Chapter 8 Policy Considerations

What is a Traditional Long-Term Care Policy?
Since long-term care benefits cover multiple types of care, a long-term care policy might cover home care, assisted living, community-based services, adult day care (both medical and non-medical), or a nursing home. As time goes by, other forms of care may be developed. With these various services in mind, a long-term care policy is a contract that provides benefits for an extended period of time in some location other than a hospital. The exact benefits will vary, but each contract will have a policy schedule that states precisely what is covered. It will include the elimination period, the maximum daily benefit for home and adult day care, the maximum nursing home benefit and the maximum lifetime benefit. Even life insurance policies may have a nursing home benefit provision.

Like other types of contracts, traditional and Partnership long-term care contracts contain specific items. There will be a copy of the original application, policy provisions and attachments, if any. The policy contract is a legally binding contract between the applicant and the insurance company. No one, including the agent, can change any part of the policy or waive any of its provisions unless the change is approved in writing on the policy or on an attached endorsement by one of the company officers.

Policy Issue
Issuance or rejection of the policy application will be based on the applicant's health and lifestyle. Both Partnership and traditional long-term care policies have underwriting.

Underwriting will be based on the answers provided to medical questions on the application and on the responses received from attending medical professionals. Intentionally incorrect or omitted information on the part of the applicant or agent can cause the policy to be rescinded or cause benefits to be denied. If the policy has been in force for less than six months an otherwise valid claim has the possibility of denial if information was knowingly omitted or given incorrectly.

Once the policy has been in force for two full years, only fraudulent misstatements in the application may be used to void the policy or deny a claim. All contracts must conform to the laws of the state of issue. They must also conform to federal law, especially if the contract is a tax-qualified form. If any provision conflicts with the laws of the issuing state, the provision is automatically changed so that it will comply with the minimum requirements of that state.

Comprehensive and Non-Comprehensive Options
The amount of benefits available depends, in part, on the type of policy purchased. A comprehensive policy provides benefits for nursing homes, assisted living facilities and home care while a non-comprehensive policy is more specific. For example, the policy might cover only the nursing home or only care at home or in the community.

Medicare Benefits
In some ways, it is easier to state what long-term care insurance is not. Unfortunately for many

years senior citizens thought they had coverage for the nursing home when, in fact, they did not. This false sense of security was most often applied to Medicare and the supplemental insurances purchased. Medicare and the related policies do a good job on hospital and doctor bills, but neither covers the cost of a long-term nursing home stay. Let's take a look at the benefits provided by Medicare and Medigap policies.

It should be noted that even if a person continues to work past Medicare's qualifying age of 65, he or she can still apply for and receive Medicare benefits. In many cases, if the employer supplies medical coverage, Medicare will become the secondary payer.

Individuals that are nearing their 65th birthday but do not currently and have no plans to begin taking Social Security income yet will need to sign up for Medicare Parts A and B. If the individual already does or plans to begin drawing Social Security income then usually they are automatically signed up for Medicare Part A. Part B will also begin unless the individual specifically refuses it. Individuals may sign up for Part A and B during the seven month period that begins three months prior to the month in which the individual turns age 65. However, if his or her birthday is on the first day of the month, then coverage begins the first day of the prior month.

Medicare is not completely free: there is a premium that will be due for Part B each month. Part A is free assuming adequate payments paid made into the Social Security program while working.

Over the years there have been some changes in (ACA) Medicare, many of them advantageous for Medicare's beneficiaries. Even the Affordable Care Act provided expanded Medicare benefits.

The ACA expanded services such as preventive care, cancer screenings, and yearly wellness visits, all of which cost the beneficiary nothing. There is expanded drug coverage also began for the so-called "donut hole" that some beneficiaries had to deal with.

There is also a Medicare tool called Medicare's Blue Button, on MyMedicare.gov. Once registered, the Medicare beneficiary may see what has been charged, how much Medicare covered, and any balances that might be due.

Medicare health plans and prescription drug plans can change costs and coverage each year so anyone with Medicare health or prescription coverage should always review the materials their plan sends them. There are yearly open enrollment periods.

There was much concern with the adoption of the Affordable Care Act and the resulting Health Insurance Marketplace, that Medicare beneficiaries might lose benefits, but that is not the case. The Health Insurance Marketplace is certainly part of the Affordable Care Act, which became effective in 2014, but Medicare is not part of the Marketplace. This is true whether benefits are received through the Original Medicare or a Medicare Advantage Plan; benefits are not affected.

There are four parts to Medicare: Part A, Part B, Part C (which is actually Parts A and B combined), and Part D.

Medicare Part A (Hospital Insurance)

Part A helps to pay for:

-Inpatient care in hospitals
-Inpatient skilled nursing facility care (never custodial or intermediate care)
-Hospice care
-Home health care
-Blood
-Inpatient care in a religious nonmedical health care institution

It is important to remember that staying overnight in a hospital does not automatically mean it is covered by Medicare. A person only becomes an "inpatient" when the hospital formally admits the individual, which must be done under a doctor's orders. Going to the hospital's emergency room and receiving treatment is not considered inpatient care.

Medicare will pay the hospital costs in the following manner:

-Semiprivate room and board (meals).

-General nursing and miscellaneous services and supplies.

-Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

-The first 60 days of confinement EXCEPT for the deductible. The deductible amount can change each January first.

-From the 61st day through the 90th day EXCEPT for the co-payment which must be covered by either the patient or their insurance company. Again, the amount of the co-payment can change each year, beginning on January first.

-From the 91st day and after:

-While using 60 lifetime reserve days. There is a co-payment that would not be covered by Medicare. The patient or their Medigap policy would cover this co-payment.

-Once lifetime reserve days are used, an additional 365 days will be covered by the Medigap insurance policy if there is one in place.

-Beyond the additional 365 days, there are no more hospital benefits under Medicare.

Skilled Nursing Care Covered Under Medicare

Medicare only covers skilled nursing care, with the supplemental insurance picking up the coinsurance amounts. Unfortunately, many consumers thought skilled nursing care was long-term

care coverage; it's not. In fact, the amount of coverage allowed is quite small. In order to receive any nursing home benefits under Medicare, the recipient must meet Medicare's requirements. This includes 3 days of hospital confinement for a related illness or injury. The patient must enter a Medicare-approved facility within 30 days after leaving the hospital.

The Medicare beneficiary, upon entering the nursing home, will receive benefits for only skilled care. Coverage is not available for either intermediate or custodial care by Medicare or their Medicare supplemental insurance policy. Custodial care may also be called maintenance or personal care and is the type most commonly received. When the level of care received is skilled (not intermediate or custodial) Medicare will pay for the first 20 days entirely. Neither the patient nor their supplemental policy will have to cover anything, as long as the charges are approved. Approval is the key point. Anything not approved by Medicare will not be covered.

From the 21st day through the 100th day, Medicare will pay all charges except for a daily co-payment which either the patient or their Medigap policy must pay. After the 100th day, there are no benefits under Medicare or a Medigap policy. From that point on, even if the care being received is skilled care, there are no benefits due.

Obviously 100 days of coverage is not sufficient and cannot be considered "long-term." Even the federal definition of long-term care defines a care period of no less than 90 days. The consumer cannot and should not rely on Medicare or their supplemental Medigap policy for long-term medical needs in a nursing home facility.

Some Medicare recipients do receive skilled care benefits. To qualify for the nursing home care that is available under Medicare, the patient must meet certain qualifications, including:

-The doctor must certify that the care is necessary.
-Skilled care must be received, not intermediate or custodial care.
-The facility must be Medicare approved or certified.
-The facility's Utilization Review Committee cannot have disapproved the stay.
-The care must be rehabilitative in nature.

Consumer's Report magazine stated that Medicare could be relied upon to pay very little for long-term nursing home care. Only two percent of those who required nursing home benefits received them through Medicare.

Not all quote the same statistics. According to the United States Department of Health and Human Services the average length of time in a nursing home is 456 days. Other sources will quote from 2.5 years to 3 years. The figure quoted will depend upon how the figures were gathered and organized. Many people require only three months or less in a nursing home, due to surgeries that require some rehabilitative treatment, such as physical therapy. When these short stays are averaged in, as they were by the Health and Human Services, average lengths of stays will appear shorter. What we do know to be true is that more people are using nursing homes than twenty years ago and people are staying longer due to the excellent care now available.

Home Health Care
Home health care may be covered under Part A of Medicare, again if all qualifications are first met. Home health care is provided on a part-time (never full-time) basis. It includes intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment, such as wheelchairs and hospital beds, medical supplies and other related services.

Hospice Care
Hospice care for the terminally ill is also covered under Part A of Medicare. It includes coverage for drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice and other services not otherwise covered by Medicare. Hospice care is typically provided in the patient's home, although Medicare covers some short-term hospital and inpatient respite care under specific circumstances.

Medicare Part B (Medical Insurance)
Medicare Part B helps to cover:

-Services from doctors and other health care providers
-Outpatient care
-Home health care
-Durable medical equipment
-Some types of preventive services
-Blood (this is covered under either Part A or Part B).

Part B of Medicare, called Medical Insurance, helps cover doctors' fees and services and outpatient hospital care. This includes doctor visits other than routine physical exams, outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment such as wheelchairs and hospital beds. Second surgical opinions are also covered. Clinical laboratory services such as blood tests, urinalysis, some screening tests, and blood are covered. It also covers some other medical services that Part A does not cover, such as physical and occupational therapists, and some home health care. In order for these services to be covered, they must be considered medically necessary under Medicare's guidelines.

There are now many preventive services available. Such as:

-Bone mass measurements are for determining bone density. This test helps to determine if the individual is at risk for broken bones and may be performed once every twenty-four months.

-Breast cancer screening is mammograms, which are covered to check for breast cancer once every 12 months for all women with Medicare who are at least forty years old.

Medicare also covers comprehensive programs that include exercise, education and counseling for patients who meet specific conditions. They cover intensive cardiac rehabilitation programs that are usually more rigorous than regular cardiac rehabilitation programs. Services are covered in the doctor's office or hospital outpatient setting. There will be a 20 percent copayment and of

course the service must meet Medicare's guidelines. Cardiovascular disease behavioral therapy with the beneficiary's primary doctor is a covered service too so that the beneficiary can have his or her blood pressure checked as well as discussions regarding aspirin therapy or other means of controlling symptoms.

There is limited coverage for chiropractic services to help correct subluxation using manipulation of the spine. There will be a 20 percent copayment and again it must meet Medicare's guidelines for them to make a payment.

There are other covered services, such as EKG's, durable medical equipment such as walkers, glaucoma tests and hearing and balance exams. We will not cover all Part B services since they do not necessarily relate to long-term care services.

Each Medicare recipient should receive a copy of the current Medicare handbook from the federal government to learn precisely what benefits will be received.

There is a cost for Part B of Medicare, which is taken out of the individual's Social Security check each month (an automatic withdrawal). The cost of Part B changes each year. In some cases, the amount charged may be higher than normal if the recipient did not sign up for Part B when he or she first became eligible for the benefits. The cost goes up 10% for each 12-month period that the person was eligible, but did not enroll. The extra cost continues for as long as the recipient continues to have Part B.

Medicare Part B rates might also vary due to income. Those with higher incomes in the previous year will be assessed additional cost.

Each year Medicare uses the amount listed on the most recent Federal income tax return to decide the coming year's premium amount for the individual. However, Medicare never goes back more than three years. Medicare requests from IRS the tax filing status, the adjusted gross income, and the individual's tax-exempt interest income. Then they add the adjusted gross income together with the person's tax-exempt interest income to get an amount called the modified adjusted gross income (MAGI). This is compared with the income thresholds set by Medicare law.

The modified adjusted gross income may include one-time only income, such as capital gains, property that has been sold, withdrawals from individual retirement accounts or conversions from traditional IRAs to Roth IRAs. One time income affects only one year of Medicare premiums.

New premium rates become effective every January first of each year. While it is not required that costs go up, they inevitably do each year. Current premium rates may be found by going online at www.medicare.gov or by calling 1-800-MEDICARE.

While Part A of Medicare is automatic and free, assuming adequate payment has been made through payroll taxes, individuals must sign up for Part B. If an individual is already receiving Social Security benefits, or Railroad Retirement benefits, he or she is automatically enrolled in Part

B starting the first day of the month in which age 65 is attained. For those who are under age 65 and disabled, enrollment is automatic after 24 months of being on Social Security disability. An individual has to be disabled for five full calendar months in a row to qualify for Social Security benefits. A Medicare card will be mailed about three months prior to the person's 65th birthday or prior to the 25th month of disability benefits. Those who do not want to pay for and receive Part B Medicare benefits must specifically reject them by following the instructions that come with the Medicare card. Otherwise, enrollment will be automatic.

Those born on the first day of the month receive Medicare benefits effective the first day of the previous month. For example, a person born on November 1 receives Medicare effective as of October 1 of the year in which they turn 65 years old.

Medicare Part C (Medicare Advantage)
Medicare Part C includes all benefits and services covered under Parts A and B and are run by Medicare-approved private insurance companies and health maintenance organizations. It usually includes Medicare prescription drug coverage, which is Part D, as part of the overall plan. In some cases there is extra benefits and services available although it may cost more to include them.

Medicare Part D (Medicare Prescription Drug Coverage)
Medicare Part D helps cover the cost of prescription drugs. It is run by Medicare-approved private insurance companies. Part D may help lower the cost of prescription drugs and it helps protect against higher costs in the future.

Medicare Supplemental Policies
Supplemental policies do not pay for long-term care services. Although there are multiple choices, none of them are designed to cover long-term care needs. Every so often, Congress will address the growing needs of long-term care for the elderly, but cost is always a primary issue. With Medicaid facing the costs expected from the baby boom generation, it is hoped that Partnership plan sales will provide some relief.

When a person first signs on with Medicare they receive coverage for hospital and doctor bills, but Medicare does not pay for everything. There are two main ways to receive Medicare coverage: through the Original Medicare plan or through a Medicare Advantage plan. Those who choose an advantage plan should not buy any type of Medicare supplemental insurance policy; in fact agents are not allowed to sell one to a person on this type of Medicare coverage.

Medicare Advantage plans combines Parts A and B to equal Part C; it also includes Part D in most cases. Therefore, Part C is merely a combination of Parts A and B under health maintenance organizations (HMO) or preferred provider organizations (PPO).

The Original Medicare Plan
The Original Medicare Plan covers most health care services and supplies, but it doesn't cover everything. Generally people choose to also buy some type of additional coverage (supplemental insurance). Original Medicare is a fee-for-service plan, which means the individual is charged a fee for each service they receive. This plan is managed by the Federal government and is

available nationwide. Those enrolled in this plan use a red, white, and blue Medicare card when they receive health care so that the provider may bill Medicare from the information contained on the card. There is a monthly fee for Medicare Part B (which is subtracted from the individual's monthly Social Security income) plus a premium for the supplemental insurance coverage if one has been purchased from an insurer.

The Original Medicare plan is coverage provided directly from Medicare, without a middle man so to speak. The beneficiary may go to any Medicare-approved provider he or she wishes to without consent from an insurer organization or a primary-care doctor. There will be deductibles and copayments and there will be a Part B premium deducted each month from their Social Security income.

To receive prescription coverage the beneficiary must sign on with a Medicare Prescription Drug plan of their choice. There will be a cost for this.

The Original Medicare plan does not cover long-term nursing home care. It will pay for skilled nursing care under specific circumstances for up to 100 days. The individual pays for a co-pay amount from the 21st through the 100th day. The first 20 days are fully covered by Medicare as long as the patient qualifies for such care (only skilled care is covered).

The Original Medicare plan will pay for both home care and hospice care under specific circumstances. The individual will pay nothing for home care services if they qualify to receive them. Medicare fully covers the cost. The beneficiary will have to pay for 20 percent of the Medicare-approved amounts for durable medical equipment.

Hospice care is care for the terminally ill. The individual must pay a copayment for hospice care for outpatient prescription drugs and a percentage of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient so the usual caregiver can rest).

The amount one pays for respite care can change each year. Medicare doesn't typically pay for room and board except in certain cases.

Medicare Advantage Plans

Medicare Advantage Plans require both parts A and B of Medicare be in place. Private companies' contract with the Medicare program to offer the coverage to those who feel this type of coverage benefits them. Belonging to this program does not mean that they have opted out of Medicare; they are still in Medicare.

Congress created Medicare Advantage Plans to provide the recipient with additional choices and perhaps even extra benefits than they would receive under the Original Medicare Plan. The beneficiary usually has to go to specific doctors, specialists and hospitals under Medicare Advantage. They are given a list of those that they may choose from. A primary doctor is chosen who then provides referrals when other specialists are needed.

Under this option, the beneficiary may choose from Medicare managed care plans or other

qualifying organizations. The individual is still in the Medicare program regardless of the advantage plan selected. That means the individual still has Medicare rights and protections. The regular Medicare services are still available but some plans may provide additional benefits. However, in all cases, there is no coverage beyond that supplied by Medicare for long-term care services.

Decisions on which type of plan to join are usually made on the basis of cost and benefits. The ability to choose doctors independently may also be a factor.

Protecting Assets

Obviously, no one really wants to go to a nursing home. That is one reason for the popularity of alternative care options, such as assisted living. At one time, AARP reported that the majority of elder Americans believed the government would take care of them through Medicare. Today, most people realize that is not the case. In the past ten years, the sale of long-term care policies have increased as people sought ways to protect their assets from medical costs.

Protecting one's assets is a valid concern. Many elderly people do eventually qualify for Medicaid, but only after they have depleted most of their personal non-housing resources. Medicaid is the joint federal-state program that pays for health care costs for needy low-income residents of all ages (not just the elderly). Benefits are typically available to the poor, to certain disabled citizens, and to persons over the age of 65 who meet the economic means test. To meet this economic means test, the person must be impoverished. Some items are exempt while still allowing qualification. One asset that would be exempt is the person's personal home, in which they have been residing. Also exempt are some personal items, one vehicle for transportation, and in a few cases, specific types of annuities. Income producing property may be exempt as long as the income goes towards the person's care. Since each state controls some aspects of Medicaid qualification, it is very important to understand your own state's guidelines. While each state pays approximately half of the cost (with the federal government paying the other half) the exact amount paid by the state varies depending on multiple factors. Each state also is allowed to administer many elements according to their own desires, as long as it does not clash with federal guidelines. As a result, what worked for Uncle Joe in California may not work for Aunt Mabel in New York.

There is one aspect of Medicaid that is uniform to all states: the fact that qualification depends upon "spending-down" assets if no Partnership long-term care insurance policy is in place. People who prided themselves on always paying their own way may find themselves in the position of having to ask for financial help.

Medicaid Benefits

Even though the states have general control of their Medicaid funds, they must also follow federal laws. Federal law requires states to provide a minimum level of services to Medicaid beneficiaries. Those services include such things as inpatient and outpatient hospital care, laboratory and X-ray services, skilled nursing home care and home health services for those aged 21 and older, examination and treatment for children under the age of 21, family planning and rural health clinics. About half of Medicaid spending goes for federally mandated services. States pay health

care providers directly for patient services and almost invariably require doctors to accept the state fees as full payment. Doctors and other medical suppliers are legally required to accept the amount paid by Medicaid, which means they cannot bill their patients for any additional amount. Therefore, some medical providers may not accept Medicaid patients.

Medicaid funding, as well as Medicare funding, has become a real concern. As the baby boom generation reaches retirement, adequate funding may not be available under current funding procedures. About 45 cents out of every dollar goes to pay for nursing home care for only about 8 percent of the beneficiaries. That means that approximately 8 people out of every 100 Medicaid enrollees use nearly half of the Medicaid funds. Funds under Aid for Dependent Children and their parents make up about 70 percent of Medicaid's caseload, but they only receive about 30 percent of the total funding. Many argue that the largest amount of money should be spent on our younger Americans rather than the older, less productive retired group. While we might like to do that, where would that leave the older generation? They must be cared for. This has brought about much debate but it has also brought about alternative developments such as assisted living facilities and community-based care programs that prevent institutionalization (which is the most expensive type of care). It is likely that the future will bring even newer developments as we try to sort out the financial aspects of a graying nation.

All aspects of government have faced budget problems. Medicare and Medicaid perhaps face the greatest challenge since they must deal with the increasing elderly population. Rising medical costs also play a role. It is common to spend the most money on the last three months of our lives. Many of the medical procedures do nothing more than delay death. However, medical professionals are reluctant to do less than everything possible since lawsuits have become pervasive in the United States.

Nearly every state has faced severe budget deficits in their Medicaid funding. Some states have actually put a ban on building additional nursing homes in an attempt to curb the rising costs. The federal and state governments have attempted to control the rising costs in some way.

Fraud and abuse in the medical field has played a major role in the rising costs associated with Medicaid and Medicare. While Medicare has a single administrator (the federal government), Medicaid has 50 separate administrators, because each state is in charge of their own program. This makes it difficult to curb fraud and abuse of the Medicaid system. There is no doubt that part of the funds end up in the pockets of dishonest medical providers.

Many elderly consumers believe the military will, in some way, provide for their nursing home needs. Due to a shortage of beds, even when the veteran might qualify, the chances of actually getting such coverage are small. It only takes a call to the military agency for them to confirm this.

The Patient Protection and Affordable Care Act

The Affordable Care Act, often known as Obamacare, was not designed specifically for those on Medicare, although some elements affect it. The ACA gives beneficiaries, according to the AARP website, more control of their health care by offering new ways to select coverage. The current

job-based Medicare program has not changed. Although the Affordable Care Act mandated insurance coverage, that element did not affect Medicare beneficiaries (Medicare is their insurance already).

There was lots of talk about the new Health Insurance Marketplace, but Medicare beneficiaries were not affected by this. The marketplace was just for people who needed to buy private individual insurance policies, not for those on Medicare or Medicaid. The Marketplace is also not applicable to those in the military. However, if financial help is needed, then the Marketplace would be where the individual would go. Medigap policies are not sold through the Health Insurance Marketplace so Medicare beneficiaries would not go there to buy one.

The Donut Hole

Most Medicare Part D prescription drug plans have a gap in coverage that is called the "donut hole." It got its name from the fact that initially there is coverage; then there is no coverage for a period of time; then there is coverage once again after a certain dollar amount is surpassed. Due to the Affordable Care Act the coverage gap is slowly closing and will completely disappear in the year 2020.

In General

Medicare has not changed due to the passage of the Affordable Care Act. The changes that did affect the program were improvements. Medicare coverage is protected so there was no need to replace any current coverage in place. There are certainly more preventive services however due to the ACA, so Medicare beneficiaries came out ahead.

Under the ACA, there is also a savings on brand-name drugs so those who are currently in the donut hole will pay less during their time of non-coverage. As previously stated, the donut hole closes completely by 2020.

Physicians will receive more support, allowing them to be paid for the extra time that elderly Americans often require. Under the care coordination of the ACA, doctors get additional resources to make sure the treatments of their Medicare patients are consistent.

The Affordable Care Act actually protected Medicare benefits for some time. The life of the Medicare Trust fund was extended to at least the year 2029, which was a twelve year extension. The extension is primarily a result of reductions in waste, fraud and abuse, and Medicare costs in general. It is expected to also save on future premiums and coinsurance costs.

State Requirements

The insurance contracts offered vary with the state, since each state requires certain features. Each policy must follow the guidelines of the state where issued. There will still be similarities from state to state, but the actual benefit features will depend upon state requirements. Each policy has benefits, exclusions and limitations that are fairly standard. All will be within the limits of the state's regulations. Many states use the NAIC guidelines.

Most states will have adopted tax-qualified LTC policies, so there will be two types available: tax

qualified and non-tax qualified. In a few states, there will also be partnership policies available. Partnership policies are a special kind designed to allow enrollees to avoid impoverishment due to a nursing home confinement. They require special agent education to market them. They may not be marketed unless this education is completed.

Relying on Insurance for LTC Payment

Over the past ten years, insurance policies for long-term care needs have become increasingly popular for those who can afford them. Not all insurance policies are adequate for long-term nursing home care, however. The consumer must choose wisely. Since many states are now mandating certain requirements, if the consumer (and selling agent) selects a policy labeled Nursing Home Policy it will probably do an adequate job. Most states have mandated specific names for specific policies in an effort to make consumer selection easier. A policy might be labeled Home Care Only, Comprehensive, or Nursing Home Facility Only policy. Each state will have their own titles, but whatever your state uses, it is important that you understand the benefits each one contains.

Federal legislation, under HIPAA, has established policies that are "tax-qualified." These tend to be uniform from state to state. Therefore, consumers must choose between non-qualified and qualified forms. When we speak of qualified and non-qualified we are always referring to the tax implications. The tax-qualified plans meet certain tax qualifications; the non-tax qualified contracts do not. However, few people choose a long-term care plan based on a potential tax deduction. Luckily, the main focus is typically on the benefits provided. In many cases, non-tax qualified plans offer better home care benefits and better benefit qualification.

Insurance Pricing

Consumers play a role in determining the cost of their long-term care policy based on their selection of benefits at the time of application. We have already mentioned another pricing factor: application age. The benefit options chosen will also affect how much the policy costs. Obviously, if greater benefits are selected, the cost of the policy will reflect that. Policy options will be discussed further in another chapter, but basically the consumer can choose from a wide variety, including an inflation rider option, the daily benefit amount, home health care benefits and the deductible (called a waiting period or elimination period). Some companies may offer additional options. Premium can also be affected by whether or not the applicant smokes and whether or not both spouses are applying. Some companies offer discounts if both spouses take out a policy. Some companies may also offer a discount in premium for those that are considered extremely healthy physically and in their lifestyle.

Premium Mode

Premium mode payment is similar to other types of policies in that they may be paid yearly, semi-yearly, quarterly, or monthly. When the consumer desires monthly payments, they might be required by the issuing company to use a monthly bank draft rather than direct billings. A few companies will allow the applicant to pay personally each month, but most companies require monthly payments to be through a bank draft. This makes good sense, since a person could easily overlook the payment of their premium if they were sick. As a result, someone who mailed in a check each month could allow their policy to lapse just when they needed it most. A few insurers allow only annually, semi-annually or quarterly payment modes, except in states that

have specific payment requirements. California, for example, does not allow the agent to collect more than one month's payment at the point of application. The consumer can pay a larger premium mode later directly through the company.

Age as a Pricing Factor

The age of the applicant will have an impact on the cost of any long-term care policy since age directly relates to the insurer's risk; age matters because the less time the insurance company has to collect premiums, the greater the company's risk exposure is. Due to the increasing risk that age brings, older applicants must expect to pay more for their policy, whether it is a traditional long-term care contract or a Partnership long-term care contract.

There are two ways to price policy applications: by attained age and by age banding. Attained age relates to the age of the person at the time of application. Age banding also looks at the age at application, but rates are based on several ages banded together.

Age banded contracts quote the same price for each age within the banding. For example, an applicant aged 69 would pay the same premium amount as an applicant aged 65 would. The 65 year old may get a better buy if he or she purchased from a company that priced by attained age whereas the 69 year old may find banding more advantageous.

Not all companies will issue a policy past the age of 79. This example showed an age banding of 80-84, but individuals will want to check with the company they are considering to see if they can obtain a policy if they are in that age bracket.

A Younger Market Developing

When long-term care policies first came on the market no one expected any interest from consumers who were not yet receiving Medicare benefits (age 65 and older). Initially, they were probably correct in their assumption. Today, however, many individuals in their forties and fifties are expressing interest. The average Partnership applicant is between 50 and 60 years old. Surprisingly most American-based insurance companies do not sell, or even offer to sell, a policy to people under the age of forty. That is beginning to change. Since prices are always lower for the younger ages, buying early is attractive to those consumers who understand the need. This younger age interest is primarily coming from those between the ages of 50 and 60, when it is possible to get better benefits for less premium cost.

Our neighbors to the North, Canada, sell policies to their citizens at much younger ages and insurers actively promote their sale. America is beginning to promote sales to people at younger ages, but it can be very difficult since citizens in the United States do not seem interested prior to age fifty.

Additionally, some of the risks associated with sales to younger people have not been overlooked by the insurance industry. They are well aware of the possible financial effects that AIDS and other devastating diseases could bring to the long-term care costs in this country. Many experts feel that the insurers are hesitant to offer long-term care policies to younger ages for this reason. Insurers have good reason to worry. AIDS, as an example, is a disease that could cause younger

people to overtake the elderly in the need for long-term care if it were to ever become wide spread in America. It is thought that underwriting may begin to use similar testing for long-term care that is currently used for life insurance products - a blood test. This may apply only to the under age 40 group or it may be applied uniformly to avoid discrimination claims. However such tests end up being applied, most underwriters are expecting to initiate such medical procedures as part of the application process in the coming years.

Reducing Benefits to Save Premium

When premium rates jump unexpectedly, not all consumers will be able to absorb the additional cost. Some individuals will allow their policies to lapse. Others will strive to find a solution. Some states have provisions allowing the policyholder to reduce their benefits, which reduces their premium. This is an attempt by the states to keep long-term care policies in force even when the consumer has to cut back on costs. It is better for both the consumer and the state to have some benefits in place rather than no benefits at all.

There are several ways that benefits may be reduced:

1.Reduce the length of benefit payments (from lifetime to 4 years, for example).

2.Reduce the daily benefit amount.

3.Discontinue some benefits, such as home health care options.

4.Convert from one policy form to another, if the state has provisions that allow this.

The premium reductions are typically based on the policyholder's age at the time of original application. This may not be true where benefits are added rather than reduced. Where there are no state provisions allowing benefit reduction in order to reduce premium, companies may require a totally new application, which means that the reduction of benefits may not save any premium if the applicant is older now than when he or she originally applied for coverage.

Although there will be policy variations, even within the same company, there will also be similarities. Of course, every policy must conform to state requirements.

Guaranteed Renewable

Long-term care policies are guaranteed renewable, meaning the contract is guaranteed to be renewed (cannot be canceled), but premiums are subject to change. In a guaranteed renewable policy the insured's contract will remain in effect during their lifetime, as long as premiums are paid in a timely manner. The policy benefits cannot be changed without the policyholder's consent.

Policy Review: 30-Day "Free Look"

While most people now realize the need to protect themselves from the costs of long-term care expenses, not everyone agrees that an insurance policy is the best avenue for doing so.

Therefore, many people desire a time to review the actual policy and think it over. Companies issuing long-term care policies allow a 30-day period to do just that. It is commonly called the "free look" period. Within that 30-day period of time, they may change their mind and return the policy to either their agent or the issuing company. All of their premium must be returned to them. The consumer need not say why they have changed their mind. The refund must be issued within 30 days of the consumer's notification to cancel the policy.

When a policy is returned during the applicant's "free look" period, the policy is null and voided. This means the policy is considered as never having been issued. It also means the insurance company is not liable for any claims.

"Notice to Buyer"

Each issued long-term care policy is designed to cover specific costs related to aging. Under the heading of "Notice to Buyer" the insurance company will list the benefits that are provided by the policy. This statement may be specifically mandated by the state where issued or it may be a general statement made by the insurance company. This notice advises the insured to carefully review the policy's limitations. This should be done within the first 30 days so that the policyholder can return their policy for a refund if they are dissatisfied with those limitations.

Policy Schedule

The policy schedule will list the insured's name and the options that were purchased by the insured at the time of application. Some of the possible items listed include the:

-Elimination period (deductible expressed as days not covered)
-Maximum daily home and adult day health care benefit
-Maximum daily nursing home facility benefit
-Maximum lifetime benefit
-Type of inflation benefit, if any.

There may be other types of benefits besides the five listed above.

The amount of premium due annually will be stated along with the amount of premium paid with the application. The amount paid with the application may be different than the annual premium stated, since the policyholder may have paid quarterly or semi-annually.

The Policy Schedule page will list the policy number and the policy effective date. The first renewal date may also be listed, which will reflect how the first premium was paid (quarterly, semi-annually or annually).