Chapter 10 Policy Definitions

Policy Definitions
All insurance contracts are legal documents using legal terminology. As part of this, definitions used in the contract will be defined. While some terms may seem standard, this should not be assumed.

The exact listing of the page heading may vary, but probably it will state "definitions" somewhere.

Whatever the page heading, it will state exactly what the policy terms mean or give the page number in the policy where the definition is listed.

The following is a list of commonly used definitions:

Activities of Daily Living
The activities of daily living are defined in each insurance contract. The federal government has also defined them for tax-qualified long-term care contracts. These may vary from company to company and between tax- and non-tax-qualified contracts. The activities listed are very important because they determine the conditions under which payment will be made. Policies that list seven conditions are more favorable for the policyholder than those which list only five (2 out of 7 are better odds than 2 out of 5). The following five are generally included:

-Eating
-Dressing
-Bathing
-Toileting & associated functions
-Transferring to and from beds, wheelchairs, or chairs.

Adult Day Health Care
Adult day health care is community based group program that provides health, social and related support services in a facility that is licensed or certified by the state as an Adult Day Health Care Center for impaired adults. It does not mean 24-hour care.

Alternate Care Facility
An alternative care facility is one that is engaged primarily in providing ongoing care and related services to inpatients in one location and meets all of the following criteria:

-Provides 24 hour a day care and services sufficient to support needs resulting from the inability to perform Activities of Daily Living or cognitive impairment;

-Has a trained and ready to respond employee on duty at all times to provide that care

-Provides 3 meals a day and accommodates special dietary needs

-Licensed or accredited by the appropriate agency, where required, to provide such care

-Provides formal arrangements for the services of a physician or nurse to furnish medical care in case of emergency

-Provides appropriate methods and procedures for handling and administering drugs and biologicals.

Many types of facilities would meet these criteria.

Caregiver Training
Caregiver training is training provided by a home health care agency, long-term care facility, or a hospital and received by the informal caregiver to care for the insured in his or her home.

Cognitive Impairment
A cognitive impairment is the deterioration of a person's intellectual capacity which requires regular supervision to protect themselves and others. This often must be determined by clinical diagnosis or tests. Cognitive impairment may be the result of Alzheimer's disease, senile dementia, or other nervous or mental disorders of organic origin.

Effective Date of Coverage
The effective date of coverage is the date listed on the Policy Schedule page, which states the first date of coverage under the policy. It is not necessarily the date of policy application.

Elimination Period
An elimination period, also called a waiting period, is the number of days of qualified care received, but not covered by the policy due to the elimination period selected at the time of policy application. Once the designated number of days has passed, benefits will begin. This time period will be shown on the Policy Schedule page.

Home & Community Based Care
Home and community-based care is required and provided in a home convalescent unit under a plan of treatment, in an alternate care facility, or in adult day health care.

Home Convalescent Unit
Home convalescent units are NOT a hospital. It may be one of the following:

-The insured's home
-A private home
-A home for the retired
-A home for the aged
-A place which provides residential care
-A section of a nursing facility providing only residential care.

Home Health Care Agency
A home health care agency is an entity that provides home health care services and has an agreement as a provider of home health care services under the Medicare program or is licensed by state law as a Home Health Care Agency.

Inability to Perform Activities of Daily Living
An inability to perform the activities of daily living means the insured is dependent on another person to help them function on a daily basis. This may be the result of injury, sickness or simple frailty due to age.

Informal Care
Informal care is custodial care provided by an informal caregiver, making it unnecessary for the insured to be in a long-term care facility or to receive such custodial care in the residence from a paid provider.

Informal Caregiver
An informal caregiver is a person who has the primary responsibility of caring for the patient in their residence. A person who is paid for caring for the patient cannot be an informal caregiver.

Long-Term Care Facility
A long-term care facility is a place which:

-Is licensed by the state where it is located
-Provides skilled, intermediate, or custodial nursing care on an inpatient basis under the supervision of a physician
-Has 24-hour-a-day nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN) or a licensed practical nurse (LPN)
-Keeps a daily medical record of each patient
-May be either a freestanding facility or a distinct part of a facility such as a ward, wing, unit, or swing-bed of a hospital or other institution.

A long-term care facility is not a hospital, clinic, boarding home, a place which operates primarily for the treatment of alcoholics or drug addicts, or a hospice. Even so, care may be provided in these facilities subject to the conditions of the Alternate Plan of Care Benefit provision, if one exists in the policy.

Maximum Lifetime Benefit
The maximum lifetime benefit is the total amount the insurance company will pay during the insured's lifetime for all benefits covered by the policy. This will be shown on the Policy Schedule page.

Medical Help System
Medical help systems is a communication system, located in the insured's home, used to summon medical attention in case of a medical emergency.

Medical Necessity
Care or services that are medically necessary include care that is:

-Provided for acute or chronic conditions
-Consistent with accepted medical standards for the insured's condition
-Not designed primarily for the convenience of the insured or the insured's family
-Recommended by a physician who has no ownership in the long-term care facility or alternate care facility in which the insured is receiving care.

Plan of Treatment
A plan of treatment is a program of care and treatment provided by a home health care agency. Each company may include additional information that may include:

A requirement that it must be initiated by and approved in writing by your physician before the start of home and community based care; and

A requirement that it must be confirmed in writing at least once every 60 days.

Pre-existing Condition
A pre-existing condition is a health condition for which the insured received treatment or advice within the previous 6 months prior to application for coverage.

Respite Care
Respite Care is provided as a service for those who perform the primary care services for an individual. It includes companion care or live-in care provided by or through a home health care agency, to temporarily relieve the informal caregiver in the home convalescent unit.

Elimination Periods in Policies
The beginning date of the benefits will depend upon some options selected. One option affecting this would be the elimination period. The elimination period is a type of deductible. Instead of being expressed as a dollar deductible, however, it is expressed in days not covered. For example, in a major medical plan we commonly see a deductible amount of $500. This amount must be paid by the insured before the insurance company will begin paying for health care claims. In a long-term care policy, the deductible will be expressed as elimination days. A policyholder who selects 30 elimination days will not receive benefits (payment) from the insurance company until the insured begins receiving covered benefits on the 31st day. The first 30 days are not covered. Benefits begin to be payable on the 31st day for covered services. Of course, eligibility must also be established before benefits would be received.

Policy Termination
It would be hard to imagine a consumer terminating a policy when benefits are in process. It would be more likely that termination would happen during a period of good health. Even so, if termination did occur during eligibility of benefits, the insurance company would continue to provide benefits, subject to all policy provisions, until the insured had not received care for the amount of time specified in the policy, usually 180 consecutive days.

If termination occurred during benefit use, it is most likely that it would be due to a group long-term care policy that was terminated by the employing company.

Mental Impairments of Organic Origin

Some aspects of elder care are of specific concern to consumers. One of those is Alzheimer's care. As a result, some policies may specifically state that Alzheimer's disease is covered. It is common for a perspective client to specifically ask if this disease is covered by the policy. Long-term care contracts do cover mental impairments of organic origin. That would include Alzheimer's disease, and also senile dementia. These diseases are determined by clinical diagnosis or tests.

Hospitalization Requirements

Previous hospitalization is required under Medicare to receive their skilled care benefits in a nursing home. This is not necessarily true of long-term care policies. In the past, long-term care policies had options for hospitalization prior to a nursing home confinement. In other words, the consumer could choose to pay extra so that their long-term care policy did not require that they first be in a hospital for the same condition which put them in the nursing home. These policies usually require:

-Hospitalization first for no less than three days
-Admittance to the nursing home for the same condition that caused the hospitalization
-The nursing home admittance to begin within 30 days of the related hospitalization

The Medicare & You booklet states: "*Most long-term care in a nursing home or at home is custodial care (help with activities of daily living like bathing, dressing, using the bathroom, and eating). Medicare doesn't cover this kind of care if this is the only kind of care you need. Medicare Part A only covers skilled care given in a certified skilled nursing facility or in your home. You must meet certain conditions for Medicare to pay for skilled care when you get out of the hospital.*"

Many states require the nursing home policy to cover nursing facilities whether or not hospitalization occurred. These policies will state that no hospitalization is required. Of course, the policyholder must still meet all eligibility requirements of their LTC policy. Since state laws vary, it is important that each agent know how their particular state views hospitalization requirements.

Many existing policies do have a hospitalization requirement. Due to this fact, many professionals feel agents should periodically send out letters to their existing clients outlining the benefits they purchased in the past. It allows them to be aware of policy requirements and change to increased benefits if they desire to.

Home and Community Based Benefits

Home and community based benefits are available in many LTC policies, either as part of the base plan or as an option that may be added for additional premium. Home and community based benefits are traditionally less expensive than a nursing home confinement so this type of care is

less expensive for the insurer to cover. Even though such care is less expensive, however, eligibility standards still exist. Those eligibility standards may have some variations, but typically they require one of the following:

-The care must be medically necessary.
-The policyholder must be unable to perform one or more of the activities of daily living stated within the policy.
-There must be some type of cognitive impairment.

Benefits payable under the policy will depend upon the options selected at the time of policy purchase. If home care is included in the contract, it will typically be paid at 50% of the institutional benefit. In other words, if $100 per day is paid for the nursing home, then $50 per day will be paid for home care. Many of the integrated plans pay the same daily amount for home and community based care as they pay for nursing home care. That's because an integrated plan uses a "pool of money" that may be applied, as the insured desires. An agent should never take this for granted; he or she should always check the policy or call the benefit department of the insurance company for details.

Bed Reservation Benefit

A Bed reservation benefit is included in many long-term care policies. A bed reservation benefit means the insurance policy will continue to pay the long-term care facility benefit to the nursing home while the policyholder is temporarily hospitalized during the course of their long-term care facility stay. This provides the security of returning to the same familiar surroundings following the hospitalization. It also prevents the family or hospital from having to locate another suitable nursing home facility.

The bed reservation benefit is for a temporary hospitalization. It would not continue indefinitely. Commonly, bed reservation benefits are limited to 21 days per calendar year. Unused days from one year can seldom be carried over into the next calendar year. It may be possible, however, to use bed reservation days to satisfy the elimination period in the policy. Again, the agent will want to check with the issuing company to make sure they allow this.

Waiver of Premium

It is now common for long-term care policies to contain a waiver of premium. A waiver of premium has to do with renewal premiums during an institutionalization or while receiving benefits under the terms of the policy. When the policyholder has received benefits under the policy for the number of days specified, their renewal premiums will be waived (they don't have to pay them). Many policies will not refund premium that has already been paid, which is why only renewals may apply. Since this is not always the case it is important to understand the terms in each contract. Some policies will refund premium based on quarterly renewal periods. In other words, a policyholder who has paid a yearly premium will receive a refund each quarter of their policy after the conditions have been met qualifying them for a waiver of premium. Some policies also allow hospitalization days during a facility or benefit stay to count towards this waiver of premium.

How the elimination period is counted towards a waiver of premium will vary from contract to contract. Some policies allow the elimination period to be part of the time counted towards the waiver qualification while others do not. Those policies that do not allow the elimination period to count towards the waiver of premium require that benefits actually be due and payable under the policy (the insured must actually be eligible to receive payment from the insurer). Therefore, it would look like this:

-Elimination Period + Benefit Days = waiver satisfaction.

For those who selected a 30-day elimination period when purchasing their policy and a 90-day waiver of premium, the equation would be:

-30 days + 90 Days = waiver satisfaction (120 days total time for waiver qualification).

Once the policyholder has not received benefits under their LTC policy for a specified time period (usually 180 consecutive days), the waiver of premium is no longer in effect. The insurance company will again expect premium payment in order for the policy to stay active.

Alternative Plan of Care

Policies may offer an alternative plan of care that is covered under the policy. If the insured would otherwise need care in a long-term care facility (nursing home), the company will pay for an alternative service, devices, or benefits. The alternative plan of care must be medically appropriate and medically acceptable. This is determined by specific requirements, including:

-It must be agreed to by the insured, the insured's doctor, and the insurance company
-It must be developed by or with health care professionals (not the patient or the patient's family).

Contracts that allow alternative plans of care follow the policy payment schedule. Naturally, these benefits will count against the maximum lifetime benefits of the policy.

No Policy Covers Everything

As every agent knows, no policy covers everything. All policies, including long-term care contracts, have a section in the contract that lists exclusions (items not covered). It is often easier to understand a policy by reading what is NOT covered.

There are traditional exclusions that are in virtually every contract. Policies will not pay for:

1.Losses due to a condition for which the policyholder can receive benefits under Workers' Compensation or the Occupational Disease Act

2.Losses due to the result of war or any act of war

3.Losses payable under any federal, state, or other government health care plan or law, except Medicaid. The company will reduce their benefits in direct relationship to the amount covered by any government health care plan or law to the extent that the combination of payments exceed 100% of the actual charge for the covered service.

Of course, no policy will pay for losses that occurred or began prior to the purchase of the policy. You can't crash your automobile and then go buy coverage for it.

All policies will list preexisting condition limitations. It is important to disclose all preexisting conditions on the application at the time of policy purchase. If this is not done, an otherwise valid claim could be denied during the preexisting period. If the undisclosed medical condition is serious enough, the policy may actually be rescinded (voided).

Agents who routinely do not disclose obvious or stated medical conditions risk being "red tagged" by the insurers. This means they underwrite all applications to a greater degree because the insurer is not confident that the agent is truthfully listing all medical conditions. In some cases the insurer may even refuse applications from a seemingly dishonest agent. Agents who knowingly fail to list all stated or obvious medical conditions are "clean-sheeting" the application.

There is another reason agents and applicants need to disclose all known medical conditions: many issued long-term care policies will cover all medical conditions immediately (even those existing at the time of policy issue), as long as the condition was listed on the application. If the condition was not listed, it is then subject to any pre-existing time periods listed in the policy. If serious enough, the policy could still be voided as well.

Age Misstatement

Age misstatement on the application is seldom considered a serious offense, although it can be in specific situations. If the age is misstated downward (stating a younger age) any additional premium must be paid to keep the policy in force. An error in age upwards (stating an older age) will trigger a premium refund, if applicable. If a younger age was purposely stated, it is usually done to save money since so many LTC policy premiums are based on age at application. Obviously, the insurers do not allow this. Sometimes the premium cost is considerable between certain ages, such as between a 69-year old and a 70- year old. That is why it is so important to consider this type of coverage at younger ages.

Few companies rescind (void) a policy due to age misstatement. It may happen, however, if the age misstatement puts the applicant in an age bracket that is not acceptable for underwriting (an 80-year old who is listed as 79 might fall into this category). The company would, however, require that the additional premium be paid. If the correct age would have meant that the policy would not have been issued at all, then the premium that was paid will be returned to the consumer and the policy voided.

Third-Party Notification

Many policies now allow a third party notification when unpaid premiums are due. The third party

is chosen by the insured, usually at the time of policy issue. The insured has the right to change the third party listing at each policy renewal, or at least yearly.

When the policyholder has listed a third party notification, that person would receive notice if the policy were in danger of lapsing due to nonpayment of premiums. The notice would be sent to them in writing at least 30 days prior to policy termination. The intent is to prevent an accidental policy lapse. This is most likely to happen as people age and forgetfulness becomes a problem. If that is the situation, a policy lapse can be especially distressful for the family.

There is one final safeguard if premiums are not paid on time: there is a 31-day grace period. This means that the policyholder has 31 days past the actual premium due date in which to make payment. The policy would remain in force and claims would be covered during this 31-day period. If a claim occurred, the premium would have to be paid in order to receive benefit payment.

Reinstatement of a Lapsed Policy

Under some circumstances, a lapsed policy may be reinstated (put back in force). Sometimes, simply paying the unpaid premium is enough to reinstate the policy. In other cases, a new application for reinstatement must be submitted and perhaps even underwritten. Any back premium will still be due.

Why would a person reinstate rather than simply apply for a new policy? The most likely reason is to keep the issue-age the same, since the policyholder was probably younger when he or she first applied for coverage.

Many states have mandated specific reinstatement requirements as a consumer protection measure. This would especially be true if the lapse were due to some cognitive impairment or some type of functional incapacity. Functional incapacity typically means the inability to perform a specified number of the activities of daily living. When this is the case, the insured will have six months following the policy lapse (due to nonpayment) to reinstate it. Such reinstatement is especially important in these cases, because the insured cannot qualify for a new policy due to their medical problems. Any person authorized to act on behalf of the insured may also apply for policy reinstatement due to cognitive impairment or functional incapacity.

The insurer will require proof of cognitive disability when the insured, or their family, requests policy reinstatement. They will accept clinical diagnosis or tests demonstrating that cognitive impairment or functional incapacity existed at the time the policy terminated. The insured must bear the expense (if any), in most cases, for supplying medical proof.

Long-term care policies can be intimidating to the consumer. Therefore, they rely on the knowledge of their agent. An agent who does not completely understand the long-term care contracts (policies) should not attempt to market them. The degree of possible error is just too high. When errors are made they may not be discovered until the insured needs to use the policy – the worst possible time to discover it.

Even when errors are discovered and the agent has left the insurance field, lawsuits may still be filed against the insurer. One of the reasons insurance companies have become so pro-active regarding agent education has to do with preventing lawsuits. Of course, if the policy is a Partnership contract there are also federal government regulations regarding suitability. Issuing insurance companies are required to adhere to these mandates and in fact there must be a specific person that makes sure all issued policies follow federal requirements.

Section 6021: Expansion of State LTC Partnership Program
The Deficit Reduction Act of 2005 (effective in 2006) provided some statutory Requirements that are important to the expansion of long-term care Partnership policies. This would include:

Dollar-for-Dollar Asset Protection
In order to provide asset protection, states must make necessary statute amendments that provide for the disregard of assets when applying for Medicaid benefits.

An individual applying for benefits must be a resident of the state when the coverage first became effective under the policy.

The Partnership policy will be a tax-qualified plan that was issued no earlier than the effective date of the state plan amendment allowing use of such LTC policies. They must meet the October 2000 NAIC model regulations and requirements for consumer protections.

Inflation Protection
Since most people will not use their long-term care benefits for many years after purchase, it is important to include inflation protection. Partnership plans have specific inflation protection requirements. The requirements were previously outlined in this course.

Plan Reporting Requirements
Partnership plan insurers must provide regular reports to the HHS Secretary and include specific information, including:

-Notification of when benefits have been paid and the amount of benefits paid.
-Notification of policy termination.
-Any other information requested by HHS.

The state may not impose any requirements affecting the terms or benefits on Partnership policies that were not also imposed on traditional non-partnership plans.

States may require issuers to report additional information beyond those listed and there may be differences among the states.

Consumer Education
It is the responsibility of each state to properly educate their consumers so they are aware of their asset-protection options.

Agent Education
Most states will be imposing some type of continuing education requirements for those agents wanting to market Partnership plans. While these agent requirements will vary, many states are adopting an initial requirement of 8 hours, with 4 hours required each license renewal period thereafter.

State Amendments Where Required
Policies are deemed to meet required standards of the model regulation or the model Act if the state plan amendment is certified by the state insurance commissioner in a manner satisfactory to the Secretary.

Reciprocity
States with Partnership contracts must develop standards for uniform reciprocal recognition of Partnership policies between participating states. This would include benefits paid under the policies (being treated equally by all states) and opt out provisions where states could notify the Secretary in writing if they do not want to participate in a reciprocity program.

State Effective Dates
Qualified state long-term care Partnership policies issued on the first calendar quarter in which the plan amendment was submitted to the Secretary.

NAIC 2000 Model Act
No one has argued against purchasing a long-term care policy to protect against the costs of receiving care for an extended period of time. However, like so many things, these early policies had many initial flaws that were not consumer friendly or, in some cases, even ethical.

Regulation is often necessary to correct industry flaws that were not corrected by the industry itself. The long-term care insurance market needed consumer protection to protect against product flaws, some intentional and some merely a result of issuing products in a new market place with little statistical data to guide the underwriters. The regulation reflected many issues, including consumer expectations, insurer pricing, and any number of other circumstances. The focus brought about recommendations by the National Association of Insurance Commissioners (NAIC), called the "model" laws and regulations.

The national Association of Insurance Commissioners is a non-profit organization made up of the insurance regulators from the 50 states, the District of Columbian and the four United States territories. They have worked with regulators, legislators, the insurance industry, and consumers to create a comprehensive uniform model law, often referred to as the NAIC Act, and related regulations for long-term care insurance.

State laws can vary widely, but the Model Act and Related Regulations are generally adopted in some form (the state either adopts them as they are or includes language from the model).

Initially, it was the premiums that brought about the attention to this new market of long-term care insurance policies. Health insurance policies had many years of trial and error to smooth out the pricing so it was fair to both the consumers and the insurance companies covering the risks. Health insurance can be adjusted yearly as the insurers see the claims come in. Long-term care policies are issued without immediate access to claims experience. Usually these policies are not accessed for ten to twenty years after issuance. Initially, they were priced to remain constant for many years. Unfortunately, some agents actually marketed them as "never increasing in price." Since one in three purchasers of long-term care insurance is under the age of 65, long-term pricing becomes necessary. While most policies did not increase with increasing age, they do contain a clause allowing for premium increases if all similar policies are increased (they may not usually be increased individually due to advancing age).

Premiums in Partnership plans may not increase individually or due to the characteristics of an individual policyholder (due to claims, for example), but policies may be increased if all such policies are increased. It was difficult for underwriters to accurately price long-term care policies since so little data existed. Additionally, a larger number of policyholders maintained the coverage than was expected. Why is this important? Because it meant that premiums companies expected to keep, without paying out claims, did not materialize. Since the policyholders kept their policies they could be expected to eventually collect benefits.

Any new insurance market may experience premium rating difficulties, but the long-term market was especially prone to this, due to the length of time between purchase and benefit submissions. In August of 2000 the NAIC adopted new regulatory requirements intended to encourage stronger state legal protections for the long-term care policyholder. The NAIC worked with various groups, including consumer groups and the insurers to develop regulation that would serve as a model for everyone. It was called the NAIC Long-Term Care Insurance Model Act and Regulation.

A major goal of the NAIC model act was premium stability. As amended in August of 2000, the model act and regulation financially penalizes companies that intentionally under-price policies (often called low-balling) and, furthermore, allow state regulators to prohibit insurers that repeatedly engage in such behavior from selling policies in their state. The new model required greater disclosure of premium increases and provided policyholders with more options when premiums did increase.

We might assume that an insurance company would not want to under price their policies, but in fact that can be a competitive strategy to lure in customers with relaxed underwriting and low premiums. At some point, the insurers know they will raise their premium rates. Since long-term care benefits are not accessed quickly (as major medical plans are, for example) insurers can low-ball policy issuances without fear of being hit financially. This is extremely bad for those who buy the policies since they pay in premiums for a policy they may have to lapse when premiums rise beyond their means.

"Level Premium" Does Not Mean Unchanging Rates

Many states have addressed the term "level premium" since this can mislead the consumer into believing that policy rates will never change. Rates can and do change in long-term care policies.

This term means that rates will not be increased due to advancing age or increased claim submission.

Financial Requirements for Rate Increases
The NAIC model provided measures that would discourage under-pricing of policies, which would inevitably increase in premium at some point. Rules were established regarding the "loss ratio" (the share of premium the insurer expected to pay in claims). These were based on estimates of future revenues and future claims over the life of the policy for all those who purchased this particular policy form. Under the NAIC model, projected claims must account for at least the sum of:

-58 percent of the revenues that would be generated by the existing premium.
-85 percent of the revenue generated by the premium increase.

Setting a higher loss ratio requirement for the premium increase than applies to the initial premium creates what is essentially a penalty for increasing rates. It is hoped it will discourage under-pricing from the beginning of the policy.

Rate Certification from the Insurer's Actuary
The Model Act requires insurers to obtain certification from an actuary that initial premiums are reasonable. When an insurer requests a premium hike the model also requires the actuary to certify that "no further premium rate schedule increases are anticipated." Reliance on this actuarial certification must assume, of course, that the actuary will use acceptable actuarial practices when evaluating the available data. It must further assume that unethical companies cannot find an actuary willing to make a certification that was inaccurate.

Consumer Disclosure
The NAIC model requires insurers to disclose rate increase histories for the past ten years for long-term care policies of similar type. Since this has been such a forward-moving industry it is unlikely that the exact policy will have been issued for a steady ten years. There may be some cases where this is not required, as in the case of insurer mergers. It is hoped that this disclosure will help consumers select the policy they wish to purchase as well as the company they wish to deal with. The purchaser must also sign a form stating that he or she understands that premiums may increase in the future (this should prevent agents from stating that premiums will remain the same).

LTC Personal Worksheet
Insurers use a long-term care worksheet called the Long-Term Care Insurance Personal Worksheet. This is provided to applicants during the solicitation of a long-term care policy. The worksheet and rate information are provided to the Insurance Department's Office for review in most cases.

Is the Policy Suitable for the Buyer?
"Suitability" means appropriate for the situation. Therefore, a long-term care policy is suitable when the buyer can afford the premiums year after year, has assets or income to protect from

Medicaid spend-down requirements, recognizes the possibility that they are likely to need coverage at some point in their lives, does not want to burden their family members, and has sufficient knowledge about the product to make a logical and informed buying decision.

A policy that is purchased and then lapsed a year or two later has benefited no one – not even the insurer in some cases since underwriting has costs associated with it. The selling agent is in the best position to determine whether or not the buyer is financially suitable for the policy they are buying. In other words, if the buyer has no assets to protect (income cannot be protected by Partnership policies – or any other type of policy) it may not be wise to purchase a long-term care policy in the first place.

Agents judge suitability on a specific set of criteria; it is not made on personal opinion alone, although there will be some aspect of that involved. Suitability refers to recommending and selecting products that are sensible or "suitable" given personal factors such age, risk tolerance and overall investment objectives.

Without specific guidelines each agent and buyer would make suitability determinations based on what they perceive to be important, whether that happens to be financial status, knowledge of products, or simply a product that appeals to the buyer. In fact, all of these components are important.

Suitability regulations require agents to recommend only suitable LTC products. Suitability standards do not imply that the insurance producer is any type of fiduciary; suitability standards are entirely different than fiduciary standards. What it does mean however, is that the agent has inquired about sufficient income or assets and determined to the degree possible that the applicant can afford the premiums today and into the future. The applicant's goals and needs and the advantages or disadvantages for that particular applicant must be considered.

At the time of or prior to the insurance presentation agents must give the consumer a copy of the "Long-Term Care Insurance Personal Worksheet." It will contain the information necessary to make an informed decision. The insurer may request more information than that contained in the worksheet if necessary for a clear buyer decision or for underwriting purposes. The completed worksheet is included with the insurance application and a copy is also filed with the commissioner's office.

If the potential applicant refuses to answer questions regarding income, assets, and other financial information necessary to make an appropriate determination, then neither the selling agent nor the issuing insurer bears any responsibility if the decision to buy turns out to be a poor choice. The insurer can reject the application if the buyer has refused to supply necessary information, but is not required to do so. It can send out a letter outlining the need for the requested information and hope the applicant then provides the information. Either the applicant's returned letter or a record any alternative method of verification of information must be made part of the applicant's file.

Every insurer, health care service plan or other entities marketing long-term care products must develop and use suitability standards. Additionally companies must train its agents in the use of the developed suitability standards and maintain copies for the state to inspect if they wish.

Agents must attempt to document whether or not an individual should purchase a long-term care insurance policy, whether that happens to be a traditional long-term care contract or a Partnership contract. Most states require companies to develop suitability standards (which agents must follow) to determine if the sale of long-term care insurance is appropriate. These standards must be available for inspection upon request by the Insurance Commissioner.

How does an agent know if a policy is suitable? Simple questions can determine that: Is insurance appropriate for this individual? Can the applicant afford the premiums year after year, especially if the rates increase? Does the policy actually address the applicant's potential needs and desires? These questions may be referred to as "needs-based" selling, but whatever name is attached to it, agents and insurers must follow all state requirements.

Consumer Publications

There are consumer publications that enable the buyer to determine themselves if a long-term care purchase is wise for their particular circumstances. "Things You Should Know before You Buy Long-Term Care Insurance" is a consumer publication. Also available is the Long-Term Care Insurance Suitability Letter for consumers.

The agent must provide a Long-Term Care Shopper's Guide to all prospective buyers of long-term care insurance, whether a traditional long-term care policy or a Partnership long-term care policy. This publication or a similar publication will have been developed by either the individual state or by the National Association of Insurance Commissioners for prospective applicants.

Post Claim Underwriting

Most policies underwrite the applicant at the time of application. The long-term care industry has not always done so. At one time some companies quickly issued the long-term care policy and delayed underwriting until a claim was submitted. Obviously, this was not good for the insured. No one wants to find out their policy is useless when a claim has been presented.

Most states prohibit post-claim underwriting since it is anti-consumer and encourages insurers to find a reason to invalidate the policy (since a claim has been submitted). Especially in long-term care policies it is important that the contract be underwritten at the time of application. In this way, the applicant can be sure that his or her policy is valid and will pay covered claims when they occur.

Additionally, many states mandate that applications contain clear and unambiguous questions on the application regarding the applicant's health status. Of course, the consumer must honestly answer the insurer's questions. A question that could be misunderstood puts the applicant in the position of possibly having their policy rescinded or a claim denied due to misrepresentation if the health questions are not worded in a manner that is easily understood.

Tax-Qualified Policy Statement
If it is a Partnership plan, then it is tax-qualified. If the insured files long-form for their federal taxes, he or she may deduct the premiums of his or her long-term care policy. Policies must include a statement regarding the tax consequences of the contract so that the insureds do not have to guess whether or not the policy meets the tax requirements. The statement must be included in the policy and in the corresponding outline of coverage.

The Outline of Coverage is a freestanding document that provides a brief description of the important policy features. The statement may read similar to the following:

"This policy is intended to be a federally tax-qualified long-term care insurance contract under section 7702(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the policy may be taxable as income."

Replacement Notices
When an application is taken for long-term care insurance, the agent must determine whether or not it will replace an existing long-term care contract. The method of determination is very specific. A list of replacement questions must be on the application forms and replacement notices. If replacement will take place, there is a specific format for the replacement process.

When a policy is replaced by another, the replacing insurer must waive the time period applicable to preexisting conditions and probational periods to the extent similar exclusions have been satisfied under the original policy. In other words, once a probational or preexisting medical period has been met under one policy, any subsequent contracts that replace the original must recognize the previous satisfaction of these conditional periods.

Policy Conversion
In some states it may be possible to convert a recently issued tax-qualified policy over to a Partnership policy if the issuing company offers Partnership policies. If this is the case, it is likely that there will be specified time limits for doing so. The insurer will mail out notices to their policyholders notifying them of this possibility. Some insurers may allow any tax-qualified policyholder to convert to a Partnership plan; benefits will remain the same since only asset protection will be added by the conversion.

When a policy is converted from one form to another states nearly always have conversion rules that apply. Typically the insurer may not impose new or additional underwriting, nor may they impose a new or extended preexisting period for claims.

An Overview

The Model Act provides guidelines for qualified long-term care policies, including:

-Policies may not limit or exclude coverage by type of illness, such as Alzheimer's disease.

-Policies cannot increase premiums due to advancing age. In other words, premiums may not increase when a policyholder has a birthday. Premiums may increase simultaneously for all who hold similar policies.

-Policies cannot be cancelled because of advancing age or deteriorating health.

-Policies must offer a nonforfeiture benefit that, if purchased, ensures the consumer that a lapsed or cancelled policy means some benefits would still be available for a specified period of time.

-Policies must offer an inflation protection that, if purchased, ensures benefits keep pace with inflation. This is especially important for those purchasing their policies at younger ages.

The NAIC Model Act Applies to All

All 50 states and DC have adopted the NAIC Model Act. The states have adopted the NAIC Model Regulation in some form, although they have not necessarily adopted all of the provisions.

The Model Act applies to all long-term care insurance policies and even to life insurance policies that have an acceleration benefit that may be used for long-term care services prior to the insured's death. Any policy or rider that is advertised, marketed, or designed to provide coverage for no less than 12 consecutive months on an expense incurred, indemnity, prepaid or other basis is considered a long-term care policy if it is providing for one or more necessary long-term care services in a non-hospitalization setting.

So, what is a qualified long-term care insurance contract? For our purposes, it would include any insurance contract if:

1.The only insurance protection provided under such contract is coverage of qualified long-term care services

2.Such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount

3.Such contract is guaranteed renewable

4.Such contract does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed

5.All refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits

6.Such contract meets the requirements of subsection (g).

Policy Renewable Provisions

These long-term care policies must have renewable provisions and include a statement of how

they are renewed. If the policy contains a rider or endorsement, there must be a signed acceptance by the policy owner.

Payment Standards Must be Defined
Standards that refer to the payment of benefits must be defined. Such terms as "usual, customary, and reasonable" must be defined in a clear, unambiguous manner. In this definition, for example, the policy must state how the usual, customary, and reasonable charge is determined. Is it based on the local areas? How often are the fees updated to reflect current costs?

Preexisting Standards
Preexisting conditions limitations will be in most of the long-term care policies, but there are restrictions as to how they limit benefits. For example, the preexisting period may be no more than 6 months following policy issue. There can be no exclusions or waivers, such as exclusion on a particular heart condition of the insured. The applicant must be accepted or denied for coverage.

Policy Type Must Be Identified
The policy must clearly state whether it is a tax-qualified or a non-tax qualified long-term care policy. All Partnership policies will be tax qualified.

ADLs
Policies must describe the ADLs in a clear unambiguous manner. Policies may not be no more restrictive that using three ADLs or cognitive impairment for benefit payments. Of course, policies may be more lenient in allowing payment of benefits, but they may not be more restrictive than that.

Benefit triggers, the conditions that begin the benefit payment process, must be explained in the policy and the policy must specify whether or not certification is required.

There must be a description of the appeals process should a claim be denied.

Life Insurance Policies with Accelerated Benefits
While many professionals feel it is best to keep benefits for death and benefits for long-term care separate, there are life insurance policies that will accelerate death benefits for use for long-term care services. When this is the case, disclosure of tax consequences of life proceeds payout must be in the policy.

How is one to know if the life policy has the option of accelerated benefits? Treatment of coverage provided as part of a life insurance contract, except as otherwise provided in state regulations, generally apply if the portion of the contract providing such coverage is a separate contract. While it is always necessary to refer to the actual policy, the term "portion" means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

Nonforfeiture Provisions
Generally a nonforfeiture provision must meet specific requirements:

1.The nonforfeiture provision must be appropriately captioned.

2.The nonforfeiture provision must provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the appropriate State regulatory agency for the same contract form.

3.The nonforfeiture provision must provide at least one of the following:
- -Reduced paid-up insurance.
- -Extended term insurance.
- -Shortened benefit period.
- -Other similar offerings approved by the appropriate State regulatory agency.

Extension of Benefits
When policies include extension of benefits, these must be available without prejudice regarding benefits that have already been paid for prior institutionalization or care.

Home Health & Community Care
Minimum standards and benefits must be established for home health and community care in long-term care insurance policies.

Additional Provisions for Group Policies
Many companies are curtailing insurance benefits in major medical coverage so it is doubtful that group long-term care coverage will be offered to any great extent. However, where it is, there must be provisions for individuals to continue their coverage when they leave the group plan. Individuals who are covered under a discontinued policy must be offered coverage under a replacement contract.

Outline of Coverage
In general an Outline of Coverage must be provided at the time of the initial solicitation. As it pertains to the agent, it must be presented during the completion of the application. There is a prescribed standard format for the Outline of Coverage in a long-term care policy. The content of the Outline of Coverage is also stipulated. Use of specific text and sequence is mandatory as is a list of categories that include:

- -Benefits and coverage
- -Exclusions and limitations
- -Continuance and discontinuance terms
- -Change in premium terms
- -Any policy return and refund rights

-The relationship of cost of care and benefits
-Tax status.

There must also be consumer contacts within the Outline of Coverage.

Policy Delivery
Once the policy has been approved and issued, the buyer must receive it within 30 days of approval. The policy must also include a policy summary.

No Field Issued LTC Policies
There was a time when long-term care policies could be field issued by the agent because underwriting was completed when a claim was filed rather than at policy issuance. Field issued policies are not allowed under the Model Act and Regulation since it is not good for the consumer. Policies must be underwritten prior to policy issuance.

Policy Advertising and Marketing
Prior to advertising a policy for long-term care benefits, whether it will be viewed on television, heard over the radio, or read in print, it must be approved by the state's insurance commissioner's office.

Any company marketing long-term care policies have standards that must be followed. There must be marketing procedures established and state training requirements for agents must be followed. The NAIC is recommending that states adopt a Partnership training requirement of eight initial hours of continuing education, followed by four hours each licensing renewal period thereafter.

The point of training agents is to ensure that marketing activities will be fair and accurate. Training will hopefully prevent a single person from over-insuring as well.

No Policy Covers Everything
As we previously discussed in this text, no policy covers everything. LTC policies must prominently display a notice to buyers that the policy may not cover all the costs associated with long-term care services. Even when agents have discussed what will not be covered, most claims will occur ten or twenty years later. It would be unlikely that the buyers would remember what the agent said and it certainly makes sense to state this in the policy as well.

Prior to the Sale
Agents and insurers have pre-sale responsibilities. They must provide the applicant with copies of personal worksheets and potential rate increase disclosure forms. They must also identify whether or not the applicant has long-term care insurance or coverage elsewhere. If there is existing coverage, the agent must find out if the applicant intends to replace the existing LTC policy with the new coverage.

The insurer must establish procedures for verifying compliance with the requirements. Written notice must be given that senior insurance counseling programs are available and provide contact information.

Such terms as "noncancellable" or "level premium" may be used only when the policy conforms. There must be an explanation of contingent benefits upon policy lapse.

Shopper's Guide
A Shopper's Guide must be given to the consumer prior to the application for long-term care coverage. If it is a direct solicitation, it must be provided at the time of application.

Illegal Practices
Some practices illegal. This would include what is referred to as "twisting," which means using the facts to suit one's own needs (not the needs of the consumer). A person who uses twisting is either changing the facts to suit their own needs or providing some facts, but omitting others in order to complete the sale. It might be omitting information that should be disclosed, or it might be stating facts in a way that will allow the consumer to assume that which is not true. Often twisting is used to make an existing policy appear unfavorable, when in fact the policy is appropriate for the consumer.

High pressure tactics are not new to the insurance industry, but it is illegal. Agents who pressure people into buying are not really helping themselves anyway, since these individuals are very likely to cancel the policy (which means lost commissions too).

Of course, any misrepresentation of the policies, the insurers, or any aspect related to the sale of insurance is illegal.

Association Marketing
There are also requirements for those who market to association members. Marketers must provide objective information, full disclosures, compensation arrangements and all brochures or advertisements must be truthful.

Following the Sale
The consumer's rights continue after the sale has been made. They have the right to return the policy if it does not meet their needs or even if they just plain change their minds. No reason for returning the policy needs to be given by the insured. As long as it is returned within 30 days a full refund will be received.

If the applicant failed to provide full information an incontestability provision exists. For material misrepresentation, the time period for rescinding the policy is six months. A misrepresentation pertaining to both material information and medical conditions the time period is two years for policy rescission. Information that was knowingly and intentionally misrepresented may cause a policy rescission for more than two years. When a policy is rescinded, benefits may not be recovered.

Failure to Pay Premiums

When a policy is in danger of lapsing due to nonpayment of premiums, the insurer has some obligations. It must notify the insured 30 days after the premium is due and unpaid. After 5 days of mailing the notice, it can be assumed that the insured has received it. Termination would be effective 30 days after the notice was given to the insured and the designated thirty-party.

Ethical Considerations

The insurance industry has specific requirements to determine whether it is logical to place a long-term care policy of any type in a consumer's home. These are called "suitability" standards, but they could just as easily be called "ethical" standards.

These suitability or ethical standards begin the moment a product is presented. Agents must determine whether the person or couple is suited to buying a long-term care product. At least part of the consideration is: "can they afford the premiums?" It is not just a matter of affording them in the first year; they must be able to afford to pay premiums (that might increase over time) year after year. Insurers are required to monitor the applications submitted for suitability but ideally the field agents will recognize when an application should not be taken in the first place.

All agents must use a suitability worksheet but decisions are often made without the consideration that is recommended. Decisions to buy or not buy should never be a matter of guessing; there is enough information available that it should not be necessary. There are three primary steps to determining the necessity of long-term care coverage: the interview between the agent and buyer, the analysis of need based on that interview, and finally a presentation of the benefits and cost of the recommended product.

Some actions on the part of the insurance producer are just plain forbidden, such as twisting information, misrepresenting any insurer (theirs or another's), or pressuring a consumer to buy. Exaggerating what a long-term care policy can or will accomplish is certainly not allowed; this may be referred to as "puffing."

We have seen some situations where one topic is advertised but another topic is actually intended. For example, a public seminar may be advertised as a financial planning educational event when the true goal is a list of people who might be sold insurance products, such as annuities or long-term care policies. This is a bait-and-switch event; the "bait" is the financial information and the "switch" is the sales presentation of an annuity or long-term care product.

Consumers may not be tempted with an offering of free gifts and rebates are usually illegal in the states. There will not be any toasters offered to consumers who open an annuity or purchase a long-term care product. The only "gift" will be the knowledge that the buyer has protected his or her assets by purchasing a product that will pay their bills when long-term care is needed for a medical or cognitive condition.

Consumers often believe that agents can somehow waive their usual commissions but in fact most states do not allow rebates. The goal is to place products that are necessary and suitable; premium rates should not be the primary focus as they might be if rebates were allowed.

Full Disclosure

It should not be necessary to state that insurance producers must provide full disclosure. While it would be impossible to cover every detail involved, sufficient information needed to make a logical buying decision must be provided. Company financial ratings, policy benefits, exclusions in coverage and realistic price information today and in the years to come must be provided. An agent's failure to do this will eventually be known but the real concern is the consumer's financial well-being. The financial necessity of having adequate long-term care coverage cannot be compared to a mistake when buying a dress or car. If a car under-performs the actions of the salesperson are not likely to have far-reaching consequences as an under-performing long-term care policy might.

Conclusion

Long-term care insurance has been closely observed by the NAIC since the product's introduction. The NAIC developed its Long-Term Care Insurance Model Act and Regulation in the 1980s with the intent of promoting the availability of coverage, protecting applicants from unfair or deceptive sales or enrollment practices, facilitating public understanding and comparison of coverages, and facilitating flexibility and innovation in the development of long-term care insurance. In short, the NAIC wants all placed products to be suitable for the purchaser and their financial situation. Generally, the NAIC Model Act and Regulation establish:

-Policy requirements: (a) requiring a standard format outline of coverage; (b) requiring specific elements for application forms and replacement coverage; (c) preventing cancellation of coverage upon unintentional lapse in paying premiums; (d) prohibiting post-claims underwriting; (e) prohibiting preexisting conditions and probationary periods in replacement policies or certificates; and (f) establishing minimum standards for home health and community care benefits in long-term care insurance policies.

-Benefit requirements: (a) requiring the offer of inflation protection; (b) requiring an offer of nonforfeiture benefits; (c) requiring contingent benefit upon lapse if the nonforfeiture benefit offer is rejected; and (d) establishing benefit triggers for nonqualified and qualified long-term care insurance contracts.

-Suitability requirements: (a) explaining and reviewing a personal worksheet with applicants; and (b) requiring that insurers deliver a shopper's guide to buying long-term care insurance to applicants.

-Insurer requirements: (a) reporting requirements; (b) licensing requirements; (c) reserve standards; (d) loss ratios standards where applicable; (e) filing and actuarial certification requirements; and (f) standards for marketing.

-Penalties and disclosure requirements.

Adequate long-term care insurance is financially important to the buyer but it is also financially important to every taxpayer. Certainly we want our homes protected from fire and we want liability to protect us if we have an automobile accident. It is just as important to have our assets protected (income is not protected) as we age and eventually require care in a nursing home, at home, or in the community.

Insurance policies are legal contracts. As such, terminology is very important. Long-term care policies must follow state and federally mandated terms. In the case of Qualified Long-Term Care plans, the definitions must satisfy those as amended by the U.S. Treasury Department.

Activities of Daily Living: Qualified long-term care policies have six activities of daily living. They are: bathing, continence, dressing, eating, toileting, and transferring.