# Chapter 3 Individual and Group Policies

**Individual and Group Policies**

In the long-term care market, coverage is available on both an individual and group basis. Though individual policies dominate, some employers offer this coverage to their employees. Of those that do, most provide the benefit only on an "employee-pay-all" basis. This means that the employer does not contribute to the cost of the premium; it is paid entirely by the individual employee. However, the employee has the advantage of a group premium rate, which usually is lower than the rate that would apply to individual policies.

Most states require that group LTC participants be granted certain rights to continue or convert their coverage in the event coverage is terminated under the group plan. These rights are explained in detail in Later Lessons.

As a point of reference, the deductible limits in 2009 were $320 for those age 40 and under; $1,190 for those age 51 to 60; and $3,980 for those age 71 and over. Other amounts apply to those between these age brackets.

**Common LTC Policy Characteristics and Features**

The long-term care insurance market is characterized by a variety of policies and policy forms: tax-qualified and non-tax-qualified, comprehensive and non-comprehensive, reimbursement and indemnity, individual and group. As mentioned, some standardization is beginning to emerge, due in large part to the requirements that have been set for tax-qualified policies and those that are defined in the NAIC's model act. Still, even within these parameters, there exists a broad array of LTCI features, options, and limitations. Here we will cover the more common policy provisions and features. Unit 6 is devoted to the requirements for long-term care policies that are sold in states that have adopted the NAIC model and that are used in conjunction with state LTC partnership plans.

**Covered Care**

As noted earlier, an LTC policy may be either comprehensive or non-comprehensive. Most policies sold today are comprehensive policies, which cover care and services in a wide range of settings, for a multitude of needs. Comprehensive coverage typically includes:

-Skilled nursing facility care
-The cost of care delivered in the home, including skilled care and personal care (Many policies also cover some level of homemaker services as well as personal services.)
-Adult day care health centers
-Respite care for caregivers
-Hospice care
-Assisted living facility care
-Memory care centers
-Skilled nursing facility care

Comprehensive policies also cover care at all levels: custodial, intermediate, and skilled.

**Eligibility for Benefits**

Once a person has applied for LTCI coverage and has been approved, he or she will be eligible for benefits after coverage becomes effective and when he or she meets the policy's benefit triggers. As we've discussed, policy triggers may vary depending on whether the policy is tax-qualified or non-tax-qualified, but because most policies are tax-qualified, the triggering events for most policy holders are cognitive impairment or the inability to perform at least two of six ADLs.

Benefits can begin after the elimination period (discussed in an upcoming section), as long as the covered services are part of an approved plan of care developed by a licensed health care practitioner of the policy holder's choice and approved by the insurer. Some policies require a doctor to verify that the ADL or cognitive impairment trigger has been met before benefit payments can begin. Some newer policies, however, pay benefits if a social worker, physical therapist, or other health care professional can show that the policy holder has experienced a qualifying event. The person who verifies that coverage has been triggered is called the gatekeeper.

**Benefit Amount**

The policy's benefit amount is the amount that the policy will pay, usually expressed as a dollar-per-day amount. The policy holder selects the daily benefit amount, typically ranging from $50 a day to $500 a day. Policy holders may be given the choice of having the same daily benefit apply regardless of where the care is delivered, or choosing a lesser amount for care delivered in the home. For example, the policy holder may elect a daily benefit of $250 for care delivered in a nursing facility and a home care benefit equal to 50 percent of the nursing facility rate for care delivered in the home.

The daily benefit is then multiplied by the number of days in the benefit period (discussed in the next section) to determine the total benefit payable under the policy. For example, assume an policy holder selects a daily benefit of $100 and a five-year benefit period. The policy will provide for a total of $182,500 in benefits:

-$100 x (365 x 5) = $182,500

LTCI policy benefits may also be expressed in terms of a lifetime maximum policy benefit. Under this scenario, the policy holder chooses a lifetime maximum benefit, for example, $100,000, $250,000, or $500,000. This is the pool of money from which benefits are paid. The daily benefit can be used in any way—for example; it can cover a combination of services, such as for home care and community-based care. When the policy's lifetime maximum has been exhausted, regardless of how paid, no further benefits are available. In addition, as benefits are paid, the policy holder is responsible for costs that exceed the benefit amount purchased.

**Benefit Period**

The benefit period is the length of time the policy will pay for covered services. It is usually defined in years. Common benefit periods are two years, three years, five years, and ten years. Many states specify that an LTC policy's benefit period can be no less than 12 months.

The benefit period begins on the date that the policy holder first makes a claim against the policy to pay for care. Payments continue for the duration of the period chosen. Some insurers allow policy holders to elect an unlimited benefit period under which payments are not limited to a specified number of years but continue for life.

A policy's premium is obviously influenced by the benefit period, as well as the benefit amount. For example, a policy that pays $100 a day for five years of long-term care will cost more than a policy that pays $50 a day for three years.

**Elimination Period**

Common to long-term care policies are elimination periods. The elimination period, sometimes called the deductible period or waiting period, is the number of days after which the policy holder qualifies for benefits but before benefits are payable. It is defined in terms of a certain number of days the policy holder must be in residence in a nursing home or the number of home care visits received before policy benefits begin.

A policy may define the elimination period in terms of service days or calendar days. Service day elimination periods count days in which the policy holder actually receives care, such as in the home or in a skilled nursing facility. Calendar day elimination periods simply count the number of days from the point that the policy holder first needed care, regardless of whether that care is actually delivered.

Common elimination periods are 30, 60, 90, 120, and 180 days. Under a 30-calendar-day elimination period, for example, the policy will begin paying benefits on the thirty-first day after the policy holder began to receive care. Under a 30-service-day elimination period, the policy will begin paying benefits on the thirty-first day of care delivered to the policy holder.

Typically, it is up to the policy holder to choose the length of the elimination period. The appropriate period should be matched to the policy holder's ability to cover the cost of his or her care out-of-pocket. The longer policy's elimination period result in a lower premium. Obviously, longer elimination periods mean higher out-of-pocket costs.

**Inflation Protection**

Also common to today's LTC policies are inflation protection features. Because the cost of care in the future is likely to be much more than it is today, and because a benefit amount purchased today may not be enough to cover higher costs years from now when care is needed, inflation protection is usually advisable. Under policies with inflation protection, the initial benefit amount will increase automatically each year at some specified rate over the life of the policy.

Most policies offer inflation protection as an option that the policy holder can elect or reject. Protection is typically defined as a set percentage of the initial benefit amount, which increases at either a simple or compounded rate over the life of the policy. Simple inflation protection increases a policy's daily benefit amount every year by a certain percentage (usually 5 percent) of the original daily benefit amount; compounded inflation protection increases the daily benefit amount annually by a certain percentage (usually 5 percent) of the current daily benefit amount of the

policy. For example, assume that Bill and Jill each purchase an LTC policy that provides a daily benefit of $100. Bill elects a simple 5 percent annual inflation protection; Jill elects a compounded 5 percent annual inflation protection. Every year, the daily benefit under Bill's policy will increase by $5 (5 percent of the original $100 daily benefit); the daily benefit under Jill's policy will compound the current daily benefit amount at 5 percent each year. The following shows the difference in daily benefits each will be able to count on in the future.

An inflation-protected policy provision can add a significant amount to the premium. However, without it, coverage may fall critically short of paying for services when they are needed. A policy that today would cover 100 percent of one's long-term care costs may, in a matter of only a few years, cover half or less of the cost if it does not include inflation protection.

**Pre-Existing Condition Limitations**

A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a licensed health care provider typically within six months before a policy's effective date. Some LTC policies contain a pre-existing condition limitation. This limitation is the period after purchasing the policy that benefits will not be payable for care related to that condition. Some policies apply pre-existing condition limitations only for medical conditions that are not disclosed on the application.

Most states require that policies covering long-term care services cannot contain a pre-existing condition limitation of more than six months after the effective date of coverage.

**Non-forfeiture Benefits**

A non-forfeiture provision is a clause in an insurance policy that allows the policy holder to receive all or a portion of the benefits or a partial refund on the premiums paid if the policy lapses due to nonpayment of premium. Essentially, it allows the policy holder to receive some value from the policy for premiums he or she had already paid. Common non-forfeiture provisions for LTC policies include:

-cash surrender option—This option allows the policy holder to surrender the policy for some cash amount if the policy lapses.

-return of premium option—This option allows the policy holder to receive some return of premiums paid if the policy lapses.

-shortened benefit period option—This option allows the policy holder to decrease the benefit period should the policy lapse. In other words, the policy holder retains the right to receive benefits under the policy equal in duration to premiums paid.

The non-forfeiture provision may be in effect only for a limited time and only after the policy has been in force for several years. Of course, no one should plan on letting an LTCI policy lapse, but a non-forfeiture clause can rescue some measure of benefits from the policy if it lapses.

**Policy Renewability**

Almost all individual long-term care policies are issued as guaranteed renewable (and those that

are tax-qualified must be). This means that the insurer cannot terminate the policy for any reason —not for the policy holder's advancing age, not for declining health, not for claims made against the policy, not for any other underwriting consideration. The policy must be renewed, and the policy holder has the right to keep the policy in force as long as the premiums are paid on time. The insurer also cannot make any changes in any provisions of the policy while the insurance is in force without the agreement of the policy holder.

Guaranteed renewable policies also provide some level of protection against premium increases. The insurer cannot increase the premium charged for an individual policy; it can only increase premiums for an entire class of policies or an entire class of policy holder. Insurers must submit premium increases to state insurance departments. States have only limited authority to deny increases, especially when claims experience supports requests for higher rates.

**Restoration of Benefits**

The restoration of benefits feature is used when the policy holder receives benefits under the policy, and then a stated time (typically six months) passes with no further benefits being paid. The maximum amount of the original benefit purchased under the policy is then restored.

To illustrate, assume Mary owns an LTCI policy with a lifetime maximum benefit of $300,000. Mary uses $20,000 of her benefit amount, but then recovers and does not require additional LTC services. After six months pass without Mary using any more of the policy's benefits, the insurer will restore the policy to the full $300,000.

Most policies provide a restoration of benefits feature at no or very low cost. This is due to the nature of long-term care and the fact that most who meet a policy's benefit trigger do not typically recover to the extent that they stop making claims against their policy for the specified period. If an additional premium is required for this feature, it is most useful for younger policy holder's who are more likely to recover from a disabling condition.

**Return of Premium**

Sometimes the benefits under an LTCI policy are never used. Perhaps the policy holder dies before becoming eligible for benefits, or the policy holder simply never requires long-term care. Traditional LTCI policies have no cash value, and some insurance citizens have avoided the product for this reason. Return of premium rider's address this issue.

When a return of premium rider is attached to an LTCI policy, and policy benefits are not used, the insurer returns a portion of the premiums paid to the policy holder or, if the policy holder is no longer living, to a named beneficiary. This option, of course, can be very expensive. It may also require the policy to have been in force for an extended period (ten years, for example).

**Waiver of Premium & Free-Look Period**

A waiver of premium provision under an LTCI policy waives the requirement of paying the policy's premium while the policy holder is receiving benefits under the policy. This provision may vary depending on the insurer and the type of policy. For example, the waiver may apply only when the benefits are payable for skilled nursing home care, not for home health care. Other insurers apply the waiver for home health care benefits as well. Some insurers allow the waiver to become

effective when the elimination period has been satisfied; others stipulate that the waiver becomes effective at some point after the elimination period is satisfied.

Long-term care policies, like all insurance policies, must provide policy holders with a free-look period. The free-look period is the time following policy purchase during which the policy holder may return the policy for any reason and receive a full refund. The free-look period is typically 30 days.

**Grace Period and Third-Party Notification**

Like most insurance policies, LTCI contracts include a grace period of at least 30 or 31 days before the policy lapses for nonpayment of premium. In other words, the insurer will accept a premium payment up to 30 or 31 days after it is due and not cancel the coverage.

Working in conjunction with the grace period is the third-party notification provision, which is unique to LTCI policies. This provision allows the policy holder to name a third party whom the insurer will notify in the event the policy is set to lapse because of nonpayment of the premium. The third party may be a relative, friend, or other advisor. With this option, the policy cannot be unintentionally terminated.

After notice is sent to the third party, the premium payment period is extended by an additional 30 or 31 days. During this time, the third party can see to it that the policy holder pays the premium or the third party can pay the overdue premium on behalf of the policy holder. This provision is particularly valuable for those with cognitive impairments.

**Bed Reservation Benefit**

If an LTC policy holder should require hospitalization during a stay in a nursing home or assisted care facility, some policies will pay to cover charges, up to the daily facility care benefit, to reserve the policy holder's bed in the nursing facility, typically for 7 to 21 days. Without this benefit, the family would have to pay to keep the bed open, or the nursing home could give the bed to someone else. Most nursing homes have waiting lists. Without a payment to hold a bed open, the policy holder would be forced to move if the home were full on his or her return.

**Premium Payment Options**

Most LTCI policies are issued on a level premium basis: that is, the same premium is due and payable as long as the policy is in force. For the payment of those premiums, the policy holder has a few options. These include:

Continuous payment option—With a continuous payment premium option, the policy holder pays premiums regularly—monthly, quarterly, semi-annually, or annually—as long as the policy is to remain in effect.

Guaranteed limited payment option—Under a guaranteed limited payment option, once the policy holder has made a certain number of annual payments, typically ten, the policy is paid up and no further premium payments are due. Of course, if rates increase during the premium payment period, the higher rate would apply. However, once the specified number of annual payments has been made, rate increases cannot affect the policy. The policy is fully paid up. Limited payment

options include 5-year pay, 10-year pay, 20-year pay, and paid-up-at-age 65.

Single premium payment—With the single premium payment option, the policy holder pays the full premium in advance. Even if rates increase, the policy holder will owe no additional amount.

**Upgrading/Downgrading Coverage**

Some insurers allow policy holders to upgrade their LTCI policies after purchase. However, a new medical questionnaire may have to be submitted. Some policies allow the option of upgrading coverage in the future without having to again prove insurability. An upgrade in coverage will require the payment of increased premiums.

Similarly, some insurers allow policy owners to downgrade their coverage, reduce their benefits, and thereby and reduce their premiums. This option is often called a step-down provision.

**Joint-Long-Term Care Policies**

Most long-term care insurance companies offer joint long-term care policies, sometimes called share care policies, for married couples. Joint policies are not a single policy; they are separate policies. However, with these policies, the total amount of coverage is pooled between the two. If one policy holder dies without having used all of his or her policy benefits, the surviving spouse has the unused benefits added to the remaining policy. Share care policies are typically more expensive than the purchase of two individual policies.

**Policy Exclusions**

LTCI policies, like all insurance, contain coverage limitations and exclusions. Generally, long-term care services are not covered when they result from the following conditions:

-Alcohol and drug addiction.
-Illnesses and/or injuries caused by acts of war.
-Wounds resulting from intentionally self-inflicted injury, such as attempted suicide.
-Treatment covered by Medicare.
-Services delivered by family members or friends.
-Some mental and nervous disorders.

It should be noted that under most state laws, long-term care policies cannot exclude Alzheimer's disease and other similar age-related dementias. Whereas Alzheimer's may be a condition for which an applicant is declined issue of a policy, it must be covered if a policy is issued. Thus, if a policy is issued and the policy holder subsequently develops this disease, coverage for its treatment cannot be excluded.

**Underwriting Long-Term Care Insurance**

When underwriting LTC policies, the focus is on the risks associated with long-term care, not acute care. For this reason, an applicant's functional and cognitive abilities are usually as or more important than medical conditions. An insurer will take into consideration a combination of factors: the applicant's age, gender, medical history, family history, current physical health, lifestyle habits, occupation, cognitive health, and similar factors. Because the LTC underwriter's job is to filter out applicants who pose a high risk of requiring care, and because cognitive disorders such as

memory loss and dementia are major contributors to long-term care claims and nursing home admissions, these conditions (or the potential for them) are closely examined and may be cause for denial. Common conditions that result in denial of LTC policy applications include

-Current or recent use of long-term care services.
-Needing help with activities of daily living.
-Having Alzheimer's or other dementia.
-Having AIDS or AIDS-related complex.

Other conditions may not preclude the issue of a policy; instead, the insurer may rate the policy and set premiums at a higher level or may impose a pre-existing condition limitation.

**Long-Term Care Insurance Premiums**

The premium for a long-term care policy is established when the policy is issued and will remain at that level (as long as the policy holder does not increase rates for the entire class of policies). This is in keeping with the concept that LTCI is designed to be maintained for the long-term. Unlike other forms of health insurance, it is not priced or subject to renewal annually. As a general rule, the younger the policy holder is at the time of application, the lower the policy's premium.

In addition to the policy holder's age and his or her personal traits, other factors affect the premiums for an individual LTC insurance policy. These include:

-Whether the policy is a comprehensive or non-comprehensive policy—Comprehensive policies cover a wider range of risks and thus are typically more expensive.

-The amount of the policy's daily benefit and the length of the policy's benefit period—The higher the benefit amount and the longer the benefit period, the greater will be the policy's premium.

-The length of the elimination period—The longer the elimination period during which the policy holder will be responsible for paying the full cost of his or her care, the lower the premium.

-Whether the policy provides for inflation protection—Policies that provide some measure to increase the level of benefits over the life of the policy are more expensive than those that do not provide this protection. Policies that use an annually compounded rate of return to increase benefits are more expensive than policies that use a simple rate of return.

-Whether the policy provides a non-forfeiture benefit—A non-forfeiture benefit allows an policy holder to receive some value from the policy for premiums paid in the event the policy is lapsed or terminated. Adding a non-forfeiture benefit to an LTC policy can significantly increase the policy's premiums.

These factors can be modified or customized to make the premiums more affordable. For example, by electing an elimination period of 180 days instead of 30 or 90 days, the policy holder can lower the policy's premium. By electing a benefit for home health care at a rate equal to 50 percent of the daily benefit for skilled nursing care instead of 75 percent, the premiums for a comprehensive policy will be less.

**Long-Term Care Claims**

Benefits under an LTCI policy are paid when the policy holder provides proof of loss—documentation that the policy holder meets one of the policy's benefit triggers. The process of claiming benefits under a long-term care policy usually begins with a call to the insurer's claims department and the submission of the necessary claims forms. As part of the process, the policy holder may be required to authorize the insurer access to the policy holder's medical records and to submit a plan of care as prescribed by a physician or other health-care practitioner. The insurer will gather the necessary information to verify that the policy holder has met the policy's benefit trigger. The review and evaluation process may take a number of weeks, but if the claim is approved, benefits are usually paid retroactively to the date the policy holder became eligible. In most cases, the policy holder is usually given the option of receiving benefits directly or having them assigned and paid to the care provider.

**Long-Term Care Partnership Programs**

As the need for long-term care grows and as greater and greater demand is made of state and federal health care programs, alternatives to the funding and delivery of such care have become necessary. One fairly new alternative comes in the form of state long-term care insurance partnership programs. Partnership programs represent something seldom seen: a genuine cooperation between business and government to address—and hopefully resolve—a major social issue before it becomes unmanageable.

**What Is an LTC Partnership Program?**

As we have learned, the cost of providing long-term care is largely borne by three parties:

-The government (primarily through Medicaid and, to a limited extent, through Medicare).
-Care recipients and their families (out-of-pocket through personal resources, assets and income, and through unpaid support delivered by family and friends).
-Insurance companies (primarily through LTCI policies).

Currently, the government carries the largest share of long-term care costs—approximately 66 percent. Citizens carry the next largest cost-share—about 22 percent—out-of-pocket. The smallest share—about 9 percent —is paid through private long-term care insurance.11 Intuitively, this seems backwards: an industry that is in the business of managing financial risk currently plays the least significant role in covering the cost of long-term care. Shifting this financial responsibility made so much fiscal sense that it became the basis for the "Partnership for Long-Term Care" initiative, a unique insurance program introduced in 1988 under the sponsorship of the Robert Wood Johnson Foundation (RWJF). The program's goal is simple: to encourage citizens to purchase affordable long-term care insurance policies and to reduce the burden on state Medicaid programs.

The partnership concept benefits all three parties to the long-term care financing issue:

-Citizen's benefit through the assurance of long-term care protection that can help them preserve personal assets (even if it becomes necessary to apply for Medicaid) while enjoying the greater choice of care options that insurance offers.

-States (specifically, their Medicaid programs) benefit by potentially reducing demand for Medicaid financing.

-Insurance companies benefit through increased ownership of their long-term care insurance products, which reinforces the insurance principle of spreading risk among a wider pool of individuals.

Originally modeled in four demonstration states (California, Connecticut, Indiana, and New York) and supported with funds and technical advice provided through the Robert Wood Johnson Foundation, the initial partnership programs were designed for the express purpose of giving seniors a way to ensure they had long-term care funding when needed and, perhaps more important, to retain more of their assets while potentially qualifying for Medicaid benefits. The defining element in these programs is a partnership-qualified long-term care insurance policy.

Purpose: Shift Financial Responsibility to Insurers

States have always relied on a simple approach to Medicaid cost recovery: shift a portion of the financial responsibility to another payor. Traditionally the "other payor" has been the Medicaid recipient, via Medicaid's financial eligibility rules. These rules require recipients to exhaust virtually all personal income and assets (or assign them to the state) in return for Medicaid payment of long-term care needs. Only a nominal amount of about $2,000 or $3,000 in assets may be retained by a Medicaid recipient. In addition, amounts Medicaid pays may be recovered at the Medicaid beneficiary's death through the process of estate recovery.

Partnership programs redefine Medicaid's "other payor" to include the LTCI industry. For individuals who own a partnership-qualified long-term care insurance policy, the insurance will pay their initial costs. If care is needed beyond the level or duration of that which the policy provides, the policy holder may apply for Medicaid coverage. Qualification for Medicaid eligibility by those who own a partnership policy allows the policy holders to retain assets equal to the amount of benefits their policies pay. In addition, the assets that were disregarded for Medicaid eligibility are not subject to estate recovery at the partnership recipient's death.

Long-term care partnership programs are aimed primarily at those who have assets they want to protect but who may not have the means to fully cover their own long-term health care out-of-pocket (or who do not have the ability to pay for an amount of LTCI that would completely finance their future health care needs). By participating in a partnership program and purchasing a qualifying LTCI partnership policy, these individuals can be assured that some amount of their assets will be protected, for themselves and their heirs, if ever they do have to turn to Medicaid for assistance.

**Minimum Standards for Group LTC Insurance Policies**

Though individual policies dominate the LTC market, coverage is also available on a group basis. Group policies may be partnership-qualifying.

With group policies, an employer is typically the policyholder; the employees are the policy holders. All group policy holders must be given a certificate of coverage describing principal

benefits and coverages, exclusions, reductions, and limitations. The NAIC Model Act and Regulations provides minimum standards for the continuation or conversion of such coverage in the event coverage terminates or is replaced.

**Continuation or Conversion of Group LTC Policies**
Continuation and conversion provisions give covered employees the right to either continue their group coverage or convert it to an individual policy providing essentially similar coverage. Either way, the terminated individual is fully responsible for paying premiums (even if the group plan was noncontributory). The DRA and the NAIC's Model Act and Regulations make continuation or conversation provisions mandatory in partnership policies, thus ensuring a terminating employee of some important rights:

-conversion—the right to convert from group coverage under the employer's policy to an individual policy without having to furnish evidence of insurability;

-continuation—the right to continue one's coverage under the employer-sponsored plan at one's own expense. The continuation of coverage may be limited in duration (for example, 18 or 36 months).

Continuation or conversion privileges apply when the employee leaves the employer, either voluntarily or involuntarily for other than gross misconduct.

**Discontinuance and Replacement of Group LTC Policies**
If a group long-term care partnership policy is replaced by another group partnership policy issued to the same policyholder, the replacing insurer must offer coverage to all persons who were covered under the previous policy on its date of termination. This coverage cannot result in an exclusion for pre-existing conditions that would have been covered under the previous policy and cannot vary or otherwise depend on the individual's health or disability status, claim experience, or use of LTC services. In addition, to the extent that an policy holder satisfied any pre-existing condition exclusion period, that time must be "credited" to any exclusion period required under the new policy.

The premium charged under the new policy cannot increase because of either the increasing age of the policy holder at ages beyond 65 or because of the duration for which the policy holder was covered under the policy.

**Minimum Standards for Marketing Partnership-Qualified LTC Insurance**
The DRA specifically cites certain provisions of the NAIC model pertaining to marketing and policy issue that insurers and producers must follow when selling LTC partnership policies. Again, it is likely that a state that has adopted the model will impose these standards on all LTC carriers and producers, regardless of whether the policies are sold in conjunction with a partnership program.

**Application Forms and Replacement Coverage**
All LTC application forms must be designed to elicit information as to whether, as of the date of the application, the applicant has another LTCI policy in force or whether a policy is intended to

replace any other accident and sickness or LTCI policy. The NAIC Model Act and Regulations sets forth specific questions to obtain this information. If it is determined that a sale will involve a replacement, the applicant must be given a copy of the "Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance."

In addition, the application must clearly provide notice that the company may have the right to deny benefits or rescind a policy if any answers on the application are incorrect or untrue. Producers must counsel their prospects and clients to provide full and truthful answers to all application questions.

**Prohibition on Post-Claims Underwriting**
Post-claims underwriting occurs when a policy is automatically issued upon application and a claim is subject to underwriting at the time the claim is filed. The usual consequence of post-claims underwriting is that coverage is denied and benefits will not be paid. This practice is specifically prohibited by the LTCI model act.

**Free Look**
Under the NAIC model, all LTC policies must provide for a free-look period of no less than 30 days and the right by the owner to return the policy for a full refund within that time for any reason.

**Treatment of Pre-Existing Conditions and Probationary Periods for Replacements**
If an LTCI policy (or, as noted, a group certificate) replaces another policy, the replacing insurer cannot apply any time periods for pre-existing conditions or probationary periods under the new contract to the extent that similar exclusions were satisfied under the original policy.

**Insurer Reporting Requirements**
For each LTCI producer, insurers must maintain records for replacement sales as a percentage of the producer's total annual sales, and the number of lapsed policies as a percentage of annual sales. Insurers must also report annually on its agents with the highest lapse and replacement rates. Replacements and lapses do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

As to qualified LTC contracts, insurers must report the number of claims denied for each class of business, expressed as a percentage of claims denied. It is likely that future versions of the NAIC model act will contain new and revised provisions for LTCI claims reviews and appeals processes for policy holders when claims are denied.

**Requirements for Marketing**
Every insurer marketing long-term care insurance, directly or through its producers, must conform to certain requirements with respect to marketing and selling LTCI policies, and establish auditable procedures for verifying compliance with these requirements. These requirements include the following:

-Establish marketing procedures and agent training requirements to ensure that marketing activities are fair and accurate and that excessive insurance is not sold or issued.

-Make every reasonable effort to identify whether a prospective LTCI applicant already has accident and sickness or LTCI and, if so, the types and amounts of any such insurance. However, in the case of qualified LTCI contracts, an inquiry into whether the applicant has accident and sickness insurance is not required.

-Make all required disclosures and provide copies of all required disclosures documents to applicants.

**Required Consumer Disclosures**

Required disclosures refer to the notices and information that an insurer must give to applicants and policy owners regarding their policies. They include policy language that clearly describes the policy's renewability, eligibility for benefits, and limitations. A partnership policy must clearly be labeled as "tax qualified." The insurer must also disclose whether and to what extent any premium rate increases have ever been imposed on the policy form.

In addition, all prospective applicants for LTC contracts must be given an outline of coverage and a copy of the NAIC's Long-Term Care Insurance Shopper's Guide(or a similar buyer's guide approved the state). The outline is intended to explain the significant features of the policy form, including its coverage and benefits, limitations and exclusions, the terms under which coverage may be continued, and the conditions under which premiums may be increased. The shopper's guide or buyer's guide helps citizens understand long-term care and the options that can help pay for long-term care services. The guide acts as a source to answer most of the questions posed by consumers and provides many tips to aid in the often complicated decision of whether to purchase LTC insurance.

**Producer Training Requirements**

Among the recent revisions to the NAIC LTCI Model Act and Regulation were those that established standards for producer training. These efforts were put on a fast track after DRA 2005 to coincide with state implementation of partnership programs. Recall that under the partnership provisions of the DRA, states must provide assurance to the CMS that producers who sell partnership policies can demonstrate an understanding of these policies and their relationship to public and private coverage of long-term care services.

The current NAIC model specifies that producers who sell LTC insurance must complete a one-time, eight-hour training course and, thereafter, ongoing four-hour continuing education every two years. The NAIC model applies the training requirements to all who sell long-term care insurance; however, a few states have limited the required training to only those who sell partnership policies.

**Suitability**

All insurers marketing long-term care must develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate for the needs of an

applicant. In addition, all insurers must train their agents in the use of their suitability standards and must maintain and make available a copy of its suitability standards for inspection by the state insurance commissioner. Because it is so important to the sale of LTC insurance, suitability will be addressed in detail in the final lesson of this course.