizeable portion of income-generating assets from investment accounts.
- The campus, age-segregated lifestyle may not suit everyone's tastes.

Self-Pay

People with considerable investment assets and income could consider planning to pay for any needed care themselves. There are several important considerations.

The chief advantage of the self-pay option is:

- Individuals can retain control of funds and leave them to heirs if LTSS are not needed or if care needs do not fully deplete their available funds.
- Paying for care on your own lets you decide when and what you'll pay for. For example, as long as the consumer can afford it, she can pay for care from a family member or hire in-home help even before the level of loss that would be required of other LTSS insurance vehicles (e.g., human help needed with 2 or more Activities of Daily Living). There are no "rules" to follow in choosing how, when, and where to get care.

Paying out of pocket for long-term care services may not be appropriate for many consumers:

- It is important that self-pay consumers' investments allow funds to be easily accessible. For example, money invested in real estate would not be able to be accessed quickly.
- If the plan is to accumulate funds over time, the need for care in the near term might arise before sufficient funds have been saved.
- Consumers need to start saving early and cannot count on the stock market and rates of return on fixed income instruments.
- It is impossible to predict how much care or expense one might need. If you intend to save on your own, you run the risk of saving too much or too little.

The National Clearinghouse for Long-Term Care Information has a savings calculator available to aid consumers in calculating how much they might need to save for future LTSS: http://longtermcare.gov/savings-calculator/.

Summary

Chapter 5 introduced five additional ways to pay for LTSS for consumers for whom long-term care insurance is not appropriate or not acceptable. Since no one solution is acceptable or will work for everyone, having a range of choices to consider is important. When you help consumers understand all the options, they can be most effective in selecting those that work best for them and their families. The Private Financing Options Overview Fact Sheet is a helpful handout to give the consumer to review the options that were discussed.

At the conclusion of this chapter you should be able to:

- Discuss several options for using the equity in a consumer's home to finance LTSS or long-term care insurance;
- Present multiple ways that a life insurance policy can be used to raise funds to pay for LTSS;
- Discuss the pros and cons of hybrid products and help consumers sort out the advantages or disadvantages of selecting a hybrid product over other options;
- Explain Continuing Care Retirement Communities (CCRCs); and
- Discuss the advantages and disadvantages of saving on one's own and planning to pay directly for LTSS.

As you begin or continue your work helping consumers sort through their thoughts, feelings, and questions for how to approach planning for potential care needs, use the handouts and reference sheets in this manual to refresh your own knowledge and to give consumers information to consider after they meet with you. Be sure to check with the National Clearinghouse for Long-Term Care Information (www.longtermcare.gov) and your state government's web resources for updated information on long-term care planning and financing options. Your work helps consumers make informed choices about the future.

APPENDIX 1 | *Annotated Policy Specimen*

ABC LIFE INSURANCE COMPANY
Home Office: 123 Main Street, Anywhere, USA

LONG-TERM CARE INSURANCE POLICY

CAUTION: The issuance of this long-term care insurance Policy is based upon the responses to questions on Your application. A copy of that application is enclosed. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind the Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the Long-Term Care Offices address shown above.

NOTICE TO THE BUYER: This Policy may not cover all of the costs associated with long-term care that You may incur during the period of coverage. You are advised to review carefully all Policy limitations.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither the Company nor its agents represent Medicare, the federal government or any state government.

THIS IS A QUALIFIED CONTRACT. This Policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 - Public Law 104-191.)

NOTE: Items marked with an asterisk (*) are required of a tax-qualified (TQ) policy. Many other items listed here are also mandatory (for example, guaranteed renewability) as all states have adopted laws requiring those provisions even if they aren't specifically required for TQ policies.

In some states, a policy can only be called a Long-Term Care Insurance Policy if it offers comprehensive coverage, which means benefits for both facility- and home-based care. A policy that only covers home care or only covers facility care may be labeled a Limited Benefit Policy or has to say on the face page that it is a Nursing Home Insurance Policy rather than calling itself a Long-Term Care Policy.

The **Caution** statement reminds you to be completely truthful and not omit any important answers on the application. If there are any incorrect or untrue answers on the application, the insurance company has the right to deny benefits or rescind (cancel) your coverage.*

The **Notice to Buyer** is generally required by state law and is meant as a reminder that, depending on the type and amount of coverage you purchase, the policy may not pay for all the costs associated with your care needs for LTSS. For example, you might be in a nursing home and need ambulance transfer to a hospital. The cost of the ambulance is not likely to be covered by a long-term care policy.

This statement tells you whether the policy you have is a **federally tax-qualified** (TQ) policy or not.* Policies issued before January 1, 1997 are generally considered automatically TQ, but will not have this statement on the cover page. If you have an older policy, call your insurance company or agent to verify whether or not it is TQ.

Guaranteed Renewable means that the insurance company cannot change any terms of the policy without your permission (unless they are required to do so by state law), and it cannot cancel or refuse to renew your coverage as long as you continue to pay the premiums and have not used up all your benefits. However, as noted, the insurer does have the right to increase the premiums. The policy provisions pertaining to premium changes are discussed in detail further into the policy.

GUARANTEED RENEWABLE FOR LIFE. You, the Policyholder shown above, have the right, subject to the terms of this Policy, to continue it as long as You pay the required premiums on time. We cannot change any of the terms of this Policy on Our own, except that, in the future, We may increase the premiums.

Limited Right to Change Premiums. This section explains that the insurance company can only raise premiums in the future on a group or "class" basis. A "class" is generally a group of individuals in the same state, of the same age and with similar coverage. This means that, if there is a rate increase, the insurer can not single out any specific individual. You cannot be singled out for a rate increase simply because you get older or use benefits. *

OUR LIMITED RIGHT TO CHANGE PREMIUMS. Premiums will not increase due to a change in Your age or health. We can, however, change premiums based on premium class; but only if We change the premiums for all similar policies issued in the same state and on the same form as this Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 45 days written notice before We change premiums.

This is also called the **"free look"** provision. It means you have 30 days from the day you receive your policy to look it over and make sure it includes everything you want and that you understand all of its benefits, limitations or exclusions. If you review the policy during the 30 days and decide you no longer want it, you can return it and get a full refund of any premiums you may have paid, as long as you do so within these first 30 days. After that, if you decide to cancel your policy, you do not get any refund of premiums you have paid (unless your policy includes a provision or rider that provides a return of premium other than during this "free look" period.)*

30-DAY RIGHT TO EXAMINE YOUR POLICY. You have 30 days from the day You receive this Policy to examine and return it to Us if You decide not to keep it. You do not have to tell Us Your reason for returning the Policy. Simply return it to Us at Our Long-Term Care Offices or to the agent or office through which it was bought. We will refund the full amount of any premium paid within 30 days of such a Policy return; and the Policy will be void from the start.

Signed for ABC Life Insurance Company.

Secretary President

This Policy is non-participating. Dividends are not payable.

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BASIC CONTRACT PROVISIONS	X
A copy of the application for this Policy	Attached
Any appropriate Riders, Endorsements, Notices and other papers	Attached

Refer to the Policy Schedule to determine the Benefits, Options and applicable coverage details.

The **Table of Contents** provides a quick way to find the page number of a specific policy provision or benefit.

A Glossary (also called Definitions or Key Terms) is included with every policy. Any word that has a special meaning as used within the policy is listed in alphabetical order. Whenever you encounter one of these special terms in the policy it is also likely to appear in boldface and capital letters. Some definitions are required by state or federal regulations; others may vary from one policy to the next, depending on how the insurance company chooses to structure its coverage.

GLOSSARY

This Section provides the definitions of words used in the Policy that have a special meaning when applied to Your coverage. To help You recognize these special words and phrases, the first letter of each word is capitalized wherever it appears.

Activities of Daily Living (ADLs). These are very important definitions as they relate to the basis on which benefits are paid under the policy. ADLs are the types of everyday personal care functions you do without even thinking about it; but if you need long-term care, your ability to do these simple everyday tasks is limited to the point where you would need help from another person to complete these tasks. There are six ADLs and they are listed here roughly in the order in which one might lose these abilities as they age, become ill or disabled. The way in which these ADLs are defined, and which ones are included, is generally uniform across all TQ policies.*

Activities of Daily Living (ADLs) means the following self-care functions:

Bathing: Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring: Moving into or out of a bed, chair or wheelchair.
Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Adult Day Care means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting Chronically Ill individuals who can benefit from care in a group setting outside the home.

Adult Day Care Center means a facility that is licensed or certified to provide a planned program of adult day care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- it provides adult day care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- it operates on less than a 24 hour basis;
- it keeps written record of services for each person; and

- it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Application means the written application form provided by Us and completed by You when You apply for coverage.

Assessment means an evaluation done by a Licensed Health Care Practitioner whom We designate to determine or verify that You are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Facility means a facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets all of the following requirements:

- it provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- it has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- it makes and keeps records of all care and services provided to each resident;
- it provides at least three meals a day and accommodates special dietary needs;
- it provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- it has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- it has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not a hospital or clinic, a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorder, a Nursing Home, an individual residence, an independent living unit or a group living situation that does not meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

GLOSSARY (Continued)

Assistive Devices and Equipment means equipment included in Your Plan of Care which:

- can enhance Your abilities to perform Activities of Daily Living;
- is functionally necessary and not just for Your convenience;
- is designed for repeated and prolonged use; and
- is suited for use in the home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Assistive Devices and Equipment. Assistive Devices and Equipment do not include any drug, medicine or equipment implanted in Your body, temporarily or permanently. Also not included are any Home Modifications, motorized scooters, or sporting, protective, athletic or exercise equipment.

Care Coordinator means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Services Provider designated by Us who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill.

Care Coordination means services that identify a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- the performance of comprehensive individualized Assessments, including reassessments as needed;
- the development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in Your condition;
- the coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by You or Your Representative and determined necessary by the Care Coordinator.

Care Coordination Services Provider means an agency, entity or person designated by Us that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Chronically Ill means that You have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect Yourself from threats to health and safety due to a Severe Cognitive Impairment.

You will not meet the definition of Chronically Ill unless within the preceding 12 month period a Licensed Health Care Practitioner has certified that You meet such requirements.

Confinement or Confined means You are a resident in a Nursing Home, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made

Covered Expenses means costs You incur for which a benefit may be payable under the Policy. Each benefit section defines its own Covered Expenses.

Domestic Partner means either of a pair of adults who have chosen to share life with each other in an intimate and committed personal relationship of mutual caring that is intended to be lifelong and who:

- share a common permanent residence on a continuous basis with each other;
- have lived together for at least six months; and
- are not married to or legally separated from another person; are not members of another domestic partnership; and are not related in any way that would bar marriage in the state in which they reside.

A Domestic Partner who meets the above requirements will be considered a Spouse under this Policy.

The word **"chronically ill"** has a special meaning in the context of a federally tax qualified long-term care insurance policy. It does not mean you have a chronic illness such as diabetes or hypertension. It means you are unable to perform a specified number of Activities of Daily Living (ADLs) without the help of another person or that you have a severe Cognitive Impairment. You must be "chronically ill" as defined in the policy to qualify to receive long-term care benefits. A tax-qualified long-term care policy cannot pay benefits unless you satisfy this requirement.*

Domestic Partner. Not all, but some long-term care policies will also allow a domestic partner to obtain coverage and receive all of the same benefits as would be available to a spouse. Some states do not allow insurance coverage to recognize domestic partners, so it may not be up to the insurance company to decide whether or not to treat a domestic partner as a "spouse" for purposes of coverage.

Elimination Period describes the amount of time you have to wait once you become eligible for benefits (i.e., become chronically ill) before you can receive benefits from the policy. The definition may vary from one company or policy to the next. Read your policy's definition to find out which type of elimination period you have. Here are some of the possibilities:

- Requires you to receive covered services for each day to count, or counts any day on which you are chronically ill;
- Counts all the days of the week toward meeting the elimination period as long as you receive a certain number of days of covered service during that week (e.g., if you have 3 home health care visits in a week, you get credit for 7 days worth of meeting the elimination period.)
- Requires you to satisfy it each time you open a claim or just once in your lifetime;
- Requires days in the elimination period to be consecutive or allows you to accumulate days;
- Lets you receive certain benefits without having to satisfy the elimination period (e.g., respite care may be available without waiting through the elimination period);
- Specifies types of service that do not count (e.g., you may be able to get respite care during the elimination period but that day of care wouldn't count toward meeting your elimination period.)

GLOSSARY (Continued)

Elimination Period means the total number of days that You remain Chronically Ill before benefits are payable. The Elimination Period begins on the first day You contacted Us if We determine that You are Chronically Ill. Each day on which You remain Chronically Ill counts toward the Elimination Period. The days do not have to be consecutive; however, they must be accumulated within 365 calendar days. The start of the Elimination Period will be no earlier than the date You contacted Us unless We can establish that You met these requirements before the filing of a claim. In such case, Your providing Us with evidence of covered services received prior to the date You contacted us may be necessary. The Elimination Period start date will not be more than: 90 days prior to Your contacting Us for a loss related to the inability to perform Activities of Daily Living; or 365 days prior to Your contacting Us for a loss due to Severe Cognitive Impairment. The Elimination Period need only be met once during Your lifetime.

Note, the Elimination Period does not apply to the Stay At Home Support Benefit or the Care Coordination Benefit.

Family Member means Your Spouse and anyone who is related to You or Your Spouse by blood, adoption or marriage (including step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

Home means the place where You maintain independent residence. Home does not include:

- a Nursing Home, Assisted Living Facility or Hospice Care Facility;
- a hospital; or
- any other institutional setting.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care Services, or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;
- keep clinical records or care plans on all patients;
- provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- have the appropriate state licensure or certification, where required or available.

Home Health Care means the following services provided in Your home:

- part-time or intermittent skilled services provided by licensed nursing personnel;
- home health aide services; and
- physical therapy, respiratory therapy, occupational therapy, or speech therapy or medical social services.

Home Modification means the labor, equipment, and supplies used to make minor changes in Your home. These changes must be designed to:

- enhance Your ability to perform Activities of Daily Living; and
- allow You to live safely and independently in Your home.

Examples include installation of a ramp or grab bars in the bathroom. It does not include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Hospice Care means services designed to provide palliative care and alleviate Your physical, emotional and social discomforts if You are Terminally Ill and in the last phases of life.

Hospice Care Facility means a facility that provides a formal hospice care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Home. Some policies allow you get home health care services while you are living in an assisted living facility, as long as you meet whatever requirements there are in order to receive home care. However, most policies allow you to receive only one benefit per day, so you would have to choose whether to use your coverage toward the home care or the assisted living facility benefit on that day. This policy specifically excludes an assisted living facility from being considered your home, so you could not receive home care benefits there. (Many assisted living facilities provide personal care help so you would not need to bring in a home health care agency there anyway.)

GLOSSARY (Continued)

Hospice Care Provider means any Nursing Home, Hospice Care Facility, Home Health Care Agency, or other licensed provider that provides Hospice Care.

Informal Caregiver means the person who has the primary responsibility for providing nonprofessional care on an unpaid basis for You in Your home. A person who is paid for caring for You is not an Informal Caregiver.

Licensed Health Care Practitioner. TQ policies require that your need for care be determined by a Licensed Health Care Practitioner, which means a nurse, physician or social worker.*

Licensed Health Care Practitioner means any of the following who is not a Family Member: a Physician (as defined in section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Lifetime Maximum means the total amount of lifetime benefits payable under the Policy as shown on the Policy Schedule. The Lifetime Maximum will be reduced by the amount of claims paid, except that Covered Expenses We incur for the Care Coordination Benefit do not count against Your Lifetime Maximum. The Lifetime Maximum will increase in accordance with the terms of any Inflation Protection Rider in force. The Lifetime Maximum will increase or decrease in accordance with any other Policy increases or decreases. The Lifetime Maximum is current as of the Policy Schedule Print Date.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance to You to conduct Your Activities of Daily Living while You are Chronically Ill. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of Your illness will be used.

Monthly Maximum means the total amount of monthly benefits payable under the Policy for the Facility Care Benefit and the Home and Community Care Benefit. Your Monthly Maximum is shown on the Policy Schedule.

Monthly Maximum. Some policies pay benefits up to a certain amount per day, but several others may set a monthly limit rather than a daily one. This gives you more flexibility to receive more care on days when family or friends cannot help out and less care on days when they can.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is operating within the scope of that license.

Nursing Home means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed, certified or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. It also:

- provides twenty-four (24) hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse (RN) or a Physician;
- maintains a daily medical record of each inpatient; and
- provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home also means a facility that is licensed as a specialized Alzheimer's Unit in all states where such licensure exists.

A Nursing Home is not: a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorder; an Assisted Living Facility; an adult residential care home; a domiciliary care facility; or Your primary place of residence in an area used principally for independent residential living; or a similar establishment. If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home only if it: meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

GLOSSARY (Continued)

Plan of Care. TQ policies require that your services be provided in accordance with an approved plan of care.*You and your family, along with any of your care providers, and the Licensed Health Care Practitioner are involved in establishing a Plan of Care that best meets your needs.

Plan of Care means a written individualized plan of services approved by Us and prescribed by a Licensed Health Care Practitioner designated by Us. The Plan of Care specifies Your long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in: Your functional or cognitive abilities, Your social situation, and Your care service needs.

Policy means the contract between You and Us.

Policy Anniversary Date means the annually recurring month and day of the year when coverage began under this Policy.

Policy Effective Date means the date coverage is effective under this Policy as shown on the Policy Schedule, and is the date which determines the Policy Anniversary.

Policy Renewal Date means the month and day Your Policy's premium payment is due. The frequency of the policy renewal date can vary depending on whether the premiums are paid on a monthly, quarterly, semiannual, annual or some other basis.

Premium Due Date means each date a premium is due, after the initial premium, in accordance with the terms of this Policy.

Qualified Long-Term Care Services. The Internal Revenue Service (IRS) has defined a set of Qualified Long-Term Care Services. TQ policies can only pay for these Qualified Long-Term Care Services. One example of a service that would not be a Qualified Long-Term Care Service is a doctor visit in a clinic. If a TQ policy pays for something that is not considered by the IRS to be a Qualified Long-Term Care Service, it jeopardizes its status as a TQ policy.*

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative means a person or entity legally empowered to represent You.

Respite Care means supervision and care You receive while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Rider Effective Date means the date a rider becomes effective under the Policy. A Rider Effective Date is shown on each rider.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

- short-term or long-term memory;
- orientation to people, places or time; and
- deductive or abstract reasoning.

Spouse means the person to whom You are legally married.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. Hands-on Assistance is the physical assistance of another person without which You would be unable to perform the Activities of Daily Living. Standby Assistance means the presence of another person, within Your arm's reach, that is necessary to prevent, by physical intervention, Your injury while You are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect You from threats to Your health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill means having six months or less to live, as certified by a Physician.

We, Us, Our means Company Name or the administrator it designates.

You, Your or Yourself means the Policyholder named on Your Policy Schedule.

Substantial Assistance. This is the basis on which a TQ policy must pay for LTSS. You must need this level and type of assistance with your everyday activities of daily living or need supervision for a severe cognitive impairment in order to receive benefits. This definition follows what is required for a TQ policy.*

Eligibility for the Payment of Benefits. This outlines the conditions you must satisfy in order to receive benefits. Some are obvious and others are easy to overlook or forget. For example, the services the policy pays for must have been received AFTER the policy went into effect and you must not have exhausted all your policy benefits. In other words, there is a start date, after which services will be covered and there may be an end date when you run out of benefits. Also, you have to receive services that are covered as defined under the policy. You also must meet the requirements for being what is called "Chronically Ill" – this means that you need help from another person with 2 or more ADLs (for a period of time expected to last at least 90 days) and/or you have a Severe Cognitive Impairment. These concepts are defined in the policy. Covered services must be qualified long-term care services that are consistent with your needs and approved in your required Plan of Care. The requirement for the Plan of Care helps you use your policy efficiently and preserves your benefits for when you truly need them. For example, if you were to need help with bathing and dressing that could be met by a home aide in a couple of sessions a day, it wouldn't be consistent with employing an around-the-clock team of registered nurses (RNs). It would also be a waste of your policy's benefits. Also remember the need to satisfy the Elimination Period (see Elimination Period section).

CONDITIONS FOR RECEIVING BENEFITS

ELIGIBILITY FOR THE PAYMENT OF BENEFITS.

Subject to all the terms and provisions of the Policy, We will pay benefits described in this Policy when We verify that You meet all of the following conditions:

- You are Chronically Ill;
- A Licensed Health Care Practitioner certifies You as being Chronically Ill;
- The service, if applicable, is covered under the Policy and is provided pursuant to a written Plan of Care for You that is appropriate and consistent with generally accepted standards;
- Coverage under this Policy is in force on the date(s) the care is received;
- You have satisfied the applicable Elimination Period unless otherwise indicated;
- You have not exhausted any monthly or lifetime limits on the specific benefits claimed, or the Lifetime Maximum for the Policy; and
- You meet the additional requirements for the specific Policy benefits You claim.

If You are Chronically Ill due to a Severe Cognitive Impairment, Your need for Substantial Supervision must be such that:

- You do not continue to operate a motor vehicle;
- You require assistance to take medication;
- You are not left alone for substantial portions of the day; and
- You are not able to leave that facility without competent adult supervision if You are a resident in a Nursing Home or Assisted Living Facility.

Many LTCI claim denials can be traced back to insured individuals not understanding the conditions that must occur for benefits to be paid. Read these policy sections carefully and make a check list:

- Is the policy in force and are benefits still left in the lifetime amount?
- Do I trigger the benefits by being chronically ill and did I get the required assessment from the right source certifying this?
- Has a Plan of Care been developed for me specifying the services and care I need?
- Did I notify the insurance company and make sure the services I am planning to receive and the providers of those services are covered?
- Did I satisfy the elimination period if one is required?

ELIMINATION PERIOD. You must complete the applicable Elimination Period before We will pay benefits. Your Policy Schedule shows the number of days for Your Elimination Period. You do not need to satisfy an Elimination Period to receive the Stay At Home Support Benefit or the Care Coordination Benefit.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care services otherwise covered by this Policy will count towards the applicable Elimination Period.

The Elimination Period need only be met once during Your lifetime. **BENEFITS PAID REDUCE THE AMOUNT AVAILABLE UNDER YOUR POLICY.** Expenses paid under any benefit except the Care Coordination Services Benefit reduce the amount available under Your Policy's applicable maximum benefits by the amount of benefits paid.

TIMELY NOTIFICATION. It is important that You notify Us as soon as possible if it appears that You will need benefits covered by this Policy. This enables Us to better help You and Your family plan for the financial obligations of Your care. The Care Coordination Services Benefit can help You identify the services You might need. This benefit is more useful to You if it is provided as soon as You need care. Even if You have not completed the applicable Elimination Period, We urge You to contact Us.

CERTAIN EXCLUSIONS MAY APPLY. There are certain conditions under which benefits will not be paid under this Policy even if You otherwise meet the Eligibility for the Payment of Benefits requirements. These exclusions are stated in the Exclusions and Limitations Section.

MULTIPLE BENEFITS PER DAY. Although the benefits of this Policy are expressed in terms of monthly units, Covered Expenses are incurred on a daily basis. If You are eligible for more than one of the following benefits, We will pay only one benefit for Covered Expenses for care on a single day:

- Facility Care Benefit;
- Home and Community Care Benefit;
- Flexible Care Benefit;
- Stay at Home Support Benefit (except as noted); and
- Future Care Benefit.

We will pay the maximum benefit for which You are eligible.

Elimination Period.
(see previous page)

Limitations and Exclusions. Every policy lists circumstances under which it will not pay for LTSS care needs even if you would otherwise qualify for benefits. These are usually limited to whatever list your state regulations allow. State law specifies which items may be included and which may not. Policies may include all or only a few of the limitations allowed by the state. These are described more fully later on in the document.

Care Coordination. This describes the type of help the policy will provide to you in terms of finding the best services to meet your needs, identifying a suitable plan of care, monitoring your care needs and making changes to the plan of care as your needs change. Companies provide care coordination in many different ways. Some provide it directly and do not charge you for it so that receiving these services does not reduce your overall coverage amounts. Other companies just let you find your own care coordinator and reimburse you for the costs that you incur for this service. These plans would likely also reduce your overall coverage amount by the dollar amount of care coordination you receive. Read this language carefully so that you understand the type of care coordination that is included in your coverage.

CARE COORDINATION BENEFIT. Care Coordination Services help You identify Your specific care needs and the long-term care services and programs in Your area that can best meet those needs. You may use a Care Coordinator to help You make the most informed decision regarding Your care. To be most effective, You or Your family should contact Our Claim Office (the toll-free phone number is on the Policy Schedule) for a Care Coordinator as soon as You anticipate You may have a claim.

About the Care Coordination Services. Care Coordination Services provide You with the knowledge and training of a Care Coordinator who will review Your unique situation and develop Plans of Care to meet Your needs. The Care Coordinator will:

- assess Your functional, cognitive and personal needs for care and services on an ongoing basis;
- work with You to determine the specific services You require;
- develop and suggest initial and subsequent Plans of Care to assist You in meeting Your needs;
- coordinate and monitor Your care needs on an ongoing basis to help You receive appropriate care; and
- help You arrange for care, if You desire.

Some Care Coordination Services Benefits are Voluntary. Some Care Coordination Services are advisory only. You are not required to use Care Coordination Services to arrange for Your care providers or to use the specific care providers identified in the Plan of Care. However, all Your Policy benefits must be provided in accordance with an approved Plan of Care.

Elimination Period Does Not Apply. You are not required to complete the Elimination Period before We will pay Care Coordination Benefits. Days on which You receive only Care Coordination Services will not count toward satisfying the Elimination Period.

Covered Expenses. Covered Expenses for Care Coordination Services means fees charged for Care Coordination Services provided by a Care Coordination Services Provider designated by Us.

How Much We Will Pay. We will pay Your Covered Expenses. The expenses You incur for Care Coordination Services will be billed directly to Us.

Benefits Paid Will Not Reduce the Amount Available Under Your Policy. Expenses paid under the Care Coordination Services Benefit will not reduce the amount available under Your monthly or lifetime benefit maximums.

Transition Planning. If You desire, the Care Coordination Services Provider will recommend a transition plan that specifies how Your care needs may be met once:

- You have exhausted the benefits under Your Policy; or
- You are no longer Chronically Ill but need some continued level of assistance.

FACILITY CARE BENEFIT. You are eligible to receive benefits during Your Confinement in a Nursing Home or Assisted Living Facility. The covered expenses and the amount of the benefit We will pay are described below.

Covered Expenses. Covered Expenses for Facility Care means expenses You incur during Your Confinement in a Nursing Home or Assisted Living Facility for:

- room and board, provided You are receiving Qualified Long-Term Care Services from employees of the facility;
- ancillary services such as therapy services;
- patient supplies provided by the Nursing Home or Assisted Living Facility for care of its residents; and
- bed reservation to keep your bed in the facility while You are absent for any reason (except discharge), for up to 30 days per calendar year.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than You (e.g., guest meals or spouse charges).

How Much We Will Pay. We will pay the Covered Expenses You incur for Facility Care during the calendar month up to the Monthly Maximum shown on Your Policy Schedule.

If You:

- do not incur Covered Expenses each day of the calendar month;
- or are not Chronically Ill each day of the calendar month;

Your benefit for the month will be pro-rated and consist of 1/30 of Your Monthly Maximum for each day You incurred Covered Expenses during the calendar month.

Facility Care Benefit. Refer to the definition section of the policy to understand clearly what is meant by a "Facility." This section describes the types of facilities that are covered and likely indicates whether or not bed reservation is included in your coverage. This feature allows you to "hold your place" in a facility if you are temporarily absent from it – either for any reason or for a specific reason like a hospital stay – and if the facility charges you a fee to "hold" your place. Some policies have a separate Bed Reservation Benefit and others include it as part of the Facility Care Benefit.

Home and Community Care. This section defines the type of services and providers for which the policy will pay for care outside of a facility. The policy may only cover care at home when provided by certain types of providers (e.g., Home Health Care Agency) or it may be broader than that and allow you to receive care from a nurse, home health aide or homemaker working independent of an agency as long as that provider is appropriately trained and experienced to provide in-home care.

HOME AND COMMUNITY CARE BENEFIT. You are eligible to receive benefits for Covered Expenses You incur for Home and Community Care. The covered expenses and the amount of the benefit We will pay are described below.

Covered Expenses. Covered Expenses for Home and Community Care means fees charged for the following services when provided to You by a Home Health Agency:

- Home Health Care Services; and
- Maintenance or Personal Care Services

Covered Expenses also include care in an Adult Day Care Center.

How Much We Will Pay. We will pay the Covered Expenses You incur for Home and Community Care during the calendar month up to the Monthly Maximum shown on Your Policy Schedule.

If You:

- do not incur Covered Expenses each day of the calendar month; or
- if You are not Chronically Ill for each day of the calendar month;

Your benefit for the month will be pro-rated and consist of 1/30 of your Monthly Maximum for each day You incurred Covered Expenses during the calendar month.

Stay at Home Support Benefit. Many policies have an array of benefits that help you remain independent in your home as long as possible. Sometimes these are listed as separate benefits and sometimes they are combined. Typically, they include such things as: caregiver training, respite and hospice care, home modifications (like grab rails or a wheelchair ramp), and assistive devices (like an in-home electronic monitoring system). Sometimes these services are available without requiring you to first meet the elimination period. There is usually a dollar limit that specifies how much of these types of services you can receive. It may be expressed as a calendar year limit or as a lifetime limit.

STAY AT HOME SUPPORT BENEFIT. You are eligible to receive benefits for Covered Expenses You incur for Stay At Home Support. The amount of the benefit We will pay and the conditions under which We will pay this benefit are described below.

Covered Expenses. Covered Expenses for the Stay At Home Support Benefit means Covered Expenses You incur for the following, as described below:

- Respite Care;
- Hospice Care;
- Caregiver Training;
- Home Modification; and
- Assistive Devices and Equipment.

How Much We Will Pay. We will pay the Covered Expenses You incur for Stay At Home Support during the calendar month up to the Monthly Maximum shown on Your Policy Schedule. This benefit is also subject to the Stay At Home Support Maximum, shown on Your Policy Schedule.

Elimination Period Does Not Apply. You are not required to complete the Elimination Period before We will pay Stay At Home Support Benefits.

RESPITE CARE. You are eligible to receive Stay At Home Support Benefits to provide temporary, short-term relief for those persons who ordinarily care for You on a regular basis.

Covered Expenses. Covered Expenses for Respite Care means:

- Covered Expenses for care in a Nursing Home or an Assisted Living Facility; or
- Covered Expenses for Home Health Care.

HOSPICE CARE. You are eligible to receive Stay At Home Support Benefits when We determine that You are Chronically Ill and You are Terminally Ill.

Covered Expenses. Covered Expenses for Hospice Care means expenses You incur during Your Confinement in a Hospice Care Facility or a Nursing Home for:

- room and board;
- ancillary services provided by the Hospice Care Facility or Nursing Home; and
- patient supplies provided by the Hospice Care Facility or Nursing Home for care of their residents.

Covered Expenses for Hospice Care also includes Covered Expenses for Home Health Care.

Covered Expenses for Hospice Care do not include the cost of drugs, supplies, equipment or physician visits. We will not pay for any charges for Your comfort and convenience such as television, telephone, beauty care and entertainment.

Subject to the other terms and conditions of the Policy, this benefit will be paid as long as Your Physician continues to certify You as being Terminally Ill and You are not receiving preventive or curative treatment.

CAREGIVER TRAINING. You are eligible to receive Stay At Home Support Benefits if You incur Covered Expenses for training an Informal Caregiver (family or friend) to provide care for You in Your Home.

Covered Expenses. Covered Expenses for Caregiver Training means expenses You incur for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for You. The training cannot be received when You are Confined

in a hospital, Assisted Living Facility or Nursing Home, unless it is reasonably expected that the training will make it possible for You to return to Your Home where You can be cared for by the person receiving the training.

HOME MODIFICATION. You will be eligible to receive the Stay At Home Support Benefit if Home Modification is recommended by a Care Coordinator in a Plan of Care and is mutually agreeable to You and Us as a cost-effective alternative to benefits otherwise provided by the Policy. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Home Modification under the Stay At Home Support Benefit will not waive any of the rights You or We have under the Policy. This benefit may not be used solely to increase the value of the Home. We determine what shall be considered Home Modification under this Policy.

Covered Expenses. Covered Expenses for Home Modification means the cost of Home Modification if Your Care Coordinator finds that modification to Your Home is a cost-effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to Your Home that will enhance Your ability to perform the Activities of Daily Living and allow You to remain in Your Home safely. Note: Home does not include an Assisted Living Facility.

ASSISTIVE DEVICES AND EQUIPMENT. You will be eligible to receive the Stay At Home Support Benefit if the use of Assistive Devices and Equipment is specified in Your Plan of Care and is mutually agreeable to You and Us as a cost-effective alternative to benefits otherwise provided by the Policy. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Assistive Devices and Equipment under the Stay At Home Support Benefit will not waive any of the rights You or We have under the Policy. The Assistive Devices and Equipment must be located in Your Home.

Covered Expenses. Covered Expenses for the Assistive Devices and Equipment are the rental charges for Assistive Devices and Equipment that are normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in Your Plan of Care. We will decide whether a rental or purchase of the Assistive Devices and Equipment is more appropriate.

ALTERNATIVE PLAN OF CARE BENEFIT. (For expenses not otherwise covered; upon approval by Us.) We reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in the Policy, or when conditions specified in the Policy are not otherwise met.

Alternative benefits and services can be authorized if We determine that they:

- are cost-effective;
- are appropriate to Your needs;
- are consistent with general standards of care;
- provide You with an equal or greater quality of care; and
- constitute Qualified Long-Term Care Services.

Any alternative benefits, treatments, or services We authorize must also be agreed to by You or Your Representative and, if appropriate, Your Physician.

We reserve the right to decline to authorize alternative benefits and services.

Benefits are not payable for any expenses incurred either: prior to the date of mutual agreement; or once You have exhausted the benefits under Your Policy. Agreement to participate in Alternative Plan of Care Benefits will not waive any of the rights You or We have under the Policy.

Alternative Plan of Care Benefits may be discontinued at any time without affecting Your right to the benefits otherwise available under the Policy.

WAIVER OF PREMIUM. We will waive the payment of premium that becomes due when the coverage is in force and You are receiving benefits under the Policy, except for Stay At Home Support Benefits or Care Coordination Services Benefits. We will waive premiums beginning the first day You receive benefits. We will refund or credit the pro-rata amount paid for periods after the premium waiver begins.

As long as You continue to receive benefits, additional premiums will not be required. If You cease to receive benefits, premium payment will again be required. You must pay future premiums, beginning within 30 days of the date You last receive a benefit.

Alternate Plan of Care. This policy provision allows you to receive services, treatment or care from providers that are not otherwise covered under the policy, as long as certain conditions are met. There will need to be an agreement signed by all parties defining and approving the alternate services that are desired. The alternative care also must be cost-effective and provide an equal or better quality of care to you. Policies use this provision differently, so read the language carefully. It is not a guarantee that you will always get approved for any "alternative" care you want and it also does not compel you to use any "alternative" care unless you want to do so and the insurance company agrees to it.

Waiver of Premium. In many policies, you are not required to pay premiums once you begin to receive benefits. In this policy, you stop paying premiums on the first day in which you begin to receive benefits, while in others, premiums may be ceased on the first day of the following month or only when you receive certain types of care (e.g., facility care). If you recover and no longer need benefits, your premium payments resume. Some policies do not apply this feature to all benefits. For example, you may need to continue to pay premiums if you are receiving respite care. Some policies have Waiver of Premium as a standard feature in the policy while others may offer it as a rider for which you'd pay an additional premium charge.

Contingent Benefit upon Lapse. Many states require this provision. It provides a continuation of your coverage, but on a limited basis, if the insurance company increases premiums for people your age (at the time you bought the policy) by what is considered a "substantial" amount. (See next item). If there is a substantial rate increase, you have the option of dropping your coverage, reducing your coverage to reduce the premium you have to pay, or to stop paying premium but receive a smaller amount of coverage. That reduced coverage amount, prescribed by state law, is equal to the sum of all premiums you paid up to that point in time or the monthly benefit amount (or 30 times the daily benefit amount of your policy), whichever is greater. Some insurers offer this Contingent Benefit Upon Lapse with a rate increase of any magnitude, even if the benefit isn't listed in the policy at the time you bought it. It is provided at the time of a rate increase to give you an additional choice when faced with a possible rate increase.

CONTINGENT NONFORFEITURE BENEFIT. This benefit is available to You if You have not elected the Nonforfeiture Benefit Rider. Your Policy Schedule shows whether or not You are covered by this benefit. The benefit will apply to You if, and only if, there is a substantial increase in the premium rates for Your coverage, as described below.

How This Benefit Works. If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be a substantial increase in premium rates, as determined by the schedule specified below, we will do all of the following:

- We will offer to reduce Your current level of coverage without evidence of insurability so that the required premium rates for Your coverage are not increased.
- We will offer to convert coverage to a paid-up status with a shortened benefit period as described below. This option may be elected at any time during the 120-day period following the date of the premium rate increase.
- We will notify You that a default or lapse at any time during the 120-day period following the date of the premium increase will be deemed to be the election of the preceding offer to convert. A default or lapse is Your failure to pay the required premiums within the grace period.

If You convert Your coverage to paid-up status in accordance with the provisions above, We will continue to pay benefits, subject to all of the terms and conditions of the Policy in effect at the time of lapse. Benefits for covered services will be paid up to the applicable monthly and lifetime benefit maximums in effect at the time Your Policy terminated due to non-payment of premium, until the Shortened Benefit Period Allowance has been reached or You no longer meet the Eligibility for the Payment of Benefits requirements of the Policy.

The Shortened Benefit Period Allowance We will pay will be the greater of : (a) one hundred percent (100%) of the sum of all premiums paid for Your coverage, excluding any waived premiums; or (b) Your Monthly Maximum in effect at the time of lapse. The Shortened Benefit Period Allowance is reduced by the sum of all benefits previously paid to You. In no event will the total of benefits payable under the Policy exceed the Lifetime Maximum.

Inflation Protection Will Not Apply to this Benefit. If You have elected an Inflation Protection Rider, any benefit paid on or after Your Policy lapses will be the benefit amount in effect on that date and no further increases in benefit amounts will occur.

When Coverage Ends. Your coverage under this option ends when the Shortened Benefit Period Allowance has been reached or the Lifetime Maximum has been exhausted.

The following table determines what constitutes a substantial premium increase.

Substantial Premium Increase. The schedule specified here is required by state law in many states. It gives you the option of maintaining a limited amount of coverage, without continuing to pay premiums, should you decide that you cannot continue to pay premiums if the insurer imposes a substantial rate increase. (See Contingent Benefit on Lapse section.)

Triggers for a Substantial Premium Increase. Cumulative premium increase over original premium that will allow Contingent Nonforfeiture to be initiated. (Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

Table 28.

Issue Age	Percentage of Increase Over Initial Annual Premium		Issue Age	Percentage of Increase Over Initial Annual Premium
29 and under	200%		72	36%
30 - 34	190%		73	34%
35 - 39	170%		74	32%
40 - 44	150%		75	30%
45 - 49	130%		76	28%
50 - 54	110%		77	26%
55 - 59	90%		78	24%
60	70%		79	22%
61	66%		80	20%
62	62%		81	19%
63	58%		82	18%
64	54%		83	17%
65	50%		84	16%
66	48%		85	15%
67	46%		86	14%
68	44%		87	13%
69	42%		88	12%
70	40%		89	11%
71	38%		90 and older	10%

Exclusions and Limitations. The specimen policy here lists the typical exclusions and limitations which are allowed by state law, although requirements may vary slightly by state. For example, this policy does not have an exclusion for care needs that might arise as a result of alcohol or drug abuse, but some other policies do include that, as allowed by state law.

EXCLUSIONS AND LIMITATIONS. This Section states the conditions under which payment will be limited, or not made at all, even if You otherwise qualify for benefits. These conditions apply to all benefits provided by the Policy.

Exclusions. This Policy will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- care or services provided by Your Family Member unless:
  - he or she is a regular employee of an organization that is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care; and
  - he or she receives no compensation other than the normal

compensation for employees in his or her job category; or

- care or services for which no charge is made in the absence of insurance; or
- care or services provided outside the United States of America, Canada or the United Kingdom except as provided for under the Flexible Care Benefit; or
- care or services that result from war or act of war, whether declared or not; or
- care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- services received while this Policy is not in force, except as provided in the Extension of Benefits provision.

No Pre-Existing Conditions Exclusion. We will not reduce or deny any claim under this Policy because of a sickness or physical or medical condition that existed before the Policy Effective Date.

Non-Duplication With Other Plans. We will not pay benefits for services for which benefits are payable by Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount). We will pay the difference between Your actual expense and the benefits payable by all other insurance, but Our payment will not exceed the amount We would have paid in the absence of other insurance. However, if Your other insurance denies payment to You for a service that We cover, We will pay the benefit as outlined in this Policy. The Care Coordinator can assist You in identifying other insurance benefits to which You are entitled that can be applied to meet Your actual expenses.

Non-Duplication of Benefits. Occasionally another type of insurance you have might pay for some of your LTSS needs. In that case, this policy feature makes sure you aren't using up more benefits than you need to. It says that only one of your sources will pay, thus preserving your long-term care policy for future needs. While some consumers see this as a disadvantage, it actually helps stretch your benefits under the long-term care policy so they last as long as possible. Often the insurance company will help you coordinate benefits with the other coverage so that you aren't left with neither policy paying for your LTSS needs.

Changes in Coverage. Most policies allow you to decrease your coverage anytime and without any medical review or underwriting. You may want to decrease your coverage if your personal circumstances change, either you need less coverage than you initially bought or you need to reduce your premium payments. The premium for your new reduced amount of coverage would be based on your original age at the time you bought the policy. If you want to increase your coverage (e.g., change from a $100/day benefit to a $150/day benefit), you have to apply for the increase and go through a similar health screening process as when you first bought the policy. If the company approves your request for an increase, you only pay for the increased portion of coverage (in this example the additional $50) based on your current (attained) age. The cost of the original part of your coverage does not change. Some companies allow such changes (in whole or in part) but may not have language specifically saying so in the policy; in that case, it is wise to check with the insurer and perhaps obtain a letter clarifying their protocols for allowing changes. Company policies for pricing coverage changes also may differ from what is described here so ask your agent before you buy and have the information provided to you in writing.

COVERAGE CHANGES PROVISIONS. This Section describes the coverage change rules of the Policy.

When Increases in Coverage Become Effective. If, within 60 days of the Policy Effective Date, You submit a written Application, including evidence of insurability, to increase coverage and the request is approved by Us, the change is effective as of the Policy Effective Date. If You submit a written Application, including evidence of insurability, to increase coverage after that time and the request is approved by Us, the change is effective as of the date Your next premium is due and paid.

You May Elect to Decrease Coverage. You have the right to reduce Your future premiums by changing to a coverage amount offered by Us. We reserve the right to determine what represents a decrease in coverage. The premium for the reduced coverage will be based on the current premium rate table in effect and Your original issue age.

We will notify You of this right to reduce coverage if Your coverage is about to lapse and in the event that premiums are increased.

If You request a change in coverage to a coverage amount that represents a decrease in coverage, You will not be required to provide evidence of insurability.

Upgrade Privilege. We will notify You of any new benefits or provisions that become available in the future that are not included in Your Policy, provided that You are not currently receiving benefits. You will be given the opportunity to acquire the new benefits or provisions that become available within 12 months of their availability. If You elect to acquire the new benefits and/or provisions, You will be required to provide an Application and evidence of insurability in a form and manner specified by Us. If We approve Your Application, We will recognize Your past insured status by granting a premium credit of an amount determined by Us.

CLAIMS PROVISIONS. This Section describes: when We must be notified of a claim; what to send Us; how We evaluate and pay claims; and other rights and responsibilities under the contract.

Your Role in the Claims Process. Early awareness by Our Claims Department will facilitate a timely claim review. You can help Us in this process by letting Us know immediately when You think You are eligible for benefits under this Policy. To file a claim, You or Your Representative may call Us, notify Us in writing or submit a completed claim form We provide.

Notify Us As Soon As Possible. We can handle Your claim request more efficiently if We are notified within 30 days after You are eligible for benefits or as soon as reasonably possible. We prefer that You notify Us as soon as You first become disabled to the extent that You may soon need care covered by the Policy. Notify Us even if You are unsure, and We can help You determine whether or not You are eligible for benefits.

How Claims Are Evaluated. When notice of claim is received, We will collect the information We need to determine whether You meet the Eligibility for the Payment of Benefits requirements. We may arrange for an Assessment, which will be performed at no cost to You. We may need to contact Your Physician or other care provider and to review Your medical records. Based on Our evaluation of this information, We will determine Your eligibility for benefits. We will not pay benefits until We determine Your eligibility for benefits. If You are determined to be eligible for benefits, We will arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner or Care Coordination Services Provider designated by Us.

Claim Forms. We will contact You and provide claim forms for the filing of proofs of loss when We receive Your notice of claim. If You or Your Representative do not get the necessary claim forms within 15 days, Proofs of Loss can be filed without them by sending Us a letter that describes the occurrence, the character and the extent of the loss for which Your claim is made. That letter must be sent to Us at our Long-Term Care Offices within the time noted below under Proofs of Loss.

Proofs of Loss. In the case of a claim for continuing loss for which the Policy provides any periodic benefits, written proof of loss must be given to Us within 90 days after the end of each 30-day period for which Covered Expenses are incurred. In the case of a claim for any other loss, written proof must be given to Us within 90 days after the date of such loss. However, a claim will still be considered if it was not possible for You to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of

Claim Payments. This section describes the procedures for submitting and receiving payment for claims. Some of the timeframes and requirements vary from one policy to the next although policies must follow state law with regard to these timeframes.

- You generally have 30 days after you need care to submit a claim. However if it takes longer for some reason (e.g., you are incapacitated and your family did not know right away that you had a long-term care policy), the company may be flexible about this.
- The insurer has 15 days after they hear from you, to send you any forms necessary to complete to start the claim process. Often companies let you initiate the claims process by calling or writing to them, and specific claim forms may not be needed.
- This section also lists the specific information the company needs to process your request for benefits. The more complete the information you submit, the easier and faster it is for the company to handle your claim. You have 90 days in which to provide this information.
- You will be told whether or not your claim is approved and if it is denied, you have the right to learn the reason for the denial and to appeal that decision.
- Most of the benefits you receive will be counted against your policy's lifetime maximum. For example, if you receive $5,000 in benefits one month, your $100,000 lifetime maximum would now be $95,000. That is what remains to be used for additional benefits. Some benefits such as care coordination may not reduce the lifetime maximum. If you have inflation protection, insurers may calculate your remaining amount of benefit differently. Some apply the annual inflation increase and then reduce it by the amount of claims paid, while others reduce it first and then apply the inflation increase to the remaining amount. Sometimes state law specifies the approach the insurer must use.

legal capacity, in no event will an expense be considered if proof for that expense is furnished more than one year after the date the proof is otherwise required.

Written Notification. You will be notified in writing whether or not You are eligible for benefits. We will notify You within ten days of receiving all the required information. If You want to receive information related to denial, that information will be sent to You within 60 days of receipt of Your written request, unless such disclosure is prohibited under state or federal law.

When Benefit Payments Will Be Made. Once You have completed the applicable Elimination Period, benefit payments will be made on a monthly basis after continued receipt of Your required claims as long as Your loss and Our liability continue. When a claim is paid You will receive an Explanation of Benefits that will show the unused balance of Your lifetime maximums.

To Whom We Will Pay Benefits. All benefits will be payable to You unless otherwise assigned. Any benefits unpaid at Your death will be payable to Your estate. If benefits are payable to an estate, We may pay a portion of those benefits, up to $5,000, directly to someone related to You by blood or marriage who is deemed by Us to be justly entitled to the benefits. We will be discharged to the extent of any such payment in good faith.

Physical Examination. We will have the right to examine You as often as We may reasonably require. This will be at Our expense. This will only apply while benefits are payable under the Policy.

Appeals. You have the right to ask the company to reconsider a decision if they deny your request for benefits. Some policies have additional levels of appeal, going all the way to an independent third party such as an administrative law judge or an independent review organization specializing in long-term care claims; others reconsider the decision on their own but allow you to provide additional information to support your request.

How You Can Appeal a Claim Decision. If You disagree with Our decision regarding Your claim, You may request in writing within 60 days of that decision that We should reconsider Your claim. You should submit any additional information that You feel We need to review before Our decision. You should include the names, addresses, and phone numbers of any care providers You think We should contact to learn more about Your loss. You are responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider Our decision and send You written notification of the results. If We deny Your appeal request and You want to receive written information related to such denial, that information will be sent to You within 60 days of receipt of Your written appeal request.

Legal Actions. No action may be brought to recover under this Policy until 60 days after proof of loss has been given. No action can be brought more than three years from the date written proof of loss was required to be given.

Legal Action. You have a window of time within which you can sue the insurance company for any reason. You cannot sue the insurance company sooner than 60 days or later than three years after you provided them with proof that you are requesting benefits.

Direct Payment of Benefits to Care Provider (Assignment of Benefits). You may instruct Us to pay benefits due to You under this coverage directly to a Nursing Home, Assisted Living Facility, Hospice Care Facility or Home Health Agency providing the care for which We are reimbursing expenses. The care provider must also agree to the assignment of benefits. You must notify Us in writing. No assignment shall be binding upon Us unless a copy is on file at Our Long-Term Care Offices. We do not assume any responsibility for the validity or effect of an assignment.

Assignment of Benefits. Most policies give you the option to have payments go directly to your care providers, or to receive the payments yourself and then you are responsible for paying the bills submitted by the providers of your care.

PREMIUMS AND RENEWAL PROVISIONS. This Section describes such things as: the importance of paying premiums on time; what happens if premiums are not paid on time; and protection available in the event of unintentional lapse of the Policy.

Premiums. This section describes how you pay premiums, what happens if you miss a payment and related issues. If you initially chose to pay premiums annually and then decide you want to pay quarterly (or some other way), you can do so. This section also includes a restatement of the insurer's right to change premiums but only on a class basis, which means across all "like" policies. They cannot single out any individual for an increase. The insurer must give you 45 days advance notice (longer in some states) if they intend to raise rates.*

Guaranteed Renewable. Each premium paid continues insurance in force until the date the next premium is due, except as stated in the Grace Period provision. We cannot terminate or refuse to renew Your coverage under the Policy before benefits have been exhausted, as long as premiums for Your coverage are paid on time.

Paying Premiums. You will pay premiums to Us. Your first premium is due on the Policy Effective Date. The premium mode on the Policy Schedule shows whether You have elected to pay premiums annually, semi-annually, quarterly, or monthly through electronic funds transfers (EFT). Please note that a Grace Period applies. You chose Your mode of premium payment on Your Application. You may change Your mode of premium payment on any anniversary of the Policy Effective Date by giving Us prior written notice. We must receive Your notice 30 days before the anniversary of the Policy Effective Date.

Protection against Unintentional Lapse. This provision lets you name someone on the application for coverage who would also receive a reminder notice if your premium is due but not paid on time. This provides you with additional protection in case you miss a premium payment because you are ill or traveling or perhaps have moved and forgot to notify the insurance company. You are not required to identify a third party to receive such notice, but it is a good idea to do so. Every 2 years, the company also has to remind you that you have the right to select a different person as your third party.*

Protection Against Unintentional Lapse. You have the right, at the time of application, to designate at least one person who is to receive notice of termination for non-payment of premium in addition to Yourself. You may change this designation at any time. To do so, You must notify Us in writing. We will remind You in writing every two years of this opportunity.

Changes In Premium Rates. Your premiums will not increase due solely to a change in Your age or health. However, if Your coverage includes an Inflation Protection with Age Graded Premiums Rider, the premiums for the annual benefits provided by that rider increase annually with Your age as Your benefits increase. Premium changes will be made only if We change premiums for all similar policies in the same state and on the same form as this Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 45 days notice before We change Your premiums.

Your Options if Premiums Increase. Most policies let you decrease your coverage in order to maintain the same premium amount if there is a rate increase so that you would not be put in the situation of having to either pay the higher premium or cancel your coverage if you found you could not afford the rate increase.

Your Options If Premium Rates Change. If the premium rates are increased for all similar policies in Your same state on the same Policy form, You will have the option of: maintaining Your current benefits at the increased premium rate; or electing a decrease in coverage to a coverage amount We offer that maintains or reduces Your current premium. The procedure for decreasing coverage is described under the Coverage Changes Section.

Unless You notify Us within 30 days after receiving Our notice, You will be considered to have elected to maintain Your current benefit amount at the increased premium rate.

Refund of Premiums Paid Beyond Your Death. If You die while covered under the Policy, We will refund the pro-rata part of any premium paid for the period after Your death. The refund will be made within 30 days of Our receipt of written notice and proof of Your death. The refund will be paid to either the Beneficiary designated in Your Application, Your Spouse, if living, or Your estate.

Refund of Premiums Paid Beyond Your Death. If you die or cancel your policy, the insurer will return any premiums paid IN ADVANCE for a period during which you now no longer have coverage. For example if you pay your annual premium on January 1, 2009 and decide to cancel coverage on April 30, 2009, the insurer would return the portion of your premiums associated with the period May 1 through December 31, 2009. Not all policies return pre-paid premiums if you elect to cancel coverage, but only in the event that you die. Before you select a frequency for premium payment, check the policy to see if it would return unearned premium if you die or cancel after you have already paid premiums in advance.

Grace Period. There is a 31-day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. We will continue coverage during the Grace Period. Your insurance under the Policy will remain in force during the Grace Period, unless We have been advised in writing by You that You want to cancel Your coverage prior to the end of the Grace Period.

Grace Period. While your premium is due on a specified date, the policy gives you a total grace period of up to 65 days in which to make your payment before they will cancel your coverage due to non-payment. During that grace period, the company is required to send you (and the third party you identified on your application) notification of the required premium payment.

Notification of Non-Payment. If Your premium is due and unpaid at the end of 30 days, We will give notice of termination to You and to the person(s) You have designated to receive notice. The notice of termination will be sent at least 35 days in advance of termination and will state the amount of unpaid premium, the date by which premium must be paid, and the date the coverage is to terminate. Our notice will be sent prepaid by United States first class mail. We will consider You and Your designee(s) notified as of five calendar days after the date the notice is mailed. If Your premium remains unpaid on the termination date stated in the notice, Your coverage will terminate as of the end of the Grace Period. Any benefits payable for covered services You received after the last date for which Your premium was paid will be reduced by the premium due from the date the last premium was paid to the date Your coverage under the Policy terminated.

Notification of Non-Payment. If you do miss a premium payment, you will be notified and have the added time of the "grace period" in which to make the payment. As an additional protection, you may name another individual to also receive notice of payment due so that in case you are unable to, someone else will be notified that your payment is due and they can help you take care of that in time. When you apply for long-term care coverage, the application has a place for you to designate this other person. You can change that person if you need or want to in the future. The company will remind you every two years about your right to change the person you name in this role.*

Reinstatement. You can ask to restore your policy if it lapses because you did not pay premiums as required, even if you were not incapacitated. However, you must apply for reinstatement and be approved through a similar underwriting process as when you first obtained coverage. Most policies give you the right to apply to restore your coverage for only one year after you let it lapse. For most policies, if you are approved for reinstatement, you have to pay back all premiums due.

Reinstatement. If Your coverage is terminated for non-payment of premium, You may apply for reinstatement by writing to Us. You will be asked to complete an Application for reinstatement. Completed reinstatement Applications must be received by Us within one year after the end of the Grace Period. We have the right to require evidence of insurability. You will be required to pay the cost of any records that may be necessary to provide this evidence. If approved, the premium due from the date of the first unpaid premium must be paid, and coverage will be reinstated retroactive to the date of termination of coverage. We have the right to decline a request for reinstatement of coverage. Any premium accepted in connection with a reinstatement will be applied to the period for which premium was not previously paid. Acceptance of premium by Our agent does not mean Your reinstatement Application has been accepted. In all other respects, You will have the same rights under the Policy as You had prior to the Premium Due Date of the defaulted premium.

Unpaid Premiums. When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

Added Protection against Lapse. This lets you reinstate your coverage without underwriting if you are unable to pay premiums on time because you had either a Severe Cognitive Impairment or Loss of Functional Capacity. Sufficient proof of loss must be provided. You have up to five months to pay the premiums and restore your coverage. Most companies require that you pay all past premiums due.*

Added Protection Against Lapse. If Your coverage terminates due to non-payment of premiums, We will provide a reinstatement of coverage as specified on the previous page, if certain conditions are met. To be eligible for this reinstatement, You must provide Us proof that You were Chronically Ill, beginning on or before the date of termination and continuing without interruption.

The proof must be in the form of a certification and Assessment from a Physician (or other proof approved by Us) that demonstrates that You were Chronically Ill. The proof must be provided to Us within five months of the termination date. You must pay all past due premiums for the coverage that was in force immediately prior to the date of lapse. In that event, Your insurance will be reinstated as of the date of that termination without interruption of insurance for that period.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS. This Section describes when the Policy becomes effective and when coverage ends.

Evidence Of Insurability. You are required to provide evidence of insurability in a form and manner specified by Us.

Policy Effective Date. You will become covered under the Policy on the Policy Effective Date shown on Your Policy Schedule, subject to the payment of the required premium.

Your Right to Cancel Coverage at Any Time. You may cancel Your coverage at any time by sending Us written notice. We must receive Your request to cancel 30 days prior to Your requested cancellation date. Termination of Your coverage will be effective within 30 days of the date We receive the request, unless Your requested termination date is later. We will promptly return the unearned portion of any premium paid. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Ends. Your coverage terminates on:

- the date of Your death;
- the date coverage is cancelled pursuant to Your request;
- the date You have received the lifetime maximums allowed under the Policy; or
- the last date through which premiums have been paid if the amount due is not received by the date stated in notice of termination of coverage as provided by the terms of the Notification of Non-Payment provision.

When Insurance Ends. There are only a few reasons that your policy would ever terminate: if you die; if you do not pay premiums as they are due (which means after the 65 day grace period); if you contact the company and ask for your coverage to be cancelled; or if you use up the maximum benefits allowed under the policy.

Extension of Benefits. If Your Policy terminates due to failure to pay premium, We will recognize Your basis for a claim for Your Confinement in a Nursing Home or an Assisted Living Facility before the date Your Policy ended in the same manner as if Your insurance was in force. Extension of Benefits stops on the earlier of the date when You no longer meet the Eligibility for the Payment of Benefits requirements; the date You are no longer Confined in a Nursing Home or an Assisted Living Facility; or the date Your lifetime maximums are reached.

Extension of Benefits. This provision protects you if premium payments are required while you are receiving facility care, and you stop paying premiums while you are in a facility. Your benefits continue through the duration of your confinement, but your policy would end once you were no longer confined in that facility. Since most policies do not require you to pay premium while you are receiving benefits, this provision is rarely necessary anymore, but it is required to be included in TQ policies.*

BASIC CONTRACT PROVISIONS. This Section describes: the documents that state all the contractual agreements; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features.

Entire Contract Changes. The entire contract consists of: the Policy; the Policy Schedule; any riders or endorsements to the Policy that are issued by Us; and Your Application. All statements made by You for the purpose of effecting insurance are considered true and complete to the best of the knowledge and belief of the persons making them. These statements are representations and not warranties. No statement will be used in any contest unless: the statement is in writing; and a copy of that statement is given to You.

Agreements. All agreements made by Us must be signed by one of Our executive officers. No agent may modify or waive any of the terms of the Policy. An endorsement or amendment changing the Policy must be signed by an executive officer of Ours.

Right to Change Policy Provisions. The insurance company can only change a provision or feature of your policy without your consent if state or federal law requires the change. The insurer can change your policy without your consent if the change is beneficial to you – i.e., if the change does not reduce benefits or increase premiums.

Changes To This Policy. No change in this Policy is effective until You accept the change in writing, with the following exceptions: a change in the premiums; a change that is required by law or regulation; or a change that does not reduce or eliminate benefits or coverage. This exception does not include an increase in benefits or coverage with a like increase in premium when requested by You and approved by Us; or when offered by Us and accepted by You.

Any change will be without prejudice to any claim incurred for benefits prior to the date of the change.

Misstatements/Incontestability. In issuing this Policy, We have relied upon the information presented by You in Your Application. We may rescind Your Policy or deny a claim due to a material misrepresentation in Your Application if Your Policy has been in force for less than six months. The Policy Effective Date is shown on the Policy Schedule.

If Your coverage has been in force for at least six months but less than two years, We may rescind Your Policy or deny a claim due to a misstatement in Your Application that is both material and pertains to the conditions for which benefits are sought.

After Your coverage has been in force for two years, no misstatement, except a fraudulent misstatement in Your Application, may be used to rescind Your Policy or to deny a claim for benefits that began after the two-year period.

Misstatements/Incontestability

This section specifies the time frames and remedies the insurance company has if it turns out you falsified or misrepresented any information on your application.

- Within the first six months of your coverage, the insurance company can question the validity of your policy or deny you benefits if they can prove you made a misrepresentation on your application that was relevant to their decision to accept you.
- For a policy that you have had for more than six months but less than two years, the insurance company can only question the validity of your policy or refuse to pay your claim if the misrepresentation is both relevant to their decision to accept your application and if it pertains to the reason for which you are seeking claim. (For example if you said you were married but you are single, and you are seeking benefits for care in a nursing home, the misrepresentation would not be likely to fulfill either of the criteria. But if you falsely said on your application that you had never had a stroke, and seven months later you require nursing home care as a result of having had the stroke, it would be likely to fulfill both criteria.)
- For the insurance company to rescind (take away) your policy or deny a claim after two years, it must be able to prove that any misrepresentations made on your application were made with the intent of committing fraud.*

Misstatement of Age. If you do not provide the correct age on your application, the insurance company has the right to adjust your premiums to reflect the correct age, or to rescind your policy if your actual age would have been a reason for them not to have accepted you in the first place. (Many policies have an upper age limit beyond which you cannot buy the policy).

Misstatement of Age. If Your age was misstated in Your application, We will adjust Your premium to the correct amount for Your insurance at Your correct age as of the Policy Effective Date. The amount of the insurance shall not be affected, provided that any necessary adjustment in premium is made and collected. If based on Your correct age Your Application would not have been accepted and a Policy not issued, We will only be liable for the refund of all premiums paid for the Policy.

Conformity With State Statutes. Any provision of Your Policy which, on the Policy Effective Date, is contrary to the applicable laws of the State where the Policy is delivered is amended to conform to the minimum requirements of such laws.

Conformity With Internal Revenue Code. If on its Effective Date, the Policy does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. Because the Policy is guaranteed renewable, We will inform You in writing of any required change in the provisions of this Policy; and You will be given the choice of accepting the change, or retaining the Policy without that change.

Time Periods. All time periods start and end at 12:01 a.m. in the time zone in which You reside.

Clerical Error. Clerical error or delays in making entries on the records by Us or Our designees will not void Your coverage if Your coverage would otherwise have been in effect. Such clerical error will not cause You to become insured if You're otherwise not eligible. Such clerical error will also not extend Your coverage if Your coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

No Dividends. This Policy will not pay dividends. It has no cash value and will not participate in any of Our surplus or earnings.

No Cash Values. This provision states that you cannot use the policy as collateral for a loan as it has no cash value for that purpose.

No Cash Values, Borrowing, or Use as Collateral. This Policy does not provide for a cash surrender value, or other money that can be: borrowed; or paid, assigned or pledged as collateral for a loan.

ABC Life Insurance Company
Long-Term Care Insurance
Policy Schedule

Policyholder: John Q. Doe Policy Number: 123456
Address: 1234 Main Street
Anytown, USA 99999

Insured: John Q. Buck
Address: 1234 Main Street
Anytown, USA 99999

Age At Issue: 45

Policy Effective Date: 01/01/2008

Current Coverage Effective Date: 06/01/2008

Insured Spouse: Jane Q. Buck

COVERAGE AMOUNTS AND MAXIMUMS

Lifetime Maximum:	$100,000; $250,000; $400,000; $500,000; $600,000; $750,000; $1,000,000
Monthly Maximum:	$2,000 and up in $1,000 increments
Stay at Home Support Maximum:	10% of Lifetime Maximum – [Dollar Amount Will Appear Here]
Shared Care Maximum:	[Amount equal to Lifetime Maximum Will Appear Here]
Care Advisory Services:	Provided by American General as specified in the Policy
Alternative Plan of Care Benefit:	Included
Elimination Period:	30, 90 or 180 or 365 calendar days

Policy Schedule. The Schedule of Benefits Page summarizes the specific benefits and maximum coverage amounts you have chosen and any other optional benefits you have either elected or declined. Companies vary in how much detail they include in the Schedule of Benefits. Some companies send a new Schedule every time you make a change in your coverage or your address, or when your benefits increase based on automatic inflation protection. Sometimes you will see both a "coverage effective date," which refers to the date on which your coverage first went into effect and a "Schedule Effective Date," which refers to the date on which any changes in benefit reflected in a new schedule took effect. This sample Schedule of Benefits page shows some information in brackets, which would be different for each person who had coverage under this policy.

Rate Classification. Various discounts may be available for those who qualify (e.g., a discount for being in excellent health). Some policies may also provide what is called "substandard" or "nonstandard" premiums which means you would pay a higher rate because you were accepted for coverage but have a condition with puts you at higher risk of needing LTSS. Most policies do not include information about your rate classification within the policy; it is typically provided when you apply for a policy or when a policy is approved.

PREMIUM INFORMATION

Rate Classification: [Preferred/Standard/Substandard]
[with Spousal Discount]

ADDITIONAL COVERAGES AND ANNUAL PREMIUMS

Basic Policy Coverage	[$xx.xx]
[Nonforfeiture Benefit Rider – Shortened Benefit Period Rider]	[$xx.xx]
[Automatic Inflation Protection – 3%/5% Compound For Life Rider]	[$xx.xx]
[Return of Premium at Death to Age 70 Benefit Rider]	[$xx.xx]
[Paid-Up Premium Rider]	[$xx.xx]
[Shared Care Benefit Rider]	[$xx.xx]
[Waiver of Elimination Period for Home and Community Care Benefits Rider]	[$xx.xx]
ANNUAL TOTAL	[$xx.xx]
Modal Premium Amount: [Monthly]	[$xx.xx]

Schedule of Benefits Print Date: [01/01/01]

WAIVER OF ELIMINATION PERIOD FOR HOME AND COMMUNITY CARE BENEFITS RIDER

This rider is attached to and made part of Your Policy as of the Rider Date shown below. Your Application and premium put this rider in force as of the Rider Date. This rider is made a part of Your Policy. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

Waiver of Elimination Period for Home and Community Care Benefits. If You meet the Eligibility for the Payment of Benefits requirements and You incur Covered Expenses for Home and Community Care, We will waive the requirement that You must meet the Elimination Period before receiving Home and Community Care Benefits.

Days on which You meet the Eligibility for Payment of Benefits requirements and incur Covered Expenses for Home and Community Care will count towards satisfying the Elimination Period for other benefits under the Policy.

Signed for Company.

Rider Date

FORM #

Waiver of Home Care Elimination Period. If you buy this rider along with your policy, then you do not have to satisfy an elimination period in order to receive care at home. Benefits for home care would begin on the first day that you are verified to be eligible for benefits and begin to receive covered home care.

Paid-Up Benefit Rider. If you buy this rider along with your policy, instead of paying premiums for as long as you have the coverage (except during the times that you are in premium waiver status – i.e., receiving benefits), you would only pay premiums until either your 65th birthday or the 10th anniversary of your policy effective date, whichever comes later. There are many different kinds of "paid up" riders which allow you to stop paying premiums after a defined period of time or up to a certain age and still maintain your coverage after that. Some policies offer a rider that lets you be "paid up" after paying for 20 years and some are "single pay" which means you pay one large premium and never have to pay premiums again. Single pay policies are much less common than the other options of paid up at age 65, the 10-pay or the 20-pay.

PAID UP PREMIUM RIDER

This rider is attached to and made part of Your Policy as of the Rider Date shown below. Your Application and premium put this rider in force as of the Rider Date. This rider is made a part of Your Policy. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Benefit Works. This rider allows Your Policy premiums to be paid as due until the later of:

- the first anniversary of the Policy Effective Date following Your 65th birthday; or
- the tenth anniversary of Your Policy Effective Date.

After the later of the above dates has occurred, no additional premiums will be due.

Prior to Your 65th birthday, You must make sure that You pay the premiums when they are due to continue Your Policy. If the premium for Your Policy increases due to the addition of any other rider, the amount of the premium increase must be paid by You until the first anniversary of this effective date of this rider following the later of the dates described above.

Premium Is Level. Prior to the first anniversary of the effective date of this option following the later of the dates described above, We have the right to change Your premium, but only if We change premiums for all policies issued to persons in Your premium class, as specified in Our Limited Right to Change Premiums section of the Policy. We will not change premiums solely due to a change in Your age or health. Any change in premiums is subject to the other terms of the Policy.

Termination. This rider will end on the earliest of:

- The date We receive Your request to change the premium payment period of Your Policy;
- The date Your Policy terminates; or
- The date Nonforfeiture coverage or Contingent Nonforfeiture coverage becomes effective under Your Policy.

Signed for Company.

Rider Date

FORM #

NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER

This rider is attached to and made part of Your Policy as of the Rider Date shown below. Your Application and premium put this rider in force as of the Rider Date. This rider is made a part of Your Policy. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Benefit Works. This benefit provides a continuation of Your coverage, but on a reduced basis, in the event that Your coverage terminates due to non-payment of premium.

This Nonforfeiture benefit provides a continuation of Your coverage up to a specified dollar amount (called the Shortened Benefit Period Allowance) if Your coverage terminates due to non-payment of premium before the Maximum Lifetime Benefit has been exhausted. The conditions under which We will pay benefits under this provision are described below.

If Your coverage terminates due to non-payment of premium on or after the third anniversary of the effective date of this provision, We will pay benefits, subject to all of the terms and conditions of the Policy until the Shortened Benefit Period Allowance has been reached or when You no longer meet the Eligibility for the Payment of Benefits provision requirements of the Policy, whichever occurs first. Benefits for Covered Expenses You incur or Covered Services You receive will be paid up to the applicable daily, monthly, annually, and lifetime benefit maximums in effect at the time Your coverage terminated due to non-payment of premium.

The Shortened Benefit Period Allowance We will pay will be the greater than: (a) one hundred percent (100%) of the sum of all premiums paid for Your coverage, excluding any waived premiums; or (b) Your Monthly Maximum Benefit in effect at the time of lapse. The Shortened Benefit Period Allowance is reduced by the sum of all benefits previously paid to You.

Inflation Protection Will Not Apply To This Benefit. If You have elected an inflation protection rider, any benefit paid will be the benefit amount in effect on the date Your Policy lapses and no further increases in benefit amounts will occur.

Nonforfeiture Benefit – Shortened Benefit Period Rider. With this rider, if you've had your policy in effect for at least three years, and you cancel your policy or it lapses for nonpayment of premium, the insurer will convert your policy to a reduced Total Benefit Amount policy on a paid-up basis (this means you do not continue to pay premiums). The new Total Benefit Amount will be equal to the 30 times the Daily Benefit Amount (or equal to the Monthly Benefit Amount) OR the total amount of all premiums (paid and waived) during the term of the policy and rider – whichever is greater. The Monthly Benefit Amount in effect under the paid-up status will be the amount in effect just before the conversion to paid-up status. Once the policy is converted to paid-up status, all riders end. There are no more inflation protection increases or other coverage changes. The Total Benefit Amount under this rider will never exceed the Total Benefit Amount that remained before it went into paid-up status. Note that there is a built-in Contingent Nonforfeiture Upon Lapse benefit in the base policy. If you could go into reduced paid-up status under either the built-in Contingent Nonforfeiture benefit or the Full nonforfeiture rider, the carrier will calculate the amount of the reduced benefit under both scenarios and give you the higher amount. With other policies this benefit may be translated into days rather than dollars.

When Coverage Ends. Your coverage under this provision will end when the Shortened Benefit Period Allowance has been reached or Your Maximum Lifetime Benefit has been exhausted. In no event will the total of benefits payable under the Policy and this provision exceed the Maximum Lifetime Benefit.

Signed for Company.

Rider Date

FORM #

SHARED CARE BENEFIT RIDER

This rider is attached to and made part of Your Policy as of the Policy Effective Date shown on Your Policy Schedule. Your Application and premium put this rider in force as of the Policy Effective Date. This rider is made a part of Your Policy. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

Eligibility For This Rider. To be eligible for this rider, You and Your Spouse must be insured under the same policy form number, have identical coverage and have the same Policy Effective Dates. If You and Your Spouse are covered under this rider, Your Policy Schedule will show Your Insured Spouse's name and indicate that You and Your Spouse are covered by the Shared Care Benefit Rider.

Unless Your Insured Spouse has died and You continue this rider by paying the entire premium for it, Your Policy and Your Insured Spouse's Policy must remain in force without interruption from the Policy Effective Date. This rider must also be in force, without interruption, from the Policy Effective Date.

How This Benefit Works. This rider establishes a separate fund, called the Shared Care Maximum, shown on Your Policy Schedule. The Shared Care Maximum is available to You upon exhaustion of Your Lifetime Maximum. The Shared Care Maximum is available to Your Insured Spouse upon the exhaustion of Your Insured Spouse's Lifetime Maximum. You and Your Insured Spouse may access the Shared Care Maximum at the same time, provided you both meet the Eligibility for the Payment of Benefits requirements and have exhausted Your own Lifetime Maximums.

How Much We Will Pay. We will pay Covered Expenses subject to the limitations and conditions of the Policy, up to the Shared Care Maximum. The Shared Care Maximum is equal to Your Lifetime Maximum, which is also equal to Your Insured Spouse's Lifetime Maximum. The Shared Care Maximum is one additional pool of benefits available to both You and Your Insured Spouse. It is not one pool of benefits each for You and Your Insured Spouse. The Shared Care Maximum is reduced by the amount of benefits paid under this rider to either You and/or Your Insured Spouse.

Shared Care Benefit Rider. This rider allows spouses or domestic partners the flexibility to expand total coverage limits by accessing any remaining benefits in the other's policy if he exhausts his own policy limits. Usually, both partners must apply for identical coverage (same policy series, same Monthly and Total Benefit Amounts, same riders). If one of the partners exhausts his policy, coverage can continue under the same conditions as before by tapping the Total Benefit Amount in the other partner's policy. This is allowed even if the other partner is using the policy. The partner whose policy is now doing "double duty" will not, of course, be able to collect as many benefits as she would have without the rider in effect. But the policy will still be paying out the full benefits under its provisions to one partner or the other – or both. Should one of the partners die without exhausting the entire policy's benefits, any unused, remaining benefits (or a portion of them, as specified in the rider) can be transferred to the surviving partner's policy or, in the event the survivor had exhausted her policy, the surviving partner can receive benefits up to the transferred amount under the same provisions in effect when her policy was exhausted. With the death of one partner, the shared care rider is dropped from the survivor's policy and the premium for the rider is eliminated. Some carriers offer a single shared policy for partners. Instead of each partner having an individual policy with three years each, for example, and the ability to dip into the other's policies, the partners share a six-year policy. This is a similar concept, but there may be differences in the event of a divorce, for example. Be sure to check the policy language for details.

Coverage Reduction If One Policy Terminates Due to Reason Other Than Death. If, while neither You nor Your Insured Spouse is in claim status, one spouse's policy or this rider terminates for any reason other than death, this rider can be continued for the spouse whose coverage remains in force so long as the required premium payments for this rider are made. The amount of coverage will equal one-half the benefits remaining under the Shared Care Lifetime Maximum amount in effect at the time of such termination or change.

Termination. This benefit will terminate at the earliest of:

- the date of the termination of Your Policy or Your Insured Spouse's policy (unless You or Your Insured Spouse have continued coverage as described above);
- the date either You or Your Insured Spouse changes coverage under your policy so that Your coverage and Your Insured Spouse's coverage is no longer identical;
- the date Your Shared Care Lifetime Maximum has been exhausted;
- the last date for which premiums have been paid for this rider.

Signed for Company.

FORM

RESTORATION OF BENEFITS RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Benefit Works. Following a period during which We had been paying benefits but You did not exhaust them, We will restore the following after You meet the Qualification Free Period:

- Your Lifetime Maximum; or
- Your Inflated Lifetime Maximum, if an inflation protection rider increased Your coverage.

Your Lifetime Maximum or Inflated Lifetime Maximum may be restored an unlimited number of times, provided the Qualification Free Period is met each time.

The Qualification Free Period is defined below.

How Increases and Decreases are Handled. Your coverage amount described above will be adjusted to reflect any voluntary increases or decreases in coverage You have elected. Your coverage amount will be restored to the lesser of:

- The most recent amount in force just prior to the last time You began to receive benefits; or
- The new reduced amount of coverage You have elected.

When Benefits Are Restored. If all of the conditions of the Qualification Free Period are met, Your coverage amount will be restored on the 181st day after the start date of the Qualification Free Period, which is the last date You incur Covered Expenses or receive covered services. No Restoration of Benefits will be available if Your Lifetime Maximum has been exhausted, which automatically terminates Your Policy.

How This Rider Affects the Return of Premium at Death to Age 70 Benefit Rider. If You have the Return of Premium at Death to Age 70 Benefit Rider, the amount of premiums returned upon Your death will be reduced by the amount of any benefits paid prior to or after the Restoration of Benefits provision being applied to your coverage amount.

Restoration of Benefits. This optional rider will restore benefits you have used if certain conditions are met. Generally, you would have to recover fully and remain that way for at least 180 days. If that happens, any benefits you had previously used would be "restored" and you'd again have access to your full lifetime maximum. Some policies will "recharge" your benefits as many times as you satisfy these requirements and others will do it only once. Some policies include this as a rider and others automatically include it in coverage. Since the chances of a full and complete recovery after a prolonged use of benefits is very small, the likelihood of seeing benefits restored is limited and the amount of benefits restored is likely to be small or else recovery would not have been likely. Think carefully before spending additional premium dollars for this type of rider. Make sure you understand all the requirements for having your benefits restored.

Nonforfeiture Benefit Rider and Contingent Nonforfeiture Benefit. If Your coverage is being continued in accordance with the terms of the Nonforfeiture Benefit – Shortened Benefit Period Rider or Contingent Nonforfeiture Benefit, this Restoration of Benefits provision will cease to apply.

Definition of Qualification Free Period. Qualification Free Period means a period of 180 consecutive days during which a Licensed Health Care Practitioner certifies and We verify that You meet the following:

- You are able to perform, without Substantial Assistance from another individual, two or more Activities of Daily Living (ADLs); and
- You do not require Substantial Supervision by another person to protect Yourself from threats to health and safety due to Severe Cognitive Impairment.
- You do not receive Qualified Long-Term Care Services that would otherwise be covered under this policy from either a paid or an Informal Caregiver.

Termination. This rider ends on the date Your Policy terminates.

Signed for ABC Life Insurance Company.

Rider Effective Date

FORM #

ANNUAL AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER

This rider is attached to and made part of Your Policy as of the Rider Date shown below. Your Application and premium put this rider in force as of the Rider Date. This rider is made a part of Your Policy. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Rider Works. We will increase each current maximum benefit by the percentage shown on Your Policy Schedule, compounded annually on the anniversary of the effective date of this rider as long as this rider and Your Policy remain in force. Your current maximum benefits are reduced by any claims paid and increased for any previous inflation protection increases. All increased amounts will be rounded to the nearest whole dollar.

Your premium rate will not change as a result of these annual benefit increases. However, Your premium may change subject to the other terms of the Policy. See the Our Limited Right to Change Premiums section of the Policy.

When Increases Become Effective. The increase will be effective on each anniversary of this rider even if You are receiving benefits.

Your premium rate will not change as a result of these annual benefit increases. However, Your premium may change subject to the other terms of the Policy. See the Our Limited Right to Change Premiums section of the Policy.

Termination. If You request that We remove this benefit from Your Policy, then on the date We receive Your request:

- Your benefit maximums will remain at the level they were as of the date We received Your request, rounded to the nearest $1,000 increment; and
- Your premium will be changed to equal the amount that would be charged for Your current benefit maximums based on Your original issue age and the rate schedule in effect at the time We receive your request. However, if this rider was added to Your Policy after the Policy Effective Date, Your premium will be based on current benefit maximums and Your age at the time this rider was added to Your Policy.

Annual Automatic Compound Inflation Protection. This statement tells how your coverage will keep pace with inflation in the costs of care over time. You obtain this Inflation Protection by purchasing a rider to your policy. Most policies offer choices of several different kinds of inflation protection. Increases occur on the anniversary date of the policy (the effective date listed on the Schedule of Benefits page). These increases occur without affecting the premium. Premiums on policies with automatic inflation protection are priced with the regular annual increases in benefits already taken into account. Each year the amount of the increase will be a percentage (in this case either 3% or 5%) of the previous year's Monthly Benefit Amount (sometimes called the Daily Benefit Amount or Maximum Daily Benefit). The Total Benefit Amount (also called Lifetime Benefit Amount or Lifetime Maximum) also increases by the specified percentage. If there are any other coverage maximums (e.g., if the policy had a $10,000 lifetime maximum for Stay at Home Support Benefits), that maximum would also increase by the amount chosen. Read the rider carefully to be sure that ALL benefit amounts increase with the Inflation Protection provided.

- Increases generally will continue to occur for the life of the policy. Increases do not end because of age, health, claim status, claim history or the number of years you've had the policy. (Some policies may offer you an inflation protection rider that is less expensive because it stop the increases in the inflation protection after a set number of years, after the benefit amounts had doubled or after you reach a specified age.)
- The rider reminds you that increases in benefits due to the inflation rider do not affect premiums BUT that the insurance company still has the limited right to raise premiums on a class basis. Some types of inflation riders do affect premium (such as the Future Purchase Option).

- The rider describes the reasons why it would terminate, for example when the policy ends or if the policy converts to paid-up status under a Nonforfeiture feature or if you write to the company requesting that they terminate the rider. It tells what happens when the rider is terminated – in this case, your benefit amounts "freeze" at the last amount to which they had reached. The insurer will recalculate the premium, however. The new premium will be based on the inflated Benefit Amounts achieved over the years priced at your age at the time you purchased the rider. If the new premium is equal to or higher than the premium with the rider still in effect, they won't allow you to terminate the rider. This is a safeguard. Think very carefully before terminating this rider. Compound inflation protection gains in a snow-ball fashion over the years. It becomes more valuable to you with each passing year.
- Not all carriers treat termination of inflation riders the same way. Get a clear statement of what would happen if an inflation protection rider were terminated from the carrier in question. Will the benefits remain at the inflated level? How will the premium be recalculated?

Annual inflation protection increases will terminate if Your coverage is continuing in effect under:

- the Extension of Benefits provision;
- the Nonforfeiture Benefit – Shortened Benefit Period Rider, if any; or
- the Contingent Nonforfeiture Benefit.

Signed for Company.

Rider Date

FORM #

ABC Life Insurance Company

BENEFIT INCREASE OFFERS (also called Future Purchase Option or Guaranteed Purchase Option)

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. It is issued in consideration of Your Application and premium submitted by You for this rider. It is subject to all the provisions of the Policy unless otherwise provided below.
In all other respects, the provisions and conditions of the Policy remain the same.

How Does this Benefit Work? While coverage is in force, You will periodically be offered the option to increase:

- Your Facility Care Monthly Maximum;
- [Your Home and Community Care Monthly Maximum]
- Your Stay at Home Benefit Annual Maximum; and
- The unused balance remaining in Your Lifetime Maximum Benefit.

The amount of the increase will be an amount determined by Us based on the Nursing Home Consumer Price Index (CPI) published by the United States Department of Labor. If the CPI is discontinued or its method of computation is not sufficient to determine the effects of inflation on long-term care charges, another nationally published index may be used.

This offer will be made not less frequently than ever thirty-six (36) months, as long as Your coverage remains in force, and You have not refused this offer twice.

Increased amounts are rounded to the nearest whole dollar.

No Evidence of Insurability Required. No evidence of insurability is required.

Additional Premium for The Increased Coverage. The premium for the amount of increased coverage will be based on Your age as of the date this offer is made to You.

The Increases Will be Automatically Put Into Effect Unless You Decline Them in Writing. The increased coverage amounts will automatically be put into effect within thirty-one (31) days after We send You notification of the increase unless You elect to decline the increase offer. You may decline this offer any time it is made.

Benefit Increase Offer also called Guaranteed Purchase Option or Future Purchase Option, this rider allows you the chance to buy additional coverage periodically or each year, based on an amount determined by the insurer; in this case, the insurer is using a CPI specific to LTSS for determining the amount of additional benefit they will allow you to purchase each time the increase offer is made. Some companies make the offer every year and some only offer it every 2 or 3 years. Sometimes a set amount like a 3% or 5% factor is applied to the benefit amounts of the prior year instead of using a CPI or other index. The cost of the increase in benefit is based on your attained age on the date of the increase, as well as your health rating and premium rates and discounts in effect at that time. These offers will continue as long as you are not receiving benefits or have not declined a specified number of previous offers. Companies have many different approaches, so read the rider carefully. Some companies will continue the increase offers when you are on claim but obviously, with premium waiver, you would not have to pay the increased premium until you were no longer in benefit. You can decline to take a benefit increase any time it is offered, but this must be done in writing. If you decline the automatic increases a certain number of times in a row (or over the life of your policy), the carrier will stop making the increases. These increase offers would also end if you terminate the rider, your policy ends (for any reason) or if you go into nonforfeiture status. Except as otherwise stated in the rider, the increase offers will not end because of age or the length of time you've had your policy. But many policies do not provide these periodic benefit increase offers while you are on claim receiving benefits. Some will "suspend" the offers and resume them once you are off claim, while for other policies, the offers stop and do not resume once you have begun to receive

benefits, even if you do recover. Keep in mind that these increases raise the premium at an increasing rate over the years because the benefit increases are priced based on your attained age. This might cause affordability concerns later in life. Read the policy's inflation rider carefully to see if the increases cease at a certain age or after a specified number of declines of the offer – and whether or not they could be restarted again and under what conditions.

However, once You have refused this offer twice, You will not be offered any future offers to increase coverage.

After that, if You want to increase Your coverage, You may apply to do so on Your own initiative. However, You must submit evidence of insurability. The process for requesting an increase in coverage is described in Section _____.

Signed for ABC Insurance Company.

The bottom line: Read the policy carefully. Benefits from different insurance companies may have similar names but may perform very differently from those shown here.

APPENDIX 2 | *Glossary*

Term	Definition
401 (k)	A defined contribution plan offered by a corporation to its employees, which allows employes to set aside tax-deferred income for retirement purposes. In some cases, employers will match the employee contribution dollar-for-dollar up to a set amount. Taking a distribution of the funds before a certain specified age will trigger a penalty. The name 401(k) comes from the IRS section describing the program.
A.M. Best Rating	Independent judgment by the A.M. Best Company, a private organization that evaluates and monitors the financial strength of life insurance companies. The company assigns letter grades from A++ (the highest) through C (the lowest).
Accelerated Death Benefit	A life insurance policy feature that lets you use some of the policy's death benefit prior to death if you have a qualifying terminal illness.
Activities of Daily Living (ADLs)	Basic actions performed by an independently functioning person on a daily basis: (a) bathing; (b) dressing; (c) toileting; (d) transferring (moving to and from a bed or a chair); (e) eating; and (f) caring for incontinence. The need for assistance with ADLs or inability to perform ADLs is used to determine eligibility for many public programs such as Medicaid reimbursed long-term care services. Most long-term care insurance policies use the inability to do a certain number of ADLs (such as 2 of 6) one of the two major criteria for paying benefits.
Acute Care	Care that has recovery as its primary goal; typically requires the services of a physician, nurse, or other skilled professional and usually provided in a doctor's office or hospital; usually short term.
Added Protection Upon Lapse	Also called Third Party Designation or Third Party Notice. Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer.
Adult Day Services	Services provided during the day at a community-based center. Programs are designed to meet the needs of functionally and/or cognitively impaired adults through an individual plan of care. These structured, comprehensive programs provide a variety of social and support services in a protective setting during any part of a day, but less than 24-hour care. Many adult day service programs include health-related services.
Advanced Directive	Also called Health Care Directive, Advanced Health Care Directive, Living Will, or Health Care Directive. Legal document used to specify whether you would like to be kept on artificial life support if you become permanently unconscious or are otherwise dying and unable to speak for yourself. It also specifies other aspects of health care you would like under those circumstances.
Alzheimer's Disease	Progressive, degenerative form of dementia that causes severe intellectual deterioration; first symptoms are impaired memory, which is followed by impaired thought and speech and finally complete helplessness.

Term	Definition
Annuity	An annuity is a type of contractual financial product sold by financial institutions (insurance companies, banks and others) that is designed to accept and grow funds from an individual and then, upon annuitization, pay out a stream of payments to the individual at a later point in time. The period of time when an annuity is being funded and before payouts begin is referred to as the accumulation phase. Once payments commence, the contract is in the annuitization phase. The payments begin on a set date and either continue for a set period of time or for the duration of a specified life or lives. The annuity is funded with a one-type lump sum dollar amount or a series of periodic premium payments from the individual establishing the annuity. Terms and conditions for payment schedules and amounts are outlined in the annuity contract.
Arthritis	Disease involving inflammation of a joint or joints in the body.
Asset Disregard	A feature of Partnership-qualified Long-Term Care Insurance Policies. This protects a specified amount of the insured's assets from Medicaid spend-down requirements, and is in addition to any other assets that are already protected. The assets are protected for both eligibility purposes and estate recovery purposes.
Assets	The term given to a person's resources, outside of income, which may include bank accounts, stock and bond holdings, IRAs, 401(k) accounts, real estate and others.
Assisted Living Facility	Residential living arrangement that provides individualized personal care, assistance with Activities of Daily Living, help with medications, and services such as laundry and housekeeping. Facilities may also provide health and medical care, but care is not as intensive as care offered at a nursing home. Types and sizes of facilities vary, ranging small homes to large apartment-style complexes. Levels of care and services also vary. Assisted living facilities allow people to remain relatively independent.
Attending Physician's Statement (APS)	Report from your doctor or a medical facility that has treated you, providing information such as medical history, medications, and diagnoses.
Bathing	Washing oneself by sponge bath, in the bathtub or shower. One of the six Activities of Daily Living (ADLs).
Benefit Period	The period of time, after the elimination period, during which LTC insurance benefits will be paid. This may be for a set number of days or years or for an unlimited period of time. Alternatively, the period of time might be used as a multiplier to determine a lifetime benefit dollar figure. For example, a three-year policy at a daily benefit of $200/day would yield a lifetime dollar amount of $219,000 (i.e., 3 years x 365 days x $200/day = $219,000).
Benefit Triggers (Triggers)	Criteria insurance companies use to determine when you are eligible to receive benefits. The most common Benefit Triggers for long-term care insurance are: (1) needing help with two or more ADLs, or (2) having a Severe Cognitive Impairment.

Term	Definition
Benefit Waiting Period	Specified amount of time at the beginning of a disability during which covered services are received, but for which the policy will not pay benefits (also known as a Deductible Period or Elimination Period). A Service Day Deductible Period is satisfied by each day of the period on which you receive covered services. A Calendar Day or Disability Day Deductible Period doesn't require that you receive covered services during the entire deductible period, but only requires that you meet the policy's benefit triggers during that entire time period.
Benefits	Monetary sum paid by an insurance company to an insured or (where the insured has requested it) directly to a care provider for services covered by the insurance policy.
Board and Care Home	Also called Group Home, residential private homes that are designed to provide housing, meals, housekeeping, personal care services, and supports to frail or disabled residents. At least one caregiver is on the premises at all times. In many states, Board and Care Homes are licensed or certified and must meet criteria for facility safety, types of services provided, and the number and type of residents they can care for. Board and Care Homes are often owned and managed by an individual or family that is involved in the every day operation of the home.
Cardiopulmonary Resuscitation (CPR)	Combination of rescue breathing (mouth-to-mouth resuscitation) and chest compressions used if someone isn't breathing or circulating blood adequately. CPR can restore circulation of oxygen-rich blood to the brain.
Care Coordinator	A health care practitioner, usually a social worker and/or nurse, who evaluates a patient to determine the nature and extent of impairment and the appropriate equipment and/or care and services needed. Care coordinators may also draw up a formal Plan of Care (Care Plan) after doing the assessment. The care coordinator typically stays in contact with the patient and/or family to help make changes to the plan of care as care needs and care options change over time.
Care Management Services	Also called care coordination services, these are services in which a professional, typically a nurse or social worker, helps determine the array and type of services that best meet someone's needs and, if desired, arranges, monitors, or coordinates long-term care services. The care plan is typically advisory only; you don't need to follow it exactly or use recommended providers.
Caregiver	A caregiver is a family member, partner, friend, neighbor or other unpaid individual who helps care for someone who needs long-term care, usually at the individual's home. 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. Thirteen percent (13%) of caregivers caring for older adults are themselves aged 65 or over. Half of all caregivers provide assistance with at least one activity of daily living; 26% perform 3 or more of these activities, and 80% provide assistance with activities like shopping, meal preparation, and housework.
Cash Surrender Value	Amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value is determined as stated in the policy.
Cash Value Life Insurance Policy	Also known as permanent life insurance policies, whole life, universal life and variable universal life policies. These policies allow for loans, withdrawals, or complete policy surrenders for a specific cash value.

Term	Definition
Charitable Remainder Trust	Special tax-exempt irrevocable trust written to comply with Federal tax laws and regulations. With this kind of trust, you transfer cash or assets into the trust and may receive some income from it for life or a specified number of years (not to exceed 20). The minimum payout rate is 5 percent and the maximum is 50 percent. At your death, the remaining amount in the trust goes to the charity that was designated to receive it as part of the trust arrangement.
Chronically Ill	A term specific to tax-qualified long-term care insurance, it refers to having a long lasting or recurrent illness or condition that causes a person to need help with 2 or more Activities of Daily Living (for a period of time expected to last at least 90 days) or someone having a Severe Cognitive Impairment, such as Alzheimer's disease.
Class Basis	A class is an insurance term for a "like" group of individuals. For LTC insurance, a "class" is typically all persons of the same age, in a given state, with the same form, type and amount of coverage. Rate increases on LTC insurance can only be made on a "class basis" which means no one person can be singled out for a rate increase for any reason.
Cognitive Impairment	A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: • short-term or long-term memory; • orientation as to people, places or time; and • deductive or abstract reasoning.
Community Spouse	The at-home spouse of a person applying for or receiving Medicaid long-term care services in a nursing home.
Community-Based Services	Care and services in the community, such as adult day services, home delivered meals, or transportation services. Often referred to as home and community-based services, they are designed to help older people and people with disabilities stay in their homes as independently as possible.
Compound Inflation Protection	A form of inflation protection that automatically increases all coverage amounts by a stated percentage every year over the prior year's amount. The individual does not pay an additional premium cost each time the coverage amounts are increased. This is because the cost of increasing benefits due to inflation protection are included in the initial premium amount the individual is paying. Coverage increases continue even while the individual is receiving benefits. All tax-qualified plans must offer at least a 5% compound inflation protection option.
Comprehensive Policy	A long-term care insurance policy that includes benefits for all types of care (home and community-based support, assisted living facilities, nursing homes) as opposed to narrower policies, such as facility-only coverage.
Continence	Ability to maintain control of bowel and bladder functions; or when unable to maintain control these functions, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag). One of the six Activities of Daily Living.

Term	Definition
Contingent Nonforfeiture	Long-term care insurance policy provision automatically included in many newer policies, which provides a limited amount of continuing coverage even if the policy lapses due to non-payment of premium, if the non-payment is due to a significant increase in premium rates. The policy defines what is considered a significant increase in premiums based on your age at the time you bought the policy. The limited amount of coverage is generally equal to the greater of 100% of the premiums paid in (less benefits) or 30 times the daily benefit amount. This coverage amount is available to the individual for whenever they might need, even though they have stopped paying coverage premiums, if they have this provision.
Continuing Care Retirement Communities (CCRC)	Retirement complex that offers a range of services and levels of care. Residents may move first into an independent living unit, a private apartment or house, on the campus. The CCRC provides social and housing-related services and often also has an assisted living unit and an on-site or affiliated nursing home. If and when residents can no longer live independently in their apartment or home, they move into assisted living or the CCRC's nursing home.
Continuous Payment Options	Premium payment option that requires a person to pay premiums for the life of the policy or until they begin to receive benefits. Premiums are usually paid on a monthly, quarterly, semi-annually or annual basis. Because the policy is guaranteed renewable, it can not be cancelled for any reason, except in the event of nonpayment of premiums or once lifetime maximum benefits have been exhausted.
Convalescent Care Facility	Also called Nursing Home or Long-Term Care Facility, these are licensed facilities that provide general nursing care to those who are chronically ill or unable to take care of daily living needs.
Countable Assets	Assets whose value is counted in determining financial eligibility for Medicaid. They include vehicles other than the one used primarily for transportation, life insurance with a face value over $1,500, bank accounts, trusts, and your home, if your spouse or child does not live there and its equity value is greater than $500,000 (in some states up to $750,000).
Covered Services	The specific services that will be paid for by a health insurance or LTC insurance policy as described in the policy. The policy also specifies the terms and conditions that a provider must meet to be considered a covered service under the policy (e.g., hold a certain type of license, registration, or certification).
Custodial Care (Personal Care)	Also called personal care, non-skilled service or care, such as help with bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. May also include care that most people do themselves, such as using eye drops.
Daily Maximum (or Daily Benefit Maximum)	Specified dollar amount that is the maximum amount paid per day for covered services. Policies may pay the full daily maximum regardless of the cost of care or may pay a percent of actual expenses up to the specified daily maximum amount. Some policies specify a single Daily Maximum for all covered services (for example, nursing home care, assisted living facility, home care) and other policies have one Daily Maximum for nursing home care and a lower amount for other covered services.

Term	Definition
Deductible Period	Specified amount of time at the beginning of a disability during which covered services are received, but for which the policy will not pay benefits (also known as an Elimination Period or Benefit Waiting Period). A Service Day Deductible Period is satisfied by each day of the period on which you receive covered services. A Calendar Day or Disability Day Deductible Period doesn't require that you receive covered services during the entire deductible period, but only requires that you meet the policy's benefit triggers during that time period.
Deficit Reduction Act of 2005	Legislation passed by the U.S. Congress and signed into law in December 2005 that is designed to trim the Federal deficit. It includes major changes in the Federal Medicaid policy.
Dementia	Deterioration of intellectual faculties due to a disorder of the brain.
Diabetes	A metabolic disease in which the body is unable to produce any or enough of the hormone insulin, which causes elevated levels of glucose (sugar) in the blood.
Disability Method	Method of paying long-term care insurance benefits that only requires you to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit in a cash payment for each day on which you are disabled, whether or not you incur expenses for LTSS.
Disabled	For Medicaid eligibility purposes, a disabled person is someone whose physical or mental condition prevents him or her from doing enough work or the type of work needed for self-support. The condition must be expected to last for at least a year or be expected to result in death. Persons receiving disability benefits through Supplemental Security Income (SSI), Social Security, or Medicare automatically meet this criterion.
Disclosure Form	Also called Outline of Coverage, is a description of benefits, exclusions, and provisions of a long-term care insurance policy. Most state laws specify the format and content of the Outline of Coverage. The Outline of Coverage must be provided to a prospective applicant for insurance before the application is taken.
Do Not Resuscitate Order (DNR)	Written order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. A DNR order may be instituted on the basis of an Advance Directive from a person, or from someone entitled to make decisions on their behalf, such as a health care proxy. In some jurisdictions, such orders can also be instituted on the basis of a physician's own initiative, usually when resuscitation would not alter the ultimate outcome of a disease. Any person who does not wish to undergo lifesaving treatment in the event of cardiac or respiratory arrest can get a DNR order, although DNR is more commonly done when a person with a fatal illness wishes to die without painful or invasive medical procedures.
Dressing	Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. One of the six Activities of Daily Living.
Durable Power of Attorney	Legal document that gives someone else the authority to act on your behalf on matters that you specify. The power can be specific to a certain task or broad to cover many financial duties. The power can be given to start immediately or upon mental incapacity. To be valid the document must be signed by you before you become disabled.

Term	Definition
Eating	Feeding oneself by getting food into the body from a receptacle, such as a plate, cup or table, or by a feeding tube, or intravenously. It is one of the six Activities of Daily Living.
Elimination Period	Specified amount of time at the beginning of a disability during which covered services are received, but for which the policy will not pay benefits (also known as a Deductible Period or Benefit Waiting Period). A Service Day Deductible Period is satisfied by each day of the period on which you receive covered services. A Calendar Day or Disability Day Deductible Period doesn't require that you receive covered services during the entire deductible period, but only requires that you meet the policy's benefit triggers during that time period.
Equity Value	Fair market value of property minus any encumbrances on the property such as mortgages or loans.
Estate Recovery	The process by which Medicaid recovers an amount of money from the estate of a person who received Medicaid. The amount Medicaid recovers cannot be greater than the amount it spent on the person's medical care.
Exempt Assets	Also called Non-countable Assets. Are assets whose value is not counted in determining financial eligibility for Medicaid. They include personal belongings, one vehicle, life insurance with a face value under $1500, and your home, if your spouse or child lives there or its equity value is less than $500,000 ($750,000 in some states).
Expense-Incurred Method	Also called Reimbursement Method. Most common method of paying long-term care insurance benefits. Your policy or certificate will pay benefits when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage pays for the lesser of the expense you incurred or the dollar limit of your policy.
Fair Market Value	Value of a property if sold at the market's current prevailing price.
Federal Housing Administration (FHA)	A US government agency created as part of the National Housing Act of 1934. The goals of this organization are: to improve housing standards and conditions; to provide an adequate home financing system through insurance of mortgage loans; and to stabilize the mortgage market.
Federal Poverty Level (FPL)	Income standard that is issued annually by the Federal government and that reflects increases in prices, as measured by the Consumer Price Index.
Fee For Service	Method of paying providers, which pays a fixed amount for each service provided. In Medicaid programs, Fee for Service gives Medicaid recipients the choice to receive care from any Medicaid participating provider for medical services.
Financial Eligibility	Assessment of an individual's available income and assets to determine if he or she meets Medicaid eligibility requirements.
Financial Planner	A qualified professional who analyzes a client's status and sets a program to achieve his or her long-term financial goals. Planners specialize in tax planning, asset allocation, risk management, retirement, and/or estate planning.

Term	Definition
Flexible Savings Account (FSA)	Pre-tax savings accounts allow employees to put aside pre-tax dollars to use for certain eligible expenses that are not covered by other benefit plans. With these accounts, an individual can be reimbursed for expenses with money set aside from earnings and not subject to federal income or Social Security tax. The most typical type of FSA expenses are specific to health and medical care and include out-of-pocket expenditures for hospital care, doctor visits and prescription drugs. There is an annual maximum amount that can be set aside on a tax-free basis for use within an FSA.
Formal Care	Paid services and supports that are provided by agencies or other professionals. Formal care is the alternative to informal care—that provided by unpaid friends or family members.
Free-Look	Typically, a 30-day period following receipt of a long-term care insurance policy during which you may return it for any reason for a full refund of any premiums paid.
Functional Eligibility	Assessment of an individual's care needs to determine if he or she meets Medicaid eligibility requirements for payment of long-term care services. The assessment may include a person's ability to perform Activities of Daily Living and/or the need for skilled care.
Future Purchase Option (FPO)	Form of Inflation Protection in a long-term care insurance policy, where the insured is offered the change to purchase an increase in benefits on a regularly scheduled period time frame (for example, annually or every three years).The increased amount is intended to reflect increases in the cost of care. Increases can be elected without providing evidence of insurability as long as the insured is not receiving benefits at the time. (Some policies also make the FPO even if the individual is receiving benefits).Other conditions may also apply. The insured pays an additional premium cost only for the amount of increased benefit which she elects to accept. Terms of the FPO vary from one company to another.
General Medicaid Eligibility Requirements	Residency and citizenship criteria for Medicaid applicants: You must be a resident of the state where you are applying; be either a United States citizen or a legally admitted alien; and be 65 or over or meet Medicaid's rules for disability, or be blind.
Group Home	Also called Board and Care Home. Is a residential private homes that are designed to provide housing, meals, housekeeping, personal care services, and supports to frail or disabled residents. At least one caregiver is on the premises at all times. In many states, Board and Care Homes are licensed or certified and must meet criteria for facility safety, types of services provided, and the number and type of residents they can care for. Board and Care Homes are often owned and managed by an individual or family that is involved in the every day operation of the home.
Group Policy	A group policy is an insurance coverage plan in which individual employees or members of another group are included under one master policy owned by the employer or group sponsor. Because the group insurance plan typically has a large number of participants, the policy often provides coverage for more services at a lower premium cost per participant. In LTC, group plans are sponsored by employers, CCRCs, multiple employer trusts and other qualifying groups. The insured individuals have a certificate of insurance and with LTC, their coverage is fully portable even after they discontinue their relationship with the sponsoring group. Group LTC insurance follows almost all the same rules and regulations as individual coverage, especially with regard to all the important consumer protections.

Term	Definition
Guaranteed Renewable	Describes a long-term care insurance policy that cannot be cancelled by an insurance company unless benefits have been exhausted or premiums have not been paid as due. The company cannot change the coverage or refuse to renew coverage for other than nonpayment of premiums, including health conditions and/or marital or employment status. In a guaranteed renewable policy, the insurance company may increase premiums only on an entire class of policies, not just on your policy.
Hands-On Assistance	Physical assistance from another person, without which the individual would not be able to perform an Activity of Daily Living.
Health Care Directive	Also called Advanced Directive, Advanced Health Care Directive, Living Will, or Health Care Directive. Legal document used to specify whether you would like to be kept on artificial life support if you become permanently unconscious, or are otherwise dying and unable to speak for yourself. It also specifies other aspects of health care you would like under those circumstances.
Health Care Proxy	Legal document in which you name someone to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions for yourself.
Health Insurance Portability and Accountability Act (HIPAA)	Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.
Health Savings Account (HSA)	Health Savings Accounts (HSAs) were created by the Medicare bill signed by President Bush in December 2003. They are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. A HAS is a special count owned by an individual used to pay for current and future medical expenses, including long-term services and supports. HSAs are used in conjunction with a "high deductible health plan" that meets specific federal requirements.
High Blood Pressure	Blood pressure is the force of blood pushing against the blood vessel walls. High blood pressure is when that force, as measured by a blood pressure cuff, is elevated above normal limits.
High Deductible Health Plan	A product that combines a Health Savings Account or a Health Reimbursement Arrangement with traditional medical coverage. It provides insurance coverage and a tax-advantaged way to help save for future medical expenses.
Home and Community-Based Waiver Services	Services offered to Medicaid recipients in their homes, the provision of which prevents them from having to enter a nursing home. The services offered and populations served vary from state to state. Generally individuals need to have a level of impairment that would other require them to be in a nursing home (called "nursing home certifiable") in order to qualify for these services.
Home Electronic Monitoring Systems	Monitored electronic communication systems designed to enable seniors and the disabled to continue living in their own while providing prompt access to emergency services or assistance if needed. In many such systems, the individuals wears a necklace or monitoring device and presses a button to signal the need for help.

Term	Definition
Home Equity	The current market value of a home minus the outstanding mortgage balance. Home equity is essentially the dollar value amount of ownership that has been built up by the holder of the mortgage through payments and the appreciation of the home's value.
Home Equity Conversion Mortgage (HECM)	FHA-insured reverse mortgages available to homeowners ages 62 and older to convert the equity in a home into a monthly stream of income and/or a line of credit to be repaid when they no longer occupy the home. The loan is funded by a lending institution such as a mortgage lender, bank, credit union or savings and loan association. The homeowner is required to receive consumer counseling and HUD-approved HECM counselor prior to undertaking the loan.
Homemaker / Chore Services	Homemaker/chore services can help you with general household activities such as meal preparation, routine household care, and heavy household chores such as washing floors, windows or shoveling snow.
Hospice Care	Short-term, supportive care for the terminally ill (life expectancy of six months or less) that focuses on pain management, and emotional, physical, and spiritual support for the patient and family. It can be provided at home, in a hospital, nursing home, or a hospice facility. Hospice care is typically paid for by Medicare and is not usually considered long-term care. However, most LTC insurance policies will provide in-home or facility-based care and support as a policy benefit when someone is terminally ill and needs hospice care. The benefit may be provided often without requiring the insured to satisfy the elimination period. The benefit also coordinates with (but does not duplicate) benefits provided by Medicare or one's health insurance.
Income	Money received in exchange for providing a good or service or through investing capital. Most people age 65 and under receive the majority of their income from a salary or wages earned from a job. Investments, pensions, and Social Security are primary sources of income for retirees.
Income Cap	Income level in certain states impose on persons applying for Medicaid payment of nursing facility services. Persons with income greater than the income cap are not eligible for Medicaid. As of 2014, the following are income cap states: Alabama, Alaska, Arizona, Colorado, Delaware, Florida, Georgia, Idaho, Iowa, Kentucky, Mississippi, Nevada, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, and Wyoming.
Incontinence	Inability to maintain control of bowel and bladder functions; or when unable to maintain control these functions, the inability to perform associated personal hygiene (including caring for a catheter or colostomy bag). Continence is one of the six Activities of Daily Living.
Indemnity Method	Method of paying benefits where the benefit is a set dollar amount, without regard to the amount of the expense incurred, as long as there is an expense incurred for a covered service. The insurance company decides if you are eligible for benefits and if the services you receive are covered under the policy. The cost of specific services is not important in determining the amount of benefits paid. The insurance company pays benefits directly to you up to the limit of the policy.

Term	Definition
Inflation Protection	Provision of a long-term care insurance policy by which benefits increase over time, either automatically or at the option of the person insured by the policy, to help offset future increases in service costs. There are many different ways that policies structure their inflation protection options. Every tax-qualified plan must offer a 5% compound annual inflation protection option and may offer others as well. Consumers can decline the offer, or purchase one of may other types of inflation protection.
Informal Care	Care provided by family members or friends who are not paid to provide care.
Informal Caregiver	A family member, friend, or any other person who provides LTSS without pay.
Instrumental Activities of Daily Living (IADL)	Are activities needed for living an independent life that require a higher level of skill or judgment than the basic Activities of Daily Living (ADL). These include using the telephone, shopping, preparing meals, managing finances, managing medication, using transportation and the like. Impairment in these IADLs often precedes impairment with ADLs and may indicate that a need for LTSS is forthcoming. Because needing help with IADLs is often cultural or situational and not based on functional or cognitive needs, these losses are not considered reliable measures of when someone needs LTSS.
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Facilities that provide care for mentally retarded adults. Residents may have a job or attend occupational therapy during the day, but return to the facility at night.
Individual Retirement Account (IRA)	An IRA and related vehicles were created by amendments to the Internal Revenue Code. IRAs are investments used by individuals to earn and earmark funds for retirement savings. There are several types of IRAs: Traditional, Roth, SIMPLE, and SEP.
Lapse	Termination of a long-term care insurance policy when a renewal premium is not paid when due. Policies include a 65-day grace period as well as a provision to restore coverage if a payment was missed because the individual was functionally or cognitively impaired.
Lien	The right of a person or entity to claim lawful possession of the property of another until the owner fulfills a legal duty to this person or entity. For example, a mortgage is a lien on a property until the full amount borrowed on the property is paid back to the lender according to the terms of the loan agreement or a contractor might have a lien on a property until charges for work done on the property are paid by the owner.
Life Estate	This refers to the right someone has to use or occupy real property for the term of his life.
Life/LTC Hybrid	A combination product that bundles a long-term service or support benefit with either a life insurance policy or an annuity. Hybrid products are underwritten for both mortality and long-term care risk.
Life Settlement	The sale of a life insurance policy to a third party for an amount in excess of its cash surrender value. The third party becomes the beneficiary of the policy and takes over the payment of any premiums going forward. The insured does not have to have impaired health or be diagnosed as terminal (as with viatical settlements), but usually has to be over age 65.

Term	Definition
Lifetime Benefit Maximum	The total amount of all benefits potentially payable under a long-term care insurance policy during the life of the policy.
Lifetime Coverage	Also called unlimited coverage. A long-term care insurance benefit period. Some insurers sell lifetime coverage that has no dollar limit—the insured person receives benefits as long as long-term care is needed. However, many insurers no longer offer unlimited coverage and instead might offer a high lifetime benefit amount (e.g., $1,000,000).
Limited Payment Option	A long-term care insurance premium payment option in which the person pays premiums for a set time period (e.g., 10 or 20 years) or only up to a certain age (e.g., 65). After the last premium payment, neither the company nor the person can cancel the policy. These plans are more expensive than continuous payment policies. Some policies reserve the right to charge an additional premium if rates change on a class basis, even if your policy is paid-up.
Living Will	Also called Health Care Directive, Advanced Health Care Directive, Living Will, or Health Care Directive, is a legal document used to specify whether you would like to be kept on artificial life support if you become permanently unconscious or are otherwise dying and unable to speak for yourself. It also specifies other aspects of health care you would like under those circumstances.
Long-Term Care Facility	Also called Long Nursing Home or Convalescent Care Facility, is a licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.
Long-Term Care	Variety of services and supports to meet health or personal care needs over an extended period of time.
Long-Term Care Insurance	Specific type of insurance policy designed to help provide financial support to pay for necessary LTSS.
Long Term Services and Supports (LTSS)	Services that include medical and non-medical care to people with a chronic illness or disability LTSS help meet health or personal needs, also called long-term care. Most LTSS assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Care can be provided at home, in the community, or in a facility. For purposes of Medicaid eligibility and payment, LTSSs are those provided to someone requiring a level of care equivalent to that received in a nursing facility.
Lookback Period	Five-year period prior to a person's application for Medicaid payment of LTSS. The Medicaid agency determines if any transfers of assets have taken place during that period that would disqualify the applicant from receiving Medicaid benefits for a period of time called the penalty period.
Medicaid	Joint federal and state public assistance program for financing health care for the poor. It pays for health care services for those with low incomes or very high medical bills relative to income and assets. It is the largest public payer of LTSS.
Medical Power of Attorney	Legal document that allows you to name someone to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions for yourself.

Term	Definition
Medical Underwriting	The process of selecting those people who can receive insurance and those who cannot. The purpose of underwriting is to balance the risks of needing LTSS across a typical group of people by excluding from the insurance program people who are already in need of care or who are known to be at great risk of needing care in the future.
Medicare	Federal program organized under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965. It provides hospital and medical expense benefits for those individuals over age 65, or those meeting specific disability standards. Benefits for nursing home and home health services are limited.
Medicare Supplement Insurance	Also called Medigap coverage, is a private insurance policy that covers gaps in Medicare coverage.
Medigap Insurance	Also called Medicare Supplement Insurance, is a private insurance policy that covers gaps in Medicare coverage.
Miller Trust	Also called qualifying income trust, is an income trust that is used in states that require a Medicaid recipient's income to be less than a state-designated level. Such trusts must contain a provision allocating all monies remaining in the trust (up to the amount paid for medical assistance) to the state upon the death of the recipient.
Minimum Monthly Maintenance Needs Allowance (MMNA)	Amount of income a community spouse is allowed to retain each month. This amount varies by state, but is based on a range of amounts stated in federal guidelines, which are adjusted annually. The amount is based on a Federally regulated formula that takes into account the community spouse's actual housing costs.
Motor Vehicle No-fault Law	A law governing automobile insurance in some states. The no-fault system is intended to lower the cost of auto insurance by taking small claims out of the courts. Long-term care policies typically exclude services for which benefits are available under a motor vehicle no-fault law.
National Association of Insurance Commissioners (NAIC)	Membership organization of state insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance. The NAIC develops "model" or sample regulations for each type of insurance and encourages states to adopt those "models" rather than having them each have to research and develop their own regulations from scratch.
Non-Cancelable Policy	Insurance contract that cannot be cancelled by the insurance company and the rates cannot be changed by the insurance company. Except for a single pay (paid-up) policy, no insurer today currently offers non-cancelable long-term care policies.
Non-Countable Assets	Also called exempt assets, are assets whose value is not counted in determining financial eligibility for Medicaid. They include personal belongings, one vehicle, life insurance with a face value under $1500, and your home if your spouse or child lives there or its equity value is less than $500,000 ($750,000 in some states).

Term	Definition
Non-Forfeiture Benefits	Long-term care insurance policy feature that either returns at least part of the premiums to you if you cancel your policy or let it lapse, or that extends our coverage on a limited basis (e.g., 30 days of care) even if you stop paying. This is usually an optional rider an individual can choose to include in their policy for an additional premium.
Nursing Home	Also called Long-Term Care Facility or Convalescent Care Facility, is a licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.
Osteoporosis	Bone disease characterized by a reduction in bone density. The bones become porous and brittle, as a result of calcium loss. Someone with osteoporosis is more vulnerable to breaking a bone.
Outline of Coverage	Also called Disclosure Form, is a description of benefits, exclusions, and provisions of a long-term care insurance policy. Most state laws specify the format and content of the Outline of Coverage. The Outline of Coverage must be provided to a prospective applicant for insurance before the application is taken.
Partnership Policy	Private long-term care insurance policy that allows an individual to protect (keep) some or all of their assets if they apply for Medicaid after using up their Partnership policy's benefits. New federal legislation, the Deficit Reduction Act of 2005, allows any state that wishes to do so to establish a Partnership Program. Under a Partnership Policy, generally, the amount of Medicaid spend-down protection you receive is equal to the amount of benefits paid to you under your private Partnership policy (State-specific program designs may vary).
Penalty Period	Specified period during which a person is disqualified from receiving Medicaid because of a transfer of assets. The length of the penalty period is determined by dividing the amount of transferred assets by the average monthly cost of private nursing home payment.
Personal Care	Also called custodial care, non-skilled service or care, such as help with bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. May also include care that most people do themselves, such as using eye drops.
Personal Needs Allowance	Designated portion of monthly income that a person receiving Medicaid long-term care services may retain for personal needs. This amount includes food and shelter costs for persons receiving home and community-based waiver services. The amount allowed varies from state to state.
Pooled Trust	Trust established and managed by a nonprofit organization that pools the assets in the trust for investment purposes. A separate account is maintained for each beneficiary, and the parents, grandparents, legal guardian, or court must have created the account on behalf of a disabled individual under age 65. The trust must contain a provision that the state be named beneficiary upon the death of the disabled individual in an amount up to the amount spent by Medicaid on the individual's behalf.
Pre-Existing Condition	Condition for which medical advice or treatment was recommended by or received from a health care provider within a stated time period prior to the effective date of insurance coverage (for example, 6-12 months). Few long-term care insurance policies sold today have exclusions from coverage for a pre-existing condition but older policies may have this.

Term	Definition
Pre-Existing Condition Exclusion	Policy provision that excludes coverage for a period of time (for example, 6-12 months) immediately following the effective date of coverage, if the care needed is the result of a condition that existed prior to the individual's policy. The exclusion may apply to any long-term care need due to the pre-existing condition, which begins during the specified period of time, or it may only exclude coverage during the specified period of time. Most policies today do not have any pre-existing condition exclusions.
Premium	The specified amount of payment required periodically by an insurer to provide coverage under a given plan for a defined period of time. The premium is paid by the insured party and primarily compensates the insurer for bearing the risk of a payout should the insurance agreement's coverage be required.
Private Care Manager	An agency or professional that helps to identify and coordinate services. Even if there is no immediate need for services, a care manager can assist with planning for future needs. Care managers are also particularly useful in helping caregivers cope with their burdens.
Probate	Process to determine assets that are available in an estate that is left to heirs through a decedent's will.
Property Essential to Self-Support	Property, such as a farm, that is essential to trade or business and is currently being used by and/or providing income to the Medicaid applicant or the applicant's spouse.
Qualifying Income Trust	Also called Miller trust. An income trust that is used in states that require a Medicaid recipient's income to be less than a state-designated level. Such trusts must contain a provision allocating all monies remaining in the trust (up to the amount paid for medical assistance) to the state upon the death of the recipient.
Reduced Paid-Up Benefits	A nonforfeiture option in a long-term care insurance policy that reduces your daily benefit but retains the full benefit period on your policy until death. For example, you buy a policy for three years of coverage with $150 daily benefit: If you let the policy lapse, the daily benefit will be reduced to $100. The exact amount of the reduction depends on how much premium you have paid on the policy. The benefit period continues to be three years. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use reduced paid-up benefits at any time after the lapse (until death).
Reimbursement Method	Also called Expense-Incurred Method. Most common method of paying long-term care insurance benefits. Your policy or certificate will pay benefits when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage pays for the lesser of the expense you incurred or the dollar limit of your policy.
Rescind	When an insurance company voids/cancels a policy. There are strict guidelines for both the timeframe and the reasons that an insurance company may do this. Generally, an individual has to have provided fraudulent information or made material misstatements on their application in order for the insurer to have the right to rescind coverage.
Respite Care	Temporary care given by a Nursing Home, Adult Day Service Center, or private party for a person receiving long-term care services, which is intended to provide time off for those informal caregivers who ordinarily care for that person on a regular basis. Respite care is usually short-term typically 14 to 21 days of care per year.

Term	Definition
Reverse Mortgage	New type of loan based on home equity that enables older homeowners (62+) to convert part of the equity in their homes into tax-free income without having to sell the home, give up title, or take on a new monthly mortgage payment. Instead of making monthly payments to a lender, as with a regular mortgage, a lender makes payments to you. The loan, along with financing costs and interest on the loan, does not need to be repaid until the homeowner dies or no longer lives in the home.
Reverse Mortgage Annuity	An option available to homeowners who wish to convert the equity in their homes into a stream of income payments over a defined period of time. Homeowners must be at least 62 years old. Loan funds can be used for care, adaptive home modifications, or to pay for long-term care insurance.
Rider	Addition to an insurance policy that changes the provisions of the policy. The rider is added at the election of the insured or applicant and may be available with or without an additional premium charge. An insurer cannot change or amend terms of a policy once issued unless such change does not reduce benefits or increase premium costs.
Self-Pay	Paying for health care or long-term care expenses out of pocket rather than relying on insurance to cover costs. Generally, this option is only used by those who have considerable investment assets and income.
Shortened Benefit Period	Nonforfeiture option in a long-term care insurance policy that reduces the benefit period, but retains the full daily maximums applicable until death. The period of time for which benefits are paid is shorter. For example, you buy a policy for three years of coverage with $150 daily benefit, but if you let the policy lapse. The benefit period is then reduced to one year, with full daily benefits paid. The exact amount of the reduction depends upon how much premium you have paid on the policy. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use shortened benefits at any time after you let the premium lapse (until death).
Single Pay Option	A long-term care insurance premium payment option where, instead of making annual (or other periodic) payments for the rest of his life (or until the premium waiver is activated), the insured makes one large premium deposit and receives a fully paid-up policy. While expensive, this type of payment option offers a protection against possible future rate increases.
Skilled Care	Nursing care (such as help with medications, caring for wounds) and therapies (such as occupational, speech, respiratory and physical therapy). Skilled care usually requires the services of a licensed professional (such as a nurse, doctor or therapist).
Skilled Care Needs	Services requiring the supervision and care of a nurse or physician, for example assistance with oxygen, maintenance of a feeding tube, or frequent injections.

Term	Definition
Social Security	In the United States, the Social Security Program was created in 1935 to provide old age, survivors, and disability insurance benefits to workers and their families. Unlike welfare, social security benefits are paid to an individual or his or her family at least in part on the basis of that person's employment record and prior contributions to the system. The program is administered by the Social Security Administration (SSA) and since 1965 it has included health insurance benefits under the Medicare program. The Federal Old Age, Survivors, and Disability Insurance (OASDI) pays out monthly benefits to retired people, to families whose wage earner has died, and to workers unemployed due to sickness or accident. Workers qualify for its protection by having been employed for a minimum amount of time and by having made contributions to the program. From http://topics.law.cornell.edu/wex/social_security
Special Needs Trust	Trust established by a parent, grandparent, court, or legal guardian solely for the benefit of a disabled individual who was under the age of 65 when it was created. The trust must contain a provision that the state be named beneficiary upon the death of the disabled individual in an amount up to the amount spent by Medicaid on the individual's behalf.
Spend Down	Requirement that an individual use most of his or her income and assets to meet Medicaid eligibility requirements.
Standby Assistance	Caregiver stays close by the individual to watch over the individual and provide physical assistance if necessary as they perform Activities of Daily Living. Someone who does not need hands-on help might need standby assistance if they are unsteady or have physical movement limitations. Standby assistance generally refers to the need for someone to be within arm's length to provide help if needed.
State Health Insurance Program	Federally funded program to train volunteers to provide counseling on the insurance needs of senior citizens.
Substantial Assistance	Hands-on or standby help required to perform Activities of Daily Living.
Substantial Supervision	Presence of person directing and watching over another an individual who has a cognitive impairment.
Supervisory Care	Long-term care service for individuals with memory or orientation problems, such as Alzheimer's disease. Supervision ensures that you don't harm yourself or others because your memory, reasoning, and orientation to person, place or time are impaired.
Supplemental Security Income (SSI)	A federal income supplement program funded by general tax revenues. The program pays monthly benefits to people with limited income and resources who are blind or have other disabilities. Benefits also are payable to people 65 and older without disabilities, if they meet the financial requirements.
Tax-Qualified Long-Term Care Insurance Policy	Long-Term Care Insurance policy that conforms to certain standards in Federal law and offers certain Federal tax advantages.

Term	Definition
Term Life Insurance	Life insurance policy that covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build cash value.
Third Party Designation	Also called Third Party Notice or Added Protection Upon Lapse. Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer.
Third Party Notice	Also called Third Party Designation or Added Protection Upon Lapse. Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer.
Toileting	Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. One of the six Activities of Daily Living.
Transfer of Assets	Giving away property for less than it is worth or for the sole purpose of becoming eligible for Medicaid. Transferring assets during the Lookback period results in disqualification for Medicaid payment of LTSS for a penalty period.
Transferring	Moving into and out of a bed, chair or wheelchair. One of the six Activities of Daily Living.
Transient Ischemic Attack (TIA)	A "warning" stroke that occurs when the blood supply to part of the brain stops briefly. A TIA is different than a stroke because the blockage is transient (temporary). TIA symptoms occur rapidly and last a relatively short time—most fewer than five minutes. A TIA usually causes no permanent injury to the brain. About 1 in 3 people who have a TIA will eventually have a stroke.
Trust	A trust is a relationship whereby property is held by one party for the benefit of another. A trust is created by a settlor, who transfers property to a trustee. The trustee holds that property for the trust's beneficiaries.
Underwriting	Process of approving or denying applications for insurance. The purpose of underwriting is to balance the risks of needing insurance across a typical group of people by excluding from the insurance program people who are already in need of LTSS or who are known to be at great risk of needing care in the future.
Universal Life Insurance	Flexible life insurance policy that lets you vary your premium payments and adjust the face amount of your coverage.
Unlimited Coverage	See Lifetime Coverage.

Term	Definition
Viatical Settlement	A plan that allows one to sell a life insurance policy to a third party and use the money to pay for long-term care. A viatical settlement is like a life settlement, but it is only possible for the terminally ill. During settlement, a company pays a percentage of the death benefit on the life insurance policy, which is based on life expectancy. The viatical company then owns the policy and is its beneficiary. The viatical company also takes over payment of policy premiums.
Voluntary Benefit	Optional products offered through an employer but paid for partially or solely by workers through payroll deferral. Voluntary life insurance premiums may be less expensive than individual life insurance premiums because of an employee group discount.
Waiver of Premium	Long-term care insurance policy provision that suspends premium payment after a specified period of time, during which the insured is receiving benefits for long-term care services. The suspension continues until recovery, at which time premium payments resume. Most, but not all, policy benefits qualify for a waiver of premium. Short-term respite care might be an example of a benefit that would not cause premiums to be waived.
Whole Life Insurance	Life insurance policies that build cash value and cover a person for as long as he or she lives, if premiums continue to be paid.
Workers' Compensation	A system whereby an employer must pay, or provide insurance to pay, the lost wages and medical expenses of an employee who is injured on the job. This form of insurance is in exchange for mandatory relinquishment of the employee's right to sue his or her employer for the tort of negligence.

Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form number(s)_____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy: (noncancellable/guaranteed renewable):_____

The Company's right to increase premiums:_____

[The company cannot raise your rates on this policy]. [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state]. [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form].

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state]. [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years]. [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s)].

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 premiums?
☐ 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 were raised, 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 noncancellable policy.

What is your annual income? (check one)
☐ Under $10,000 ☐ $10,000-20,000 ☐ $20,000-30,000 ☐ $30,000-50,000 ☐ 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 will you pay for the difference between future costs and your daily benefit amount?
☐ From my Income ☐ From my Savings\Investments ☐ Family will pay

The national average annual cost of care in [insert year] was $[46,000], but this figure varies across the country. In ten years the national average annual cost would be about $[_____] 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 Income ☐ From my Savings\Investments ☐ Family will pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation.

or

☐ I choose not to complete this information.

(Check one.)

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____ _____

(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application].

Signed: _____ _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care

A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the Company can increase premiums in the future.

The Personal Worksheet includes questions designed to help you and the Company determine whether this policy is suitable for your needs.

Medicare

Medicare does not pay for most long-term care.

Medicaid

Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.

Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Long-Term Services And Supports: A Fact Sheet

What are Long-Term Services and Supports LTSS?

- Help from another person with everyday activities such as bathing, dressing, or feeding — also called Activities of Daily Living (ADLs). You may need help with these everyday tasks because of an accident, disability, chronic illness or due to the frailty of old age.
- You may need care for a short time, perhaps to recover from an accident or illness, or for a long time because of a chronic illness, disability or cognitive impairment such as Alzheimer's Disease.
- You may receive LTSS at home or in a nursing home, assisted living facility or adult day care center.
- LTSS may be provided by a family member or friend, a home health aide, a nurse or other paid professional. Usually people receive a variety of types of care from a variety of types of providers over their lifetime.
- Also called long-term care (LTC).

What Are Your Chances of Needing LTSS?

For people over age 65:

- About 70% will need some type of LTSS at some point in their lives. Some will need it for only a short time or might only need care from family members. Others may need care for an extended time and as a result may incur significant care-related expenses.
- About 40% will need nursing home care sometime during their lives.

Younger people may also need LTSS because of an accident, heart attack, stroke or other reason. Of the 13 million Americans in need of LTSS today, nearly 40% of them are between the ages of 18 and 64.[1]

What Does it Cost to Pay for LTSS?

LTSS can be expensive. In 2014, the average cost of one year of care in a nursing home was more than $85,000 for a semi-private room. One year of care at home, based on a mix of both free family care and paid care, costs over $35,000. But keep in mind that care at home costs vary greatly based on the frequency and type of care that is needed. Care in an adult day care center costs about $69 per day. Finally, a month in 1-bedroom unit in an assisted living facility costs over $4,200, but there may be additional personal care costs if you need help with ADLs.

Many people receive care from both family members and friends as well as care from paid providers. Considering individuals who receive at least some paid care, the average lifetime expenditure on LTSS, after age 65 (expressed in 2014 dollars), is roughly $213,000. For a female, this figure is higher ($247,000) as compared to $161,000 for a male. Keep in mind that these are just averages. Some people have little or no costs while others, who need care for a longer time and/or who do not have family upon whom they can rely, will see greater costs.

Who Pays for LTSS?

Most of the costs for LTSS are paid out of pocket from a person's income and assets.

Medicare pays only for skilled care and only when several stringent conditions are met. Private health insurance and disability insurance generally do not cover LTSS .

Medicaid pays for LTSS but there are strict income and asset guidelines to qualify. There are also certain health and disability eligibility requirements. With Medicaid, choice and care options are limited.

Planning ahead can help you evaluate the best strategies for paying for LTSS in the event that you need care in the future. Your counselor can help you plan based on your own personal circumstances, needs, and preferences.

[1] Source: GAO report.

A Closer Look at Medicaid and Long-Term Care

Medicaid is a joint federal and state government program that helps pay medical costs for some people with limited incomes and resources. People with Medicaid may get coverage for services such as nursing home and home health care, but only if they meet all of the eligibility requirements for Medicaid. Who is eligible and what services are covered vary from state to state. Most often, eligibility is based on your income and personal resources, but for coverage of LTSS, you generally must also meet certain health or functional criteria to be eligible.

Within federal guidelines, each state decides what services to cover under its Medicaid program and the financial criteria for eligibility for Medicaid services. For applicants who are not married, the financial criteria for Medicaid eligibility are quite strict. In most states, applicants cannot have more than $2,000 in countable assets (not including their homes). For married applicants, the asset maximum is slightly higher. All applicants must provide a complete record of their finances, including both income and assets. The state decides whether the applicant meets the financial requirements for Medicaid coverage.

Many people do not qualify for Medicaid coverage when they first need LTSS. However, the expenses associated with LTSS may deplete their financial assets to the point at which they may qualify financially for Medicaid coverage.

For qualified applicants, most state Medicaid programs provide a relatively broad package of LTSS, including nursing home care and, on a more limited basis, home and community-based services. However, there may be waiting lists to get home and community-based services, and long-term care providers are not required to accept Medicaid patients, and some do not — limiting the choice of providers.

If a client thinks he qualifies for Medicaid or would quickly become eligible if he needed long-term care services, you should counsel them not to buy long-term care insurance. Long-term care insurance is only for people who have significant assets to protect (at least $50,000 not counting their house).

Planning "IQ" Quiz

This quiz is designed to provide a quick impression of how much "planning" for LTSS you may have done. It will also give you ideas for easy "first steps" to take. Answer each question below YES or NO.

1. **Is it possible that you might someday need long-term services or supports (LTSS)?**

   Yes ☐ No ☐

2. **Do you have a good sense of how much LTSS costs?** For example, have you looked into what it would cost if you ever needed nursing home care? Or looked into what community-based services are available to provide care in your home and what they cost? (Specifically, have you visited or called nursing homes or home healthcare agencies to find out what they cost? Or do you know first-hand what they cost because someone in your family has needed care?)

   Yes ☐ No ☐

3. **Have you ever talked with your spouse, adult children, friends or siblings about whether they would want to or be able to care for you if you became ill or disabled for a long time**? Or have you ever told them how you feel about relying on their help?

   Yes ☐ No ☐

4. **Have you ever looked into alternative living options,** such as moving in with family, moving to an assisted living facility, retirement community, continuing care community, moving to an easier-to-care for apartment or house or modifying your home to make it easier to get around and to care for?

   Yes ☐ No ☐

5. **Have you ever talked with a financial planner, insurance agent, attorney or other financial advisor** about how you would pay for long-term care services if you needed them?

   Yes ☐ No ☐

6. **Have you thought about how much of your current income and assets you could afford to set aside to pay for care expenses for LTSS** if you needed care due to an extended disability or illness?

   Yes ☐ No ☐

7. **Have you reviewed your current health care insurance** (Medicare, Medigap, HMO, etc.) to understand whether it would pay for your care if you needed LTSS for an extended disability or illness?

   Yes ☐ No ☐

8. **Have you specifically set aside funds to pay for LTS**S if you need it and done so in a way that assures you that you won't use these funds for anything else until you are certain that you won't need long-term care? This might include a medical IRA, long-term care annuity, long-term care insurance or reverse annuity mortgage.

   Yes ☐ No ☐

9. **Have you discussed with your family physician whether you might be at increased risk** for needing LTSS someday based on your medical and family history or lifestyle risk factors?

   Yes ☐ No ☐

10. **Have you ever read a consumer's guide about LTSS?**

   Yes ☐ No ☐

Now, give yourself one point for every "YES" answer.

7-10 "YES" ANSWERS. You have obviously given this topic some important consideration. Congratulations! By planning ahead, you can have more control over your care choices and the financial impact of paying for care. Planning ahead also provides important peace of mind for you and your loved ones.

4-6 "YES" ANSWERS. It is very good that you have given this important topic some consideration. That is a critical first step. Planning ahead for LTSS care needs is not easy, but it can pay off in terms of having more control over your care choices and your financial situation as you age. Planning ahead also provides important peace of mind for you and your loved ones.

0-3 "YES" ANSWERS. Unfortunately, you are not alone. Many of us do not plan far enough in advance for the possibility that we might need LTSS. It is easy to postpone thinking about something that we hope will never happen. But the reality is that most of us will need some type of extended care So, planning ahead is important. It gives you more control over your care choices and the financial impact of paying for care. Planning ahead also provides important peace of mind for you and your loved ones.

A Closer Look at Medicare and Long-Term Care

Medicare covers a limited subset of LTSS under special conditions. Medicare does not cover personal care assistance with activities of daily living, which comprises the majority of LTSS.

Medicare's Skilled Nursing Facility Care Benefit

Medicare's Skilled Nursing Facility benefit is a post-acute care benefit designed to help people recover from an acute care episode requiring a hospital stay. It does not cover custodial care in a nursing home.

Medicare will pay the full cost of the first 21 days a person spends in a nursing home, and costs in excess of $157.50/day (2015) for days 22 to 100, but only if **all** the following conditions are met:

1. The patient had a qualifying hospital stay of three consecutive days or more, not counting the day of discharge from the hospital (You must have inpatient status. Even if you are in the hospital overnight for "observation" you might not be considered an inpatient in some situations.)
2. The patient entered the nursing home within 30 days of leaving the hospital.
3. A doctor has determined that the patient needs daily skilled care.
4. The patient is receiving services in a Medicare-certified Skilled Nursing Facility.
5. The care received in the nursing home is for the same condition for which the patient was treated in the hospital.

In many cases, Medicare supplemental insurance (Medi-Gap) will cover the co-payment amount ($157.50 per day for coverage of days 22 through 100, in 2015).

Medicare's Home Health Benefit

Medicare covers some skilled nursing care and certain other health care services received at home if **all** the following conditions are met:

1. A doctor decides the patient needs medical care at home and approves a plan for care at home with a home health agency.
2. The patient needs at least one of the following services on a part-time basis, but not every day: skilled nursing care, physical therapy, speech/language pathology services or occupational therapy.
3. The patient is homebound. That means that the patient typically leaves home only infrequently and for a short time only, for example to attend religious services, get medical treatment, including therapeutic or psychosocial care or to get care in a licensed or certified adult day-care program.
4. The home health agency caring for the patient is approved by the Medicare program.

Most people who need LTSS do not need skilled nursing care and therefore do not qualify for Medicare home health care coverage. Also, most people with LTSS needs require continuous care (for example, a person who needs help eating needs help with every meal), not intermittent care (for example, a person needs a drain changed every three days or speech therapy once a week).

Many people with personal care needs, however, also have serious medical conditions, such as diabetes or chronic heart disease, which do require skilled nursing care in the home. They may qualify to receive skilled nursing visits under the Medicare program, but must arrange for their long-term care personal services through other means.

Private Long-Term Care Financing Options at a Glance

If consumer is uninsurable:

1. Home Equity options: Home Equity Line of Credit
   Reverse Mortgage
   Reverse Mortgage Annuity
   Sale
   Sale and Leaseback

2. **Existing** Life Insurance options: Accelerated Death Benefit
   Loans, Withdrawals, Policy Surrenders
   Viatical Settlement
   Life Settlement

3. Most Annuities: Deferred and Immediate (have medically underwritten if life expectancy is limited due to health condition)
4. Some Annuity/LTC Hybrids
5. Some Continuing Care Retirement Communities (CCRCs): Only the unbundled type with no paid LTC provided through contract

If consumer is older:

1. Home Equity options: Reverse Mortgage
   Reverse Annuity Mortgage
2. Life insurance options: Life Settlement
3. Continuing Care Retirement Communities (CCRCs): most types

If the consumer has a limited life expectancy:

1. Viatical Settlement
2. Medically underwritten annuity: in order to get maximum pay-out.

If the consumer is insurable:

1. Long-term Care Insurance (standalone or linked benefit products with life or annuity)
2. Continuing Care Retirement Communities (CCRCs): full service contracts

Long-Term Care Planning Worksheet

Consumer Name _____ Date _____

Information needed to assess the consumer's situation and to help determine appropriate options.

Objectives (check as many as applicable)

____ To protect financial resources and leave an inheritance
____ To avoid burdening others
____ To be able to choose the place and type of care
____ Peace of mind
____ To remain independent of others' support
____ To protect spouse or other dependents
____ To avoid relying on Medicaid

Health

____ Excellent – no chronic conditions or major events (stroke, etc.)
____ Good – minor health problems (one minor chronic condition like controlled hypertension)
____ Fair – one or more chronic conditions requiring medical supervision and/or hospitalization in last year
____ Poor – heart disease, pulmonary disease, cancer, diabetes w/ complications, stroke history

Family heath history

____ Family history of longevity
____ Family history of chronic illnesses (Alzheimer's, pulmonary, cancer, neurological)
____ No family history of chronic illness

Current Insurance Coverage

Medical insurance _____

Existing LTC coverage* _____

Other _____

Age_____ (Actual DOB: _____)

Actively at work? _____

Retired? _____

Assets and Income

Liquid assets (cash, bank accounts)_____

Qualified assets (pension plans, IRA's, 401K, etc.) _____

Non-qualified assets (stock accts., etc.) _____

Real estate: Primary residence_____

Second residence _____

Investment or other real property_____

Other assets (trusts, life insurance, etc.) _____

Total Assets: _____
If consumer does not wish to detail the assets, just ask for an approximate total value.

Earned income (approx date to end)_____

Investment income_____

Social Security income _____

Pensions _____

Support from family or divorce settlement _____

Total income: _____

Total discretionary income: (Total income minus total living expenses) _____

What is your current housing situation? (type of house—ranch, multi-level, etc.; size, etc. Is your current house aging-friendly or are modifications needed?)

Do you plan to move? When? Where? Why?

Have you considered any LTSS planning options already?

If yes, which ones? _____

What are trying to accomplish with this planning? (Ask the consumer to explain in his own words what he wants and why he wants to do this planning.)

_____

_____

*Please note that many people think they have LTC insurance but they may be confusing their coverage with a Medi-Gap policy, life insurance or disability. Ask the customer to provide the name of the insurance company and (ideally) provide some information about when it was purchased and the nature of coverage. It may be worth reviewing an older policy (pre-1996 and possibly more recent than that) to see if an alternative or second policy might not provide improved coverage. But before counseling about replacement, be sure to read the relevant sections on that topic.

Long-Term Care Insurance Policy Comparison Worksheet

Use this worksheet to compare two long-term care insurance policies. Answer as completely as possible. Use this as the basis for a direct comparison of features and benefits. Your counselor can help you complete this worksheet and understand the differences between the two policies. Use the Annotated Specimen Policy if you need help understanding key terms and provisions.

	Policy 1	Policy 2
Insurance Company		
Policy series or name		
Insurance company rating		
Agent		
Agent's contact information		
Tax-qualified?		
Partnership-qualified?		
Benefit triggers listed		
Activities of Daily Living (ADL's) listed		
Who certifies impairment and need?		
Types of care covered (enter skilled, custodial or both)		
Nursing homes?		

	Policy 1	Policy 2
Assisted living facilities?		
Care services covered?		
Room & board covered?		
Adult Day Care Centers?		
Home health care?		
Skilled & custodial services?		
Chore services?		
Non-agency affiliated providers (Independent Providers)?		
Family caregivers covered?		
Hospice - at home and/or facility?		
Respite care covered without requiring you meet an elimination period?		
Other care settings?		
What is the elimination period?		
Cumulative, once only?		
Care delivery required (service days) or impairment only (calendar days)?		
Combined for any type of care (facility care & home care?) or are separate Eps required?		

	Policy 1	Policy 2
What is the benefit period?		
Days/Years or dollar maximum?		
Restoration of Benefit included?		
What are the criteria for triggering it?		
Same maximum for all care or separate facility & home-based max.?		
Total lifetime maximum		
What is the daily or monthly maximum?		
For nursing home care?		
For assisted living facility care?		
For home care?		
For Adult Day Care?		
Are benefit paid daily or care at home or is there an option for weekly or monthly? For added premium or automatically included?		
Can you buy a home care benefit that is less than 100% of the facility care amount?		
Inflation protection		
Automatic Simple?		
What %?		
Do increases ever cease?		
Is premium affected by increases?		
Both daily/monthly max. & lifetime max. increase automatically		

	Policy 1	Policy 2
Automatic Compound?		
What %?		
Do increases ever cease?		
Is premium affected by increases?		
Both daily/monthly maximum & lifetime maximum?		
Automatic based on CPI?		
Future Purchase option?		
How often offered?		
Based on % or index (e.g. CPI)?		
Does option ever cease? When? Why?		
Does lifetime maximum increase with daily/ monthly increases?		
How is premium affected? What would your projected premium be in 5, 10, 15, 20 or more years?		
Other benefits		
Premium waiver		
When does it take effect?		
For nursing home care?		
Assisted living facility care?		
Home care?		
Dual waiver included for partner policy?		
Nonforfeiture benefit		

	Policy 1	Policy 2
Contingent benefit included?		
Reduced paid-up benefit?		
Return of premium on death?		
Death benefit included?		
Survivorship Benefit – describe		
Shared care benefit?		
Individual policy or shared policy with 2 or more insureds?		
Cost of policy		
Lifetime payment method?		
Limited payment term?		
What is the discount for a married couple and might it apply to you?		
Is there a good health discount? If it applies to you, how much does it provide?		

Is Long-Term Care Insurance Right for Me?

People buy long-term care insurance for many reasons. Some people don't want to use their own assets to pay for care; some want to be sure they can choose the type of care they get; others don't want their family to have to provide or pay for care or don't want to go on Medicaid. Long-term care insurance is expensive and may not be right for everyone. Use this questionnaire to help you decide if it makes sense for you. First, consider the following:

- The national average annual cost of nursing home care in a semi-private room in 2015 was over $85,000. If these costs of care were to increase 5% annually, in 14 years the national average annual cost would be over $170,000.
- Long-term care insurance helps pay for care in a nursing home or assisted living facility. Most policies also help pay for care at home or in other community settings. Policies vary in coverage.
- Medicare does not pay for most types of long-term services and supports (LTSS).
- Your choice of LTSS may be limited if you are receiving Medicaid.
- Medicaid pays for LTSS only if you have very little income and few assets. If you are now eligible for Medicaid, long-term care insurance is unlikely to be a good choice for you.
- You should not buy long-term care insurance unless you can afford to pay the premiums every year. The insurance company may increase premiums in the future.

This worksheet includes questions designed to help you determine whether long-term care insurance is suitable for your needs based on a wide variety of factors.

Questions Related to Your Income, Assets & Health Status

If you buy long-term care insurance, will you be able to pay for premiums from your income, without having to use any savings or investments or without needing help paying premiums from family?

☐ Yes, I can afford premiums using just my income.
☐ No, I would need to rely on funds from my savings/investments or help from family.

While many people do use funds from more than just their income to pay for long-term care insurance, you should think about how you feel about doing so.

Does the premium cost you are considering represent less than 7% of your current household income?

☐ Yes ☐ No

If you answered **No**, consider changing the coverage to a more affordable plan or think about other financial resources can use to afford care (for example, interest income from investments). Review the section *Questions Related to Your Insurance Objectives* — the decision to buy is based on more than just financial considerations.

Have you considered if you could afford to keep the policy if premiums went up, for example, by 20%?

☐ Yes ☐ No

Do you expect your income to increase or at least stay the same over the next 10 years?

☐ Yes ☐ No

Think about how you would pay premiums if you expect your future income to decrease. Do you have other resources you can use to continue to pay your premiums? Think about whether your decreased future income might still be adequate. Remember that premium payments typically cease when you begin to need care.

Think about your assets and investments. If your assets are less than $50,000, other options may be more suitable for financing your long-term care. Are your assets over or under $50,000?

☐ over $50,000 ☐ under $50,000

Do you consider yourself to be in excellent or good health?

☐ Yes ☐ No

Do you have a family history of Alzheimer's, Parkinson's or other disabling disease?

☐ Yes ☐ No

Does your family history include close family relatives who lived into their 80s or 90s?

☐ Yes ☐ No

Questions Related to Your Insurance Objectives

How important is it to preserve some or all of your assets (savings and investments) to pass on to your heirs?

☐ Very Important ☐ Somewhat Important ☐ Not Very Important ☐ Not at all Important

How important is it for you to be able to remain at home if you need to receive long-term care?

☐ Very Important ☐ Somewhat Important ☐ Not Very Important ☐ Not at all Important

How important is it for you to avoid having to rely on family or friends to provide more than about one-third of the care you might need?

☐ Very Important ☐ Somewhat Important ☐ Not Very Important ☐ Not at all Important

How important is it for you to ensure that your spouse has adequate finances to maintain his or her existing lifestyle should one of you need long-term care?

☐ Very Important ☐ Somewhat Important ☐ Not Very Important ☐ Not at all Important/ Not Married

How concerned are you with the possibility of someday needing long-term care?

☐ Very Concerned ☐ Somewhat Concerned ☐ Not Very Concerned ☐ Not at all Concerned

Results

If you answered mostly "Yes" or "Very Important/Somewhat Important," there is a good chance that long-term care insurance is an appropriate option for you to consider.

Long-Term Care Insurance: How to Be a Smart Shopper

- Choose an insurance company with a strong financial rating from A.M. Best or another financial rating service.

- Don't buy out of fear or emotion. Take your time. Shop carefully. Make sure your questions have been answered and that you understand how the coverage works.

- Don't buy more insurance than you think you may need. You may have enough income to pay a portion of your care costs and may need only a small policy for the remainder. You also may have family willing and able to supplement your care needs at home.

- Think carefully about whether you can afford to pay some of your care costs on your own (or rely on family care). This may enable you to buy a more "modest" amount of coverage and make it easier to find an affordable premium.

- Don't buy too little insurance. Consider how you will pay for care costs that won't be covered. While you can usually decrease how much coverage you have in the future, it is more difficult to increase coverage, especially if your health has declined.

- Look carefully at the policy you are considering. There is no one-size-fits-all policy. Consider how much coverage YOU need – do not base your coverage decisions on what your neighbor did or on what the agent says she prefers. Use the worksheet ***How to Design the Right Policy for Your Needs***.

- Make sure the agent is "listening" to your specific needs and preferences. If the agent is doing most of the talking, find another agent. This isn't their chance to impress you with their product knowledge; it is their chance to listen to your needs and customize a plan that best meets them.

- Does the policy put limits on what it will cover or pay for when you are in a facility? If so, plan for other expenses, such as rent, meals, supplies, medications, linens and other things that may not be covered.

- You should look at more than one policy and use the ***How to Compare Policies*** worksheet to help decide which policy is best for you. Compare coverage from different insurance companies and also look at options within each of them.

- It costs less to buy coverage when you are younger. Buying at a younger age means there are usually fewer health problems to affect the underwriting process.

- Make sure that buying the long-term care insurance policy is a sound financial decision and affordable for you. You will be maintaining this policy over many years – beyond retirement. Make sure you can afford this policy on your projected retirement income, even if there should be a rate increase.

- Make sure your policy will keep pace with inflation over the years. Examine the types of inflation protection that are available from the insurance company and choose the one that will best serve your needs. Even if you don't buy a plan with inflation protection, make sure you think about and anticipate the need to pay for rising care costs over time.

- If you decide you would like to buy a long-term care insurance policy, be careful to complete the application completely and accurately. The insurance application becomes a part of the insurance contract by attachment. The carrier relies on the answers to the application questions to determine whether or not to issue coverage. If you omit important information or do not answer accurately and completely, the insurance company may have a legal basis to deny a future claim or rescind (withdraw) your coverage.

- Make sure your family and friends know that you have this coverage and where your policy can be located. When asked if you want to identify someone beside yourself that should receive notification in the event of cancellation due to nonpayment (Third Party Notification), you should do this. This provides you with extra protection against accidentally missing a premium payment.

- If you are planning to replace your policy with a newer policy, more suited to your needs, be careful not to cancel the existing policy before you have received and checked over your new policy.

- Remember you have a 30-day *free look* period after you receive your new long-term care insurance policy. Read the policy again. Ask any questions you may have. If you are not completely satisfied, you may return the policy for a full premium refund within this 30-day period.

Can Everyone Buy Long-Term Care Insurance?

Unfortunately, some conditions mean you won't qualify for long-term care insurance. However, insurance companies have different standards, so while you may be denied coverage by one company, another might accept you. In general, about 75% to 85% of those who apply for coverage can be approved. The younger you are at the time you apply, the greater your chances of being approved for coverage. (For example, only 12% of applicants under age 50 are declined, but if you wait until age 70-79 to apply, the decline rate is close to 40%). If you apply as a married couple, and you find one of you cannot be approved for coverage, it is even more important for the other spouse to obtain coverage.

The most common uninsurable conditions are listed below. You will probably not be approved to purchase a policy if:

- You currently are receiving LTSS.
- You already need help with Activities of Daily Living.
- You have AIDS or AIDS Related Complex (ARC).
- You have Alzheimer's disease or any form of dementia or cognitive dysfunction.
- You have a progressive neurological condition such as Multiple Sclerosis or Parkinson's Disease.
- You have had a stroke within the past 12 to 24 months or a history of strokes or multiple Transient Ischemic Attacks (TIAs).
- You have metastatic cancer (cancer that has spread beyond its original site).

Other health conditions are evaluated in deciding whether or not you can obtain long-term care insurance, but these are the primary conditions that would likely disqualify you.

Once you are accepted for coverage, your coverage cannot be cancelled for any reason other than non-payment of premium as due or if you have received the policy's maximum benefits. If you develop one of these health conditions **after** obtaining coverage, you would be covered for the care you need for that condition.

How Can the Long-Term Care Insurance Partnership Help You Plan Your Future?

The federal government has taken an important step to help Americans plan for their futures. It passed legislation that allows each state to implement a Long-Term Care Insurance Partnership Program. In doing so, the government is helping to make long-term care insurance more accessible and encouraging Americans to take personal responsibility for planning ahead for their potential long-term care needs.

What is a Partnership Program Long-Term Care Insurance Policy?

A Partnership Program is a collaboration between a state and private insurance companies. A partnership insurance policy is like other long-term care insurance policies, except that it offers a special feature known as Medicaid Asset Disregard. This feature allows you to keep a specific amount of assets if you were to become eligible and interested in applying for Medicaid for continued long-term care services after using their insurance policy. With a Partnership policy, you can retain assets equal to the amount of benefits you received under your Partnership-qualified long-term care insurance policy, over and above the asset amounts that your state's Medicaid program normally allows you to keep.

Each state may determine if and when it wants to offer a Long-Term Care Insurance Partnership Program and the rules to which the Program and the Asset Disregard will adhere. The Partnership program rules in one state may vary to some degree from rules in another state.

The only states without a Partnership program (as of 2014) are: Arkansas, Hawaii, Illinois, Massachusetts, Michigan, Mississippi, New Mexico, Utah and Vermont.

What Are the Characteristics of a State-Certified Partnership Policy?

A Partnership policy is a long-term care insurance policy that has been certified by a state as qualified to participate in its Partnership Program. Each state determines the requirements for its Partnership Program. However, in general your age at the time you buy, and the type of inflation protection you select under your long-term care insurance policy, will determine whether the policy qualifies as a Partnership policy. The policy must also have certain, important consumer protections. Also, only federally tax-qualified policies can be Partnership qualified.

When you buy a Partnership-qualified policy, you will receive a Consumer Disclosure notice indicating to you that you have a Partnership policy. Just like your long-term care insurance and other important documents, keep this notice and your policy in a safe place, and make sure your family knows you have a Partnership policy.

How Do Partnership Policies Differ from Non-Partnership Policies?

What makes a long-term care insurance policy Partnership Qualified? In general, if you purchased the required level and type of inflation protection specified by the state, and the state has reviewed the policy to be sure it contains all the state's required consumer protection provisions, then you will have a Partnership Qualified (PQ) policy.

An Example of How the Partnership Asset Disregard Works

Ruth is a widow who wants to preserve her assets for her sons. At age 58, she buys a Partnership policy with total lifetime benefit amount of $200,000. She also purchases the type of inflation protection required of someone her age to have a Partnership qualified policy (In this case, she bought a plan with an automatic inflation protection of 3% compound annually).

Years later, when she needs long-term care, Ruth begins to receive benefit payments from her Partnership policy. As her care needs continue, Ruth now receives care in a nursing home; she is close to using up the maximum benefits allowed under her policy. As a result of the inflation protection feature, her policy's maximum benefit now equals $400,000.

Ruth still needs care, and she is nearing the maximum on her Partnership policy. She also has only limited income, so she applies for Medicaid to continue to cover her nursing home care.

When she applies to Medicaid, instead of requiring her to spend down all but $2,000 of her assets as Medicaid would typically do, because she has a Partnership policy with its special Asset Disregard provision, she is allowed to keep additional assets equal to the amount she received in long-term care benefits. That means she can keep $402,000 of her assets.

Is a Partnership Policy's Special Asset Disregard Recognized Outside of the State in which It Is Purchased?

In all but two cases, if you move to another state that also has a Partnership program they will provide you with reciprocity with the other Partnership states. That means you can also apply for Medicaid and, if eligible, obtain Asset Disregard according to that state's Partnership rules. You would also have to meet all the other Medicaid requirements of the state to which you have moved, and these may differ from the requirements in your original state. (As of 2015, only New York and California do not offer reciprocity with the other states offering Partnership programs.)

For more detailed information about Partnership Policies, see the handout ***Frequently Asked Questions about the Partnership Program***.

Note: This information does not apply to the Partnership Programs in New York, California, Connecticut and Indiana. Also, eligibility for Medicaid is not automatic. You must also meet general eligibility, income, and functional criteria. The long-term care services provided under Medicaid may change over time and may differ from those covered under your Long-Term Care Partnership Policy.

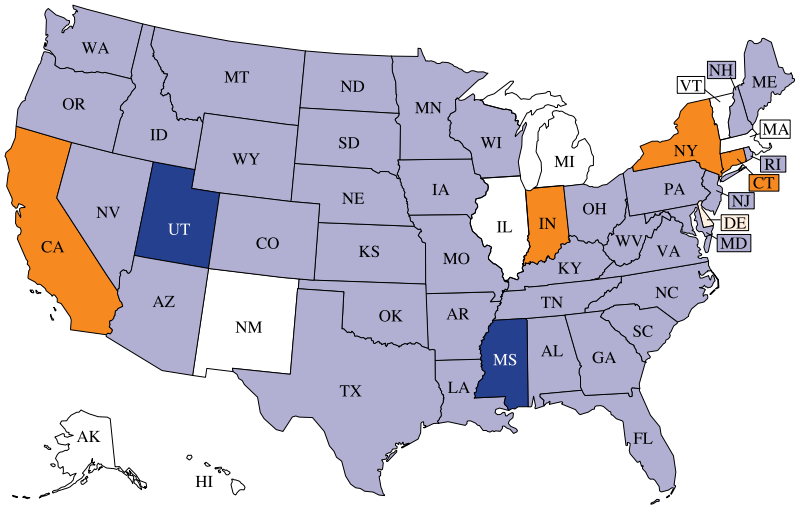


Figure 4: State Long-Term Care Partnership Activity Across the Country
(as of January 2014)

MAP KEY:

- Operational Partnerships under DRA
- Grandfathered partnership state
- Partnership Enabling Legislation
- State Medicaid plan amendment approved by HHS

My Rates Went Up! What Do I Do Now?

If you receive a notice that your Long-Term Care Insurance rates will be increasing, you have several options. Work with your agent directly or with the insurance company to review potential benefit changes to your policy that would make it less expensive. Typically, when you are notified in advance of a rate increase, the letter you receive will outline various options available to you. These most often include one or more of the following:

- Accept the rate increase and keep your coverage unchanged. Usually, no action is needed on your part if this is what you'd like to do.
- Change your coverage – make a decrease in benefits – in order to maintain or even lower the premium from what you are currently paying. This lets you avoid the rate increase and may even produce a lower premium. The letter is likely to identify specifics for how to make this change.
- Accept a contingent nonforfeiture option. This choice is worth considering if neither of the options above is feasible for you. But keep in mind that it will only provide you a small amount of "transition" care – e.g., 30 days worth of care – after which your coverage terminates. You do not need to continue to pay premiums under this provision and can use these "30 days of care" in the future if you need LTSS.
- Drop your coverage altogether. You'd obviously avoid any rate increase but you also would no longer have LTSS coverage and might not be insurable (or find affordable insurance) elsewhere.

Here are some viable options for reducing your coverage to make premiums more affordable if there is a rate increase that you do not want to or cannot afford to take on. The insurer might have options available that aren't mentioned in the rate increase letter, so feel free to contact them and explore these and any other possibilities that might be open to you:

1. Consider reducing the policy's lifetime maximum dollar amount (or shortening the benefit length). For example, check with the insurer to see if changing your existing policy from covering five years of coverage to four or even three years of coverage would give you the desired premium reduction to fit your budget.
2. Consider changing to a longer elimination period. Think about how much more out-of-pocket cost this will mean to you, since long-term care costs are likely to increase over time. Do you have the resources to cover this cost?
3. How much would changing your payment schedule reduce premium increase? For example, does changing from a monthly payment to one annual payment help you fit this in your budget? This is likely to have only a small impact but can be worth considering. Paying annually can sometimes be slightly less expensive overall than making more frequent payments.
4. If you have had your policy for a long time, you might consider eliminating the automatic inflation option. However, if dropping this benefit puts you back to the original benefit amount, it is probably not a wise choice. In addition, switching to a lesser inflation option

(for example, from compounding to simple) would mean wasting the extra premium you paid for the compound inflation option in the policy's early years. The value of compounding inflation protection can really only be seen after the 12th year the policy is in force.

5. Additionally, some policies have more than one option for the rate at which inflation protection adjust your benefits. So if you currently are at 5% annual rate, you might easily consider 3% or 4%. Remember that the rate of inflation specific to LTSS is less than what we commonly think of as medical care inflation. In today's low interest rate environment, LTSS costs are also growing much more slowly. If you've had a 5% rate of inflation, your benefits have probably already grown ahead of inflation, so you can easily afford to cut back on the rate of growth (and reduce premiums) without compromising how well your benefits keep pace with LTSS costs. This may not always be the case, but is true today.

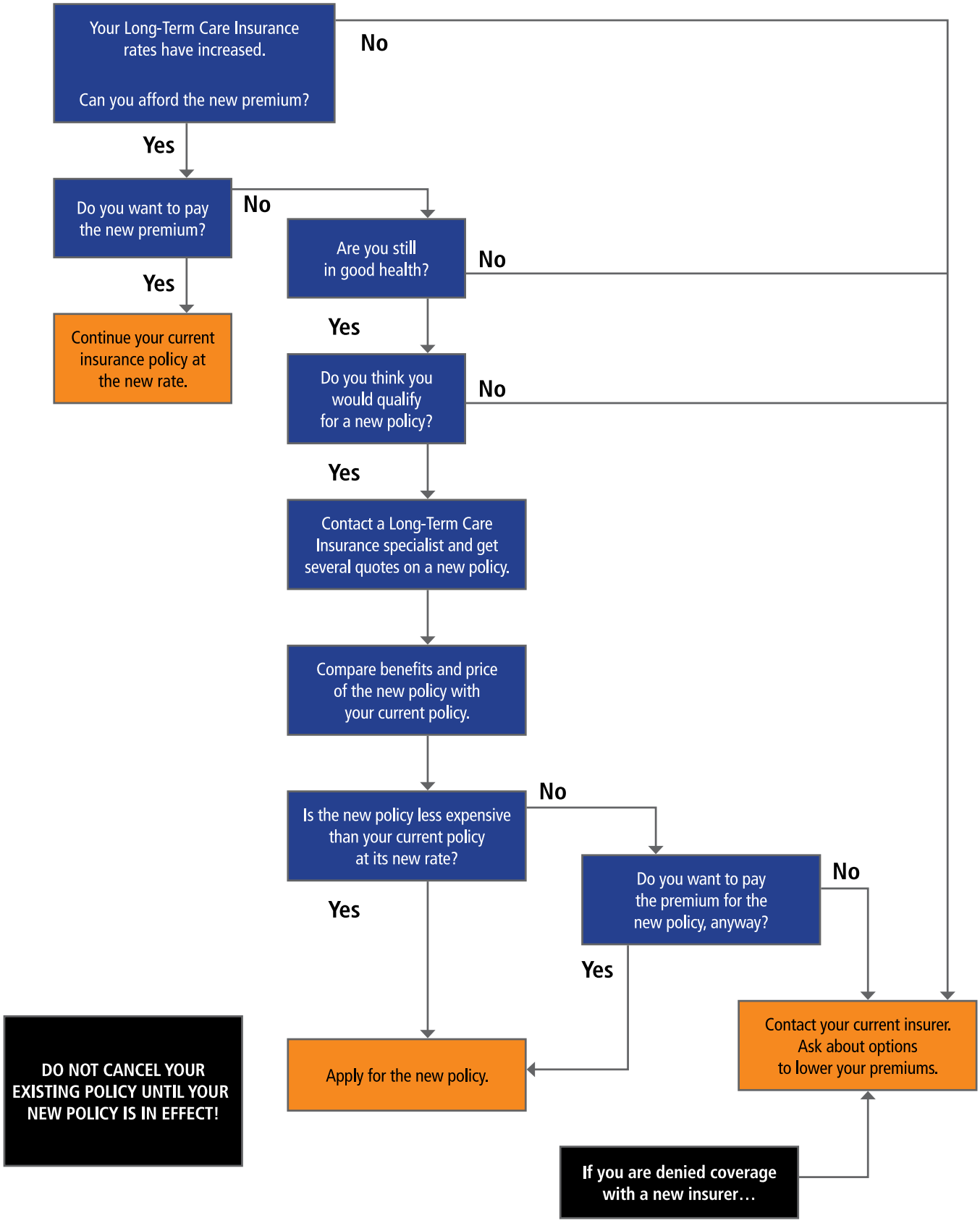
6. Changing the daily benefit amount can help make premiums more affordable. A 10% reduction in daily benefit offers a 10% reduction in premium cost. Consider how this impacts the "gap" between the benefit amounts and costs of care. And don't forget to think about where you'll be living when you need care. You may not have planned to relocate in retirement when you first bought your policy, but perhaps now you are thinking about moving to an area where LTSS costs are lower than where you now live. If this is the case, reducing your daily benefit is good way to avoid a premium impact (or lower premiums).

7. Dropping optional benefits. If you bought coverage with additional riders, such as a "Restoration of Benefits," a "Surviving Spouse Premium Rider," or "Paid-Up Survivor Benefit," you may be able to avoid or reduce the premium increase by dropping one of these options. Take a close look at what the rider provides and the value of it today based on your life circumstances. You may find that it is easily a feature that you can do without. Each insurer has different rules about when and whether optional riders can be added or dropped, so check with them as well.

If you are in good health and likely to qualify for a new policy, you may wish to contact a Long-Term Care Insurance expert and request quotes on a new policy. Since many policies have had rate increases or are charging more today for comparable coverage compared with a decade ago, finding a new policy at a reduced premium from what you would be paying even if you accepted the premium increase is becoming less likely. In most cases, you are better off staying with the coverage you have – whether you modify it to avoid the rate increase or accept the increase.

If you do decide to obtain a new policy, <u>be sure to keep your existing policy in force until the new policy is in effect</u>! The Flow Chart on this handout walk you through some of these decisions.

Figure 5: My Rates Went Up! What Are My Options?



Handout – Tax Treatment At A Glance

Long-term care insurance has certain tax advantages. Over 98% of the policies sold today are federally tax-qualified.

Here are the advantages of a tax-qualified long-term care insurance policy:

- The benefit payments you receive are tax-free.
- The premiums you pay may be tax-deductible under certain circumstances. Specifically, the cost of premiums can be combined with other medical expenses, including any out-of-pocket long-term care expenses you may have. If these itemized medical expenses exceed 10% of your adjusted gross income, you can deduct a portion of your long-term care insurance premium. (Until 2017, this figure is 7.5% if you are over age 65 and in a nursing home or assisted living facility.)
- The amount of premium you can deduct depends upon your age. Each year, the IRS specifies the maximum premium amount, by age group, which you can deduct, if you qualify for the deduction (see below).

Table 29. Maximum Deduction for Qualified Long-term Insurance Premiums Under Code § 213(d)(10)

Age Attained Before Close of Year	2014	2015
40 or Less	$370	$380
More Than 40 But No More Than 50	$700	$710
More Than 50 But No More Than 60	$1,400	$1,430
More Than 60 But No More Than 70	$3,720	$3,800
More Than 70	$4660	$4,750

- Self-employed individuals can deduct 100% of the premiums for tax-qualified long-term care plans, up to these age-specific amounts.
- Employees cannot pay for long-term care insurance premiums with pre-tax dollars as part of Section 125 "cafeteria plans" and other similar arrangements.
- Unlike medical, dental and pharmacy expenses, the premiums you pay for long-term care insurance cannot be counted against amounts you set aside for a health care Federal Savings Account (FSA). This is also true of the premium amounts you pay for health insurance.
- Several states offer either a tax credit or tax deduction for long-term care insurance, either in addition to or instead of the federal deduction — you may not always be able to take both. The following states at one time offered some sort of tax advantage specific to long-term care insurance (and many may still do so): Alabama, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Virginia, West Virginia and Wisconsin.

- Policies that pay a cash benefit also receive a portion of that cash benefit on a tax-free basis, up to a certain amount. In 2014 and 2015, the amount is $. If you receive a cash benefit in excess of that "per diem" limit, the excess amount may be subject to taxes. However, if you can document that all or a portion of that excess amount was spent on long-term care services, the excess may be deemed tax-free. Always check with your tax accountant or attorney to be sure how to handle the cash benefit that exceeds the specified tax-free maximum.

If you see this notice on the front page of your policy, then you know it is tax-qualified.

Long-Term Care Insurance Policy:

Tax Qualified Status Disclosure Notice

IMPORTANT NOTICE: This Policy is intended to be a tax qualified long-term care insurance contracted under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191.

If you purchased your policy prior to January 1, 1997, it will not have this *tax status* notice on the front. However, all policies sold prior to that date are automatically considered to be federally tax-qualified. So the same rules described above even apply to those older policies.

Always consult your tax accountant or attorney for information and advice about these issues and whether and how they specifically apply to your situation.

Long-Term Care Partnership Program Frequently Asked Questions

Q: Why are states offering Partnership Programs?

A: State governments benefit from encouraging individuals to provide for their LTSS needs by obtaining long-term care insurance, because it may help lower state Medicaid costs.

Q: What is a Partnership Program?

A: A Partnership Program is a collaboration between a state government and the private insurance companies selling long-term care insurance in that state. It offers a special feature known as Medicaid Asset Disregard that allows people to retain additional assets if, they continue to need services after they have used their private long-term care insurance policy coverage, and choose to apply to and are approved for Medicaid for continued long-term care services. With a Partnership policy, someone can retain additional assets over and above the asset amounts that the state's Medicaid program normally allows one to keep equal to the amount of the benefits received under the Partnership-qualified private long-term care insurance policy.

Q: How does the Asset Disregard feature of a Partnership Policy work?

A: With a Partnership-qualified policy, Medicaid lets a person keep $1 of additional assets for every $1 of long-term care insurance coverage purchased and used. This amount of assets is protected both at the time the person applies for Medicaid and when the person dies. Without a Partnership policy, a person has to satisfy the usual asset threshold Medicaid applies (for example, a single person typically gets to keep only about $2,000 in assets to qualify for Medicaid). There may be some state variations with respect to Asset Disregard (for example, at least one state requires people to first exhaust their long-term care insurance before they can apply for Medicaid; most states do not). It is important to check the specific requirements of your state.

Q: What makes a policy Partnership-Qualified?

A: A Partnership-qualified policy is a long-term care insurance policy that has been certified by a state as qualified to participate in their Partnership Program. Each state determines the requirements for its own Partnership Program. However, typically the type of inflation protection selected and the person's age at the time the policy is purchased will determine whether the policy qualifies as a Partnership policy.

All Partnership policies must also be federally tax-qualified (TQ) policies.

Q: What happens if a person bought a policy before the state developed a Partnership Program?

A: It may be possible to exchange a previously purchased policy for one that is Partnership-qualified. The state may require insurers to notify consumers who bought policies within a certain timeframe, or who have policies with certain qualifying features, of this right to exchange their existing policies for Partnership-Qualified policies. In some cases, a person may need to agree to add inflation protection (if it is not already a part of the policy or is not of a type or amount that Partnership-Qualified). This may mean an increase in the premium associated with the additional coverage and it may mean the person has to pass underwriting to be approved for the change. People are not required to exchange existing coverage for Partnership-Qualified policies, even if the insurance company notifies them that they have the right to do so.

Q: How do Qualified Partnership policies differ from non Partnership-Qualified policies?

A: What makes a policy Partnership-Qualified is whether the individual buying it has purchased the required level and type of inflation protection and received the required disclosures and notices from the insurer. Otherwise, the benefits and coverage in the private insurance policy are the same, whether it is partnership qualified or not, as long as the policy form is the same. Insurers may only opt to have their most recent policy forms certified for Partnership qualification, so an older policy form may differ from the newer one – not as a result of Partnership, but simply because the insurer has introduced new language or benefits to its more recent policy form.

Q: Do Partnership Policies cost more?

A: Partnership policies and other long-term care insurance policies with the same benefits and features and on the same policy form from the same company have identical premiums. If a person is younger at the time he purchases his policy, a Partnership policy may have an inflation protection benefit that an otherwise identical policy may not have. In this case, the Partnership policy will cost more because of the additional benefit it provides. The Medicaid Asset Disregard feature of a Partnership policy does not add to the cost of the Partnership policy.

Q: If a person with a Partnership policy uses all or most of her benefits, is she automatically eligible for Medicaid?

A: No. The person still needs to satisfy other Medicaid eligibility requirements pertaining to health status, income, home value and other criteria.

Q: What other considerations should consumers be aware of?

A: Services received under Medicaid may differ from services covered under a partnership qualified long-term care insurance policy and may change over time. Partnership policies protect a specified amount of assets from counting against eligibility for Medicaid, but they do not protect income. The person must still satisfy whatever income criteria the state requires.

Q: What advantage does buying a Partnership policy offer?

A: Partnership and non-Partnership policies are virtually the same except that Partnership policies have the added benefit of Medicaid Asset Disregard. Partnership policies may be of particular value to those who are unable to afford a large amount of long-term care insurance, but who have assets they want to protect. An individual in these circumstances can even tailor the lifetime maximum to the amount of assets he wants to protect. For example, if he wants to protect $75,000, he buys a partnership policy with a $75,000 lifetime maximum. In this way, partnership policies offer an incentive to those of more modest means to buy at least a small lifetime amount of long-term care insurance.

Q: How do I know whether the policy I bought is Partnership-qualified?

A: You should receive a Consumer Disclosure statement from the insurance company that indicates whether or not the policy is Partnership-qualified.

Q: Are Partnership policies transferable from one state to another state?

A: This depends on whether or not the state to which the person moves both has a Partnership program and has agreed to provide reciprocity with other Partnership states. As of 2014, all the states with Partnership Policies (except California and New York) offer reciprocity with each other. That means that the new state to which the consumer moves will recognize their right to Medicaid Asset Disregard. However, the person would also have to meet all the Medicaid requirements of the state to which she has moved, which may differ from the requirements in the original state.

Q: Does a person have to use up all her Partnership policy benefits before she can apply for Medicaid?

A: This depends upon the specific rules of the state in which she is applying for Medicaid. Most states with Partnership programs currently do **not** require a person to use up the policy's benefits before she can apply for Medicaid.

Q. Do all insurers offer Partnership Qualified policies?

A: Not all but many insurers, including all of the leading insurers, currently or intend to offer Partnership-qualified policies. Your state's Department of Insurance website or Partnership website (which many states have established) is likely to list the companies from which you can buy a Partnership-qualified policy in your state.

Q: Which states currently offer Partnership programs?

A: The list may change. As of 2015, only the following states did NOT have a Partnership program as described here: Alaska, Hawaii, Illinois, Massachusetts, Mississippi, Utah, and Vermont. Always check with your state insurance department for the most up-to-date information.

Can Everyone Buy Long-Term Care Insurance?

Unfortunately, some conditions mean you won't qualify for long-term care insurance. However, insurance companies have different standards, so while you may be denied coverage by one company, another might accept you. In general, about 80% to 85% of those who apply for coverage can be approved. Approval rates are highest for the youngest applicants and decline with age (e.g., 88% for some age 40-49 in contrast to 60% for someone age 70-74). If you apply as a married couple, and you find one of you cannot be approved for coverage, it is even more important for the other spouse to obtain coverage.

The most common uninsurable conditions are listed below. You will probably not be approved to purchase a policy if:

- You are currently or have recently received LTSS. You already need help with Activities of Daily Living.
- You have AIDS or AIDS Related Complex (ARC).
- You have Alzheimer's disease or any form of dementia or cognitive dysfunction.
- You have a progressive neurological condition, such as Multiple Sclerosis or Parkinson's Disease.
- You have had a stroke within the past 12 to 24 months or a history of strokes or multiple Transient Ischemic Attacks (TIAs).
- You have metastatic cancer (cancer that has spread beyond its original site).

Other health conditions are evaluated in deciding whether or not you can obtain long-term care insurance, but these are the primary conditions that would disqualify you.

Once you are accepted for coverage, your coverage cannot be cancelled for any reason other than non-payment of premium as due or if you have received the policy's maximum benefits. If you develop one of these health conditions **after** obtaining coverage, you would be covered for the care you need for that condition.

Overview of Private Financing Options for LTSS

Different financing options may be suitable depending upon an individual's:

- Health status
- Age
- Financial status

The chart below summaries these options based on various criteria

Table 30. Consumer Health Status: Which Financing Options Are Most Suitable?		
Relatively Good Health • Long-Term Care Insurance • Continuing Care Retirement Community • Life Insurance with a LTC Benefit	**Poor Health or Terminally Ill** • Accelerated Death Benefits • Viatical Settlements	**Health Considerations are Not Important** • Some Annuity/LTC hybrids • Using home equity to fund long-term care services • Life Settlement

Some private payment options are good choices for older people; others make more sense for a younger person.

Table 31. Consumer Age: Which Financing Options Are Most Suitable?	
Better Option for Younger Person • Long-Term Care Insurance • Self-Pay (Save on your own)	**Better Option for Older Person** • Annuity/LTC and Life/LTC Hybrids • Sell home options • Reverse Mortgage • Life Settlement • Continuing Care Retirement Community

Also, if an individual has a limited life expectancy, he should consider one of the following:

1. Viatical Settlement
2. Medically underwritten immediate annuity – in order to get maximum pay-out.
3. Accelerated death benefit

Of if they have <u>considerable wealth</u>, these other options may be suitable:

1. Long-term care insurance
2. Linked benefit products (life or annuity with LTSS rider) of all kinds
3. Continuing Care Retirement Communities (CCRCs)
4. Self-pay

Quick Facts about Reverse Mortgages

- All borrowers must be 62 or older.
- There is no health requirement; your health status is not a factor.
- The home must be your primary residence.
- You won't be required to provide an income or credit history.
- Reverse mortgage funds must be used to pay off any existing mortgage or other debt against the home and to make required home repairs. You can use any remaining funds for any purpose. You must have little or no outstanding balance on your current mortgage.
- A reverse mortgage must be in first lien position, which makes it very difficult to borrow any more against your home once you have a reverse mortgage. You can refinance a reverse mortgage if the house increases significantly in value.
- All potential borrowers must first meet with a HUD-approved reverse mortgage counselor before they can start the loan process. These counselors can give you information to help decide whether a reverse mortgage is right for you.

There are three types of reverse mortgages. These include:

- **Home Equity Conversion Mortgage (HECM)** – This program is offered by the Department of Housing and Urban Development (HUD) and is insured by the FHA. HECMs are the most popular reverse mortgages, representing about 90 percent of the market.
- **Fannie Mae Home Keeper Loan** – Borrowers may receive more cash from these loans than with a HECM since the loan limit for these loans is higher.
- **Financial Freedom Cash Account Loans** – These loans are designed for seniors who own expensive homes.

Most people get a reverse mortgage through a mortgage lender. Consider a company affiliated with the National Reverse Mortgage Lenders Association Some credit unions and banks, along with state and local housing agencies, as these may also offer these loans.

Important consumer protections:

- Borrower(s) continue to own the house and can never be forced to leave as long as they maintain the home, and make property tax and hazard insurance payments.
- You must first meet with a government-approved reverse mortgage counselor before your loan application can be processed or you incur any costs.
- Borrowers (or their heirs) will never owe more than value of the home at the time they sell the home or repay the loan, even if the value of their home declines.
- For HECM loans, most up front costs are regulated, and there are limits on the total fees and interest rates that can be charged.

For more information:

http://www.aarp.org/money/credit-loans-debt/reverse_mortgages/. This site includes a guide for comparing your options and a calculator to estimate how much you can get from a loan.

www.reversemortgage.org. This site offers consumer publications, a reverse mortgage calculator and help finding a lender in your state.

If you are not in good health and uninsurable:

1. Home Equity options: Home Equity Line of Credit
   Reverse Mortgage
   Reverse Annuity Mortgage
   Sale
   Sale and Leaseback

2. **Existing** Life Insurance options: Accelerated Death Benefit
   Loans, Withdrawals, Policy Surrenders
   Viatical Settlement
   Life Settlement

3. Most Annuities: Deferred and Immediate (have medically underwritten if life expectancy is limited due to health condition)
4. Some Annuity/long-term care Hybrids
5. Linked Benefits or Life Insurance with a LTC rider or extended benefits rider
6. Some Continuing Care Retirement Communities (CCRCs): Only the unbundled type with no paid LTC provided through contract

If you are older (62 +):

1. Home Equity options: Reverse Mortgage
   Reverse Annuity Mortgage
2. Life insurance Options: Life Settlement
3. Continuing Care Retirement Communities (CCRCs): Most types

If you have a limited life expectancy:

1. Viatical Settlement
2. Medically underwritten immediate annuity – in order to get maximum pay-out
3. Accelerated death benefit within a life insurance policy

If you are healthy and insurable:

1. Long-term care insurance: Free-standing or a linked benefit product (life or annuity with a LTC coverage component)
2. Continuing Care Retirement Communities (CCRCs)

If you are young and healthy:

1. Long-term care insurance
2. Life/LTC or Annuity/LTC hybrid

If you have considerable wealth:

1. Long-term care insurance
2. LTC combination (hybrid) products of all kinds
3. Continuing Care Retirement Communities (CCRCs)
4. Self-pay

Comparing the Options for Using Home Equity to Fund Long-Term Care Needs

If you want to stay in your home…

Sale/Leaseback

Pros	Cons
• You stay in your home • All your equity in the home is available for your use • Taxes and maintenance no longer your responsibility	• You lose title to your home and have to move • Have to pay rent • Changes to home need landlord approval

Home Equity Loan

Pros	Cons
• You stay in your home • Retain title to property • 80% of your equity in the home is available for your use	• You make monthly equity loan payments • Taxes and maintenance still your responsibility

Reverse Mortgage

Pros	Cons
• You stay in your home • Retain title to property • About 50% of your equity in the home is available for your use • No monthly payments required • Only the house secures the loan	• High up-front fees • Debt increases over time • Ends when you are no longer living in the home so can't be used to pay for facility care

If you don't want to stay in your home…

Sale/Leaseback

Pros	Cons
• All your equity in the home is available for your use • Less responsibility if you move to a smaller home or rent	• House not able to be left for heirs

APPENDIX 5 | *Additional Resources*

CHAPTER 1: LTSS BASICS

About LTC

Centers for Disease Control and Prevention (CDC), Long Term Care Services in the United States, 2013 Overview. http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf

Bipartisan Policy Center, 2015. America's Long-Term Care Crisis.
http://bipartisanpolicy.org/wp-content/uploads/2015/06/BPC-Health-Long-Term-Care.pdf

NIHSeniorHealth, NIHSeniorHealth.gov, 2015. Long-Term Care.
http://nihseniorhealth.gov/longtermcare/whatislongtermcare/01.html
http://nihseniorhealth.gov/longtermcare/whatislongtermcare/video/LTCincludes_na.html?intro=yes
http://nihseniorhealth.gov/longtermcare/quizzes.html

National Association of Health Insurance Underwriters. Consumer Guide to Long Term Care.
https://www.nahu.org/consumer/LongTermCareGuide.cfm

Home and Community Care:

NIHSeniorHealth.
http://nihseniorhealth.gov/longtermcare/communitybasedservices/video/daycare_na_intro.html
http://nihseniorhealth.gov/longtermcare/homebasedservices/01.html

National Adult Day Services Association. 2015. "Learn More About Adult Day Services."
http://nadsa.org/learn-more/about-adult-day-services/

U.S. Department of Health and Human Services. 2015. "Fact Sheet: Adult Day Care."
http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Adult_Day_Care.aspx

Facility Care:

NIHSeniorHealth.
http://nihseniorhealth.gov/longtermcare/facilitybasedservices/01.html

U.S. Department of Health and Human Services, 2015. "Fact Sheet: Assisted Living."
http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Assisted_Living.aspx

National Center for Assisted Living. "What is Assisted Living."
http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/AssistedLivingNCAL.pdf.

The SCAN Foundation. Residential Care Facilities for the Elderly. 2011.
http://www.thescanfoundation.org/sites/default/files/ltc_fundamental_7_0.pdf

Costs and Paying for Care:

NIHSeniorHealth.
http://nihseniorhealth.gov/longtermcare/payingforlongtermcare/01.html

Centers for Medicare and Medicaid Services (CMS).
http://www.medicare.gov/what-medicare-covers/part-a/paying-for-nursing-home-care.html

PBS News Hour.
http://www.pbs.org/newshour/updates/paying-long-term-care/

Genworth 2015 Cost of Care Survey.
https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_040115_gnw.pdf

CHAPTER 2: LTSS PLANNING

PBS News Hour. "Taking Care" Series.
http://www.thescanfoundation.org/pbs-newshour

Minnesota Department of Human Services (DHS). Own Your Future Minnesota.
https://www.youtube.com/watch?v=ljs8hWHnSns

NIHSeniorHealth.
http://nihseniorhealth.gov/longtermcare/planningforlongtermcare/video/planningforLTC_na.html?intro=yes

CHAPTER 3: LONG TERM CARE INSURANCE

National Association of Insurance Commissioners (NAIC). 2013. A Shopper's Guide to Long-Term Care Insurance.
http://www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf

LTC Tree, 2012.
https://www.youtube.com/watch?v=5cmjyjk8qIA

Life Happens. Long-Term Care Insurance 101.
https://www.youtube.com/watch?v=T1RmHZy2_JA

American Association for Long Term Care Insurance.
http://www.aaltci.org/long-term-care-insurance/learning-center/fast-facts.php
http://www.aaltci.org/long-term-care-insurance/ask-the-ltc-answer-guy/

Publications.usa.gov. America's Health Insurance Plans (AHIP). 2013. Guide to Long-Term Care Insurance.
http://publications.usa.gov/USAPubs.php?PubID=5879

WISER Research Guide to Long-Term Care.
https://www.wiserwomen.org/images/imagefiles/Long%20Term%20Care%20Resource%20Guide.pdf

CHAPTER 4: SPECIAL TOPICS IN LTCI

Tax Treatment:

Think Advisor. How are LTC Insurance Premiums and Benefits Taxed? March 2014.
http://www.thinkadvisor.com/2014/03/19/how-are-ltc-insurance-premiums-and-benefits-taxed

American Association for Long Term Care Insurance. Long-Term Care Insurance Tax-Deductibility Rules. http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php/

Partnership for LTC Program:

American Association for Long-Term Care Insurance. 2012. "Long-Term Care Insurance Partnership Plans."
http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php

Center for Health Care Strategies Inc. 2009. Long-Term Care Insurance Partnership: Considerations for Cost-Effectiveness.
http://www.chcs.org/resource/long-term-care-insurance-partnership-considerations-for-cost-effectiveness/

Center for Health Care Strategies. 2007. Long-Term Care Partnership Expansion: A New Opportunity for States. 2007.
http://www.chcs.org/resource/long-term-care-partnership-expansion-a-new-opportunity-for-states/

Minnesota's LTC Partnership. NewmanLTC.
https://www.youtube.com/watch?v=zdgDSMyYvzc

InfoLTC. About Partnerships.
https://www.youtube.com/watch?v=7AQyUXR9TDI

Health Savings Accounts:

HSACenter.Com
http://www.hsacenter.com/2015-hsa-contribution-limits.html

Zene Benefits. Health Savings Accounts Rules and Benefits.
https://www.zanebenefits.com/blog/Health-Savings-Account-HSA-2015-Rules-Requirements

Rate Increase:

Long Term Care Insurance Partners.
https://www.ltcipartners.com/blog/how-i-handled-my-in-force-rate-increase

USA Today. How to handle long-term care premium hikes.
http://www.usatoday.com/story/money/columnist/powell/2014/03/16/powell-long-term-care-insurance-retirement/6428373/

Claims Issues:

American Association for Long Term Care Insurance.
https://www.aaltci.org/subpages/resources/claimsreport.pdf

AARP Public Policy Insitute.
http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/ltc-insurance-2012-update-AARP-ppi-ltc.pdf

LifePlans Inc., Private Long Term Care Insurance: Value to Claimants. The Gerontologist. 2010.
https://www.lifeplansinc.com/inthenews/Private%20Long-Term%20Care%20Insurance%20Value%20to%20Claimants%20The%20Gerentologist%203-22-2010.pdf

The SCAN Foundation. Understanding Satisfaction Among Older Adults using LTSS.
http://www.thescanfoundation.org/sites/default/files/lifeplans_understanding_satisfaction_among_older_adults_using_ltss-9-18-13.pdf

CHAPTER 5: OTHER PRIVATE OPTIONS FOR FINANCING LTC NEEDS

Options:

The SCAN Foundation. Overview of LTC Financing Options. 2013.
http://www.thescanfoundation.org/sites/default/files/tsf_ltc-financing_current-financing-options_tell_3-20-13.pdf

Annuities and LTC:

Kiplinger. New Ways to Pay for Long Term Care.
http://www.kiplinger.com/article/insurance/T036-C000-S002-new-ways-to-pay-for-long-term-care.html

Kiplinger. Using Annuities to Pay for Long Term Care.
http://www.kiplinger.com/article/retirement/T003-C000-S001-use-annuities-to-pay-for-long-term-care.html

Intercompany Long Term Care Insurance Conference. Annuity and LTC Combination Products.
http://www.iltciconf.org/index_htm_files/21-Annuitycombos203.pdf

Life Insurance and LTC:

American Council of Life Insurers (ACLI) Living Benefits from Life Insurance.
https://www.acli.com/Consumers/Life%20Insurance/Pages/Living%20Benefits.aspx

American Council of Life Insurers (ACLI). "What You Need to Know About Accelerating Life Insurance Benefits." https://www.acli.com/Consumers/Life%20Insurance/Pages/Accelerating%20Benefits.aspx.

American Elder Care Research Organization. "Using Accelerated Death Benefits to Pay for Long Term Senior Care."
www.payingforseniorcare.com/longtermcare/resources/death_benefit_loans.html.

American Elder Care Research Organization. "Using Viatical Settlements to Pay for Long Term Senior Care."
www.payingforseniorcare.com/longtermcare/resources/viatical_settlements.html.

Merkel, Steven. February 13, 2006. "A New Approach to Long Term Care Insurance."
http://www.investopedia.com/articles/retirement/06/newltcplan.asp.

Reverse Mortgage:

Consumer Financial Protection Bureau. What is a Reverse Mortgage?
http://www.consumerfinance.gov/askcfpb/224/what-is-a-reverse-mortgage.html

National Reverse Mortgage Lenders Association.
https://www.nrmlaonline.org/

Investopedia. How does a reverse mortgage work?
http://www.investopedia.com/articles/personal-finance/103014/how-does-reverse-mortgage-work.asp

Forbes. New and Unexpected Ways to Fund Long-Term Care Expenses.
http://www.forbes.com/sites/jamiehopkins/2014/04/21/new-and-unexpected-ways-to-fund-long-term-care-expenses/#5414523c143c

NOTES

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