Overview and Learning Objectives

This module takes a closer look at the features, benefits and policy provisions of long-term care (LTC) insurance.

At the conclusion of this module, you will:

- Know what services are generally covered in a LTC insurance policy;
- Understand how products have evolved and improved over the years;
- Become familiar with the typical structure and amounts of coverage that is available for consumers to select;
- Understand how “inflation protection” works and why it is important to consider in choosing a LTC insurance policy. Understand the “pros” and “cons” of different approaches to “inflation protection”; and
- Learn about other important policy provisions.

Self-Assessment

- What services are typically covered in today's LTC insurance policies?
- If someone has a "facility care only" policy, what services might it cover?
- In evaluating how well suited a policy might be for their specific circumstance, what questions should a consumer ask about how LTC services are covered within a policy?
- What reasons might someone have for buying a "facility care only" policy instead of comprehensive coverage?
- What is the most common type of "lifetime maximum" for today's LTC insurance policies? Describe how this generally works.
- What reasons might someone have for choosing or not choosing an "unlimited" lifetime maximum for his or her policy?
- What are the primary approaches for benefits to keep pace with rising costs of care over time? What are the pros and cons of each approach?
- What factors influence the amount of "out of pocket" expenses that someone might have during their "elimination period?"
- What does "premium waiver" mean and how does it usually work?

Covered Services

Long-term care policies vary in terms of the specific services they will cover and the nature and extent of coverage provided for those services. The vast majority of coverage sold today is "comprehensive" in that it provides benefits both for facility-based care and for care at home or in the community. This is in contrast to the earliest LTC policies, which emphasized institutional care and provided little or no coverage for care at home. Today about 70 percent of policies sold are "comprehensive" in terms of the care settings and services covered.

The best way to understand what services are covered and what is not covered is to review the Outline of Coverage and, if necessary, a specimen policy. The Outline of Coverage will summarize the services covered and the benefit amounts for each service, and will list any important exclusions or limitations on coverage (e.g., whether care provided by immediate family can be covered or is excluded). Marketing literature is useful and the Outline of Coverage will provide a brief description of important features of the policy, but the "contractual full story" is found in the actual policy language.

Facility Care

Generally, LTC insurance covers care in different types of LTC facilities:

- Nursing home
- Assisted living facility (also called residential care facility or alternate care facility)
- Alzheimer's care facility
- Hospice care facility
- Adult day care facility

Nursing Home

Nursing home care is generally provided in a licensed facility, but is not limited to Medicare-certified or skilled care facilities only. Some LTC policies will also cover care in a non-licensed nursing facility, such as a Christian Science care facility or a private, non-licensed nursing home associated with a Continuing Care

Retirement Community (CCRC). [Currently in Texas, there are two CCRCs, Bienvivir Senior Health Services in El Paso and The Basics at Jan Werner in Amarillo. Also known as Programs of All-Inclusive Care for the Elderly (PACE).]

Assisted Living Facility (ALF)

There are many different types of names and definitions for an "assisted living facility (ALF)." Many LTC policies will define the specific care-related criteria that an "assisted living facility" must meet in order to be covered. In Texas, a definition of such home or facility may not be more restrictive than one requiring that it be operated pursuant to state and federal law. The intent of LTC insurance is not to pay for rent or independent living costs – whether at home or in an assisted living environment.

Home and Community Care

Policies that provide what is called "comprehensive" coverage also include the following types of home and community care services and settings:

- Home health care;
- Adult day care;
- Maintenance or personal care services provided by a home health aide;

and may also include:

- Hospice care
- Respite care; and
- Case management services

Home health care includes a broad range of services including:

- Skilled nursing care and occupational, speech, physical, respiratory, and other therapies);
- Personal care (help with ADL) from a home health aide or personal care worker; and

- Homemaker services, such as meal preparation or housekeeping.

Policies may limit home health care to services provided by a licensed home health care agency, but do not require that the agency be Medicare-certified. However, many LTC policies allow care at home to be provided by "independent providers" which may include nurses, therapists, personal care workers, or homemakers who are qualified by training and experience to provide such care but who are not working through or affiliated with a home health care agency.

Some policies cover homemaker services (e.g., laundry and housekeeping help) even if that is the only service received. Polices may also pay for this type of care when it is provided as part of a visit to help an individual with bathing or dressing. Regardless, the policy will not pay for homemaker services unless an individual receiving them has a qualifying level of impairment – needing help with 2 or more ADLs or suffering from a cognitive impairment.

Policies also generally pay for care in (and transportation to/from) an adult day care facility, which provides personal care, help with medication and/or supervision, and support during the day.

Hospice Care

Most LTC policies provide benefits for "hospice care" for individuals who are both terminally ill and who need LTC. These benefits include personal care support and services (both at home and in a facility). The policy does not pay for physician care, pain medications, or other "medically-related" care. These services are generally covered under a Medicare hospice care benefit.

An LTC policy supplements other "hospice care" programs; it is not a substitute for traditional hospice care. An individual must also need help with ADLs (or have cognitive loss) and be terminally ill to receive hospice care as part of a LTC policy. Some LTC policies allow an individual to access hospice care benefits without requiring that you satisfy the elimination period.

Respite Care

Respite care is designed specifically for people who only need care for a short amount of time each year because they have family, friends, or other unpaid caregivers who can meet their care needs.

Most LTC policies pay for temporary care while family members or unpaid caregivers take "time off" from their caregiving responsibilities. Respite care may be provided in a facility or at home. Generally, individuals can receive respite care in any of the LTC service settings that the policy covers (see above).

Many policies limit the amount of respite care to 15 to 30 days each year because it is not generally necessary to first meet an elimination period in order to access these benefits. If care is needed for longer than the brief "respite" needed to support family caregivers, then an individual can satisfy the elimination period and begin to receive covered services on an on-going, extended basis.

Supportive Services

Finally, many policies pay for a variety of services or devices to support the needs of people with disabilities living at home. These include:

- Equipment and devices such as an "in-home electronic monitoring system";
- Home modification such as grab rails and ramps;
- Transportation to medical appointments;
- Meals-on-wheels; and
- Training for an informal caregiver on how to safely and appropriately provide personal care.

Daily Coverage Amounts

People can select the amount they want their LTC policy to pay for care each day. All policies provide a choice of the amount paid for nursing home care. Many policies pay the same amount for care in an assisted living facility as for nursing home care. Benefit amounts for "facility care" generally range from $50 per day to $300 per day or more. While some states may specify the minimum benefit amount that can be offered, Texas does not have a minimum benefit amount. .

Many policies also allow consumers to choose the amount they want the policy to pay for care at home. These amounts range from $50 to $300 per day. Or they may simply decide whether they want the "benefit amount" for home care to be the same as the facility care amount (100%) or if they want the home care benefit to be lower than the facility care amount. Typical choices other than 100% are 50%, 60%, 75%, or 80%. Some policies simply have one benefit amount that applies to all covered services. While this is simpler to understand, it can be more costly than a policy that lets the consumer select a lower payment amount for home care.

A higher home care benefit amount makes it easier to pay for "round the clock" care at home. However, this level of coverage costs more. Most people receiving care at home do not need constant formal care, especially if there are family members or friends who can help by supplementing paid care. On average, people receiving home care spend about $1,800 a month or about $60 per day.

While most LTC policies pay expenses up to the daily benefit amount selected, some policies are more flexible. These policies have a weekly or monthly limit, not a daily limit, on how much they will pay. This allows you to spend more on care on days when you might not have any family care (e.g., Monday through Friday while a spouse is at work), and spend less or nothing on days when family care is available. A weekly or monthly limit approach results in a greater amount of home care costs being covered than with a daily benefit limit approach.

Example: Leo needs 8 hours of home care each day Monday through Friday, costing $80 per day. He does not need any paid care on the weekend when his wife is home. His weekly home care costs is $400 (5 x $80 per day).

Policy	Daily or Weekly Limit?	Amount Paid	Expenses Not Covered
Policy A	Daily limit up to $60 per day	$60/day x 5 days = $300/week	$400 - $300 = $100/week
Policy B	Weekly limit up to $60 x 7 = $420	Expenses up to $420/week	None. Policy pays all $400/week since the weekly limit of $420 has not been reached.

Choosing a Daily Benefit Amount. How should individuals decide what daily benefit amount (DBA) is appropriate? It is an important idea to look into how much care costs in their area (or plan to live when you need care). Ask friends or family who have needed care, or call some nursing homes, assisted living facilities or home care agencies to get a sense of area costs. Costs can vary quite a bit from one provider to another.

To help consumers select the DBA that makes sense for them, the chart in the Appendix of Module 1 shows the average costs of nursing home care in each state. Consumers with Internet access may also log onto the Federal Long-Term Care Insurance Program website at www.ltcfeds.com. The website contains numerous planning tools, including an Estimator that provides average costs in some major areas. While the site is geared toward federal employees, the basic information serves as a useful tool.

Total Coverage Amounts (or Lifetime Maximums)

Most policies pay LTC expenses up to a total coverage amount (or lifetime maximum benefit). Today, most LTC policies specify an overall dollar amount that applies to all covered services as the "total coverage amount." Older policies limit coverage to a specified number of days (or years), rather than dollars, or specify separate limits by each type of service (e.g., pay for up to two years of home care and up to four years of nursing home care).

The policies today, therefore, provide more flexibility, allowing consumers to decide how they want to spend the overall dollar limit on any of the covered services. A consumer can receive it all at home, or all in a facility, or any combination, up to the overall dollar limit.

Consumers can usually choose the "total coverage amount" they prefer. The "total coverage amount" is usually calculated by multiplying a number of years times 365 days per year times the nursing home daily benefit amount chosen:

3 years x 365 days x $100/day = $109,500 or
3 years x 365 days x $150/day = $164,250 or
5 years x 365 days x $100/day = $182,500 or
5 years x 365 days x $150/day = $273,750

Not all choices are available from all insurers, but generally, consumers can choose from as little as "two years" worth of coverage to as much as 10 years of coverage. In addition, a popular choice is "lifetime" or "unlimited" coverage, which does not have any dollar limit – coverage continues for as long as the person continues to need care.

How long will coverage last? How long coverage will last depends upon how often individuals receive care (daily or less often) and how much that care costs. If individuals receive care less often than every day and/or at less than the full cost allowed in their policy, it is possible to "stretch" the coverage and make it last even longer than the "minimum" used in calculating the total coverage amount. The combinations are almost limitless – that is one of the advantages of the "pool of dollars" approach.

Table 1. Consider a Total Coverage Amount of $109,500

	Nursing Home ($100/day)	Assisted Living ($100/day)	Home Care ($50/day)
Minimum:	At least 3 years, if care is received everyday at $100/day	At least 3 years, if care is received everyday at $100/day	At least 6 years, if care is received every day at $50/day
Stretching the Benefit	Would last 4 years if care costs $75/day	Would last 4.3 years if care costs $70/day	Would last 14 years if only needed care 3 days/week

While 80 percent of people who enter nursing homes stay five years or less, lifetime coverage can provide peace of mind that care needs will not outlast benefits. However, not everyone can afford lifetime/unlimited coverage. Each person has to select the coverage amount that best meets their "comfort level" and their ability to afford the insurance. There is no "one size fits all."

Training Exercise

Participants should calculate how long benefits would last under the following scenarios.

Total Coverage Amount:	$109,500
Nursing Home Daily Benefit:	$100/day
Assisted Living Facility Benefit:	$100/day
Home Care Benefit:	$ 50/day

Scenario A: You receive care in a nursing home. It costs $100/day for your care and you are there everyday. How long will your benefits last?

Scenario B: Same as above except you find a less costly nursing home that charges $80/day. How long will your benefits last?

Scenario C: You receive care at home every day. It costs $50/day for your care. How long will your benefits last?

Scenario D: You receive care at home 4 times a week. It costs $50/day (or $200/week). How long will your benefits last?

Scenario E: You receive care in a nursing home. It costs $150/day for your care and you are there everyday. How long will your benefits last?

Will your benefits ever be used up more quickly than 3 years? Why not?

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Name some ways you can "stretch" how long your benefits last?

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Training Exercise - Answers

Participants should calculate how long benefits would last under the following scenarios.

Total Coverage Amount:	$109,500
Nursing Home Daily Benefit:	$100/day
Assisted Living Facility Benefit:	$100/day
Home Care Benefit:	$ 50/day

Scenario A: You receive care in a nursing home. It costs $100/day for your care and you are there everyday. How long will your benefits last?

[**Answer:** 3 years]

Scenario B: Same as above except you find a less costly nursing home that charges $80/day. How long will your benefits last?

[**Answer:** 3.75 years]

Scenario C: You receive care at home every day. It costs $50/day for your care. How long will your benefits last?

[**Answer:** 6 years]

Scenario D: You receive care at home 4 times a week. It costs $50/day (or $200/week). How long will your benefits last?

[**Answer:** 10.5 years]

Scenario E: You receive care in a nursing home. It costs $150/day for your care and you are there everyday. How long will your benefits last?

[**Answer:** 3 years]

Will your benefits <u>ever</u> be used up more quickly than 3 years? Why not?

[**Answer**: No. Because the most that can be paid on any day is $100/day even if care costs more than that. So, $109,500 divided by $100/day will always be 3 years. Benefits can't be used up any faster than $100/day.]

Name some ways you can "stretch" how long your benefits last?

[**Answer**: By receiving care at less cost that the full daily benefit amount or by receiving care less often than every single day of the week.]

Inflation Protection

Inflation is such an accepted fact of life that most of us do not think about it. It is important to consider how inflation affects the costs of LTC and the value of the coverage that is bought today. Most people buy coverage years in advance of when they might need it. But the costs of care increase each year – the current rate of inflation in LTC costs is about four percent per year. Thus, those who do not plan for the effects of inflation may find their coverage is inadequate in the future.

Long-term care is different than "medical care." Where medical care is very "high tech," LTC is much more "high touch." Inflation in LTC costs closely matches the inflation rate in the labor market, while health care inflation costs are rising more rapidly, typically because of the "technology" involved in medical care (e.g., MRIs, organ transplantation, etc.)

In Texas, all individual LTC policies must offer inflation protection to each applicant. Group policies can let the group policyholder (e.g., the employer) decide whether and how to include inflation protection in the policy unless the group is an association. Inflation protection must be offered to all members of an association group.

There are three basic approaches to inflation protection:

- **Compound Inflation Protection.** All coverage amounts automatically increase each year by five percent (5%), compounded annually, as long as the individual maintains coverage, even while receiving benefits. The premium cost for this rider is designed to not change over the life of the policy even as the coverage amounts increase each year. All insurers are required to offer the five percent (5%) compounded inflation protection and receive a rejection in writing from the applicant before any other form of inflation protection can be offered.

- **Simple Inflation Protection.** This approach is the same as the above, except that the amount of the increase is the same each year, based on five percent (5%) of the initial coverage amounts.

- **Future Purchase Option.** (also called Benefit Increase Option, Guaranteed Purchase Option, or CPI Increase.) This option allows consumers to buy additional coverage amounts on a periodic schedule, to keep benefits in step with the rising costs of care. Generally, every two or three years, the insurance

company will offer their policyholders an opportunity to purchase additional coverage at an additional premium cost without having to provide proof of insurability. With this approach, you would pay an additional premium cost based on your attained age every time you choose to accept the offer of additional coverage.

Table 2. Comparing Coverage Increases with Compound and Simple Inflation Protection

Year	Daily Benefit Amount (DBA)		Total Coverage Amount	
	Compound	Simple	Compound	Simple
1	$130	$130	$142,350	$142,350
5	$158	$156	$173,010	$170,820
10	$202	$188	$221,190	$205,860
15	$258	$221	$282,500	$241,995
20	$329	$253	$360,255	$277,035

Compound inflation protection better matches with how costs of care will increase. But simple inflation protection increases are reasonably close to the compound increases for the first 10 years of coverage. Thus, simple inflation protection may be more appropriate for older buyers who may be closer to needing care than someone who buys coverage in their 40's or 50's.

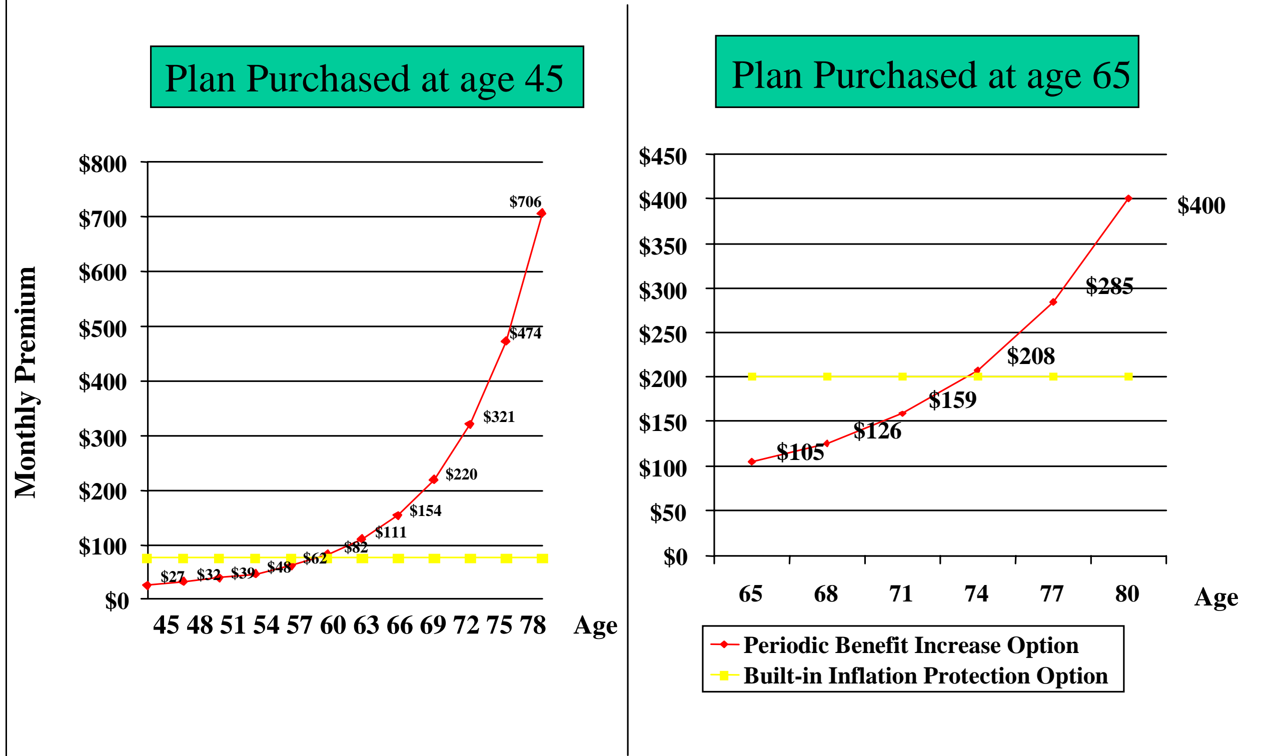
The Future Purchase Option (FPO) is mostly offered in the employer group market. The rationale for that is that younger, working age consumers will have salary increases through their prime earning years, so they will be able to afford to "buy" additional coverage amounts to keep pace with inflation. While approaches vary, the FPO usually works as follows:

- Every two or three years, the insurer offers additional coverage amounts;
- The additional coverage might be a flat dollar amount (e.g., $10 to $25) or might be a percentage increase over the existing coverage amounts (e.g., five percent per year since the last offer);

- An individual can accept the additional coverage amount or decline it;
- If they accept additional coverage, they will be charged an additional premium for the amount of the increased coverage, based on their age at the time of the offer;
- If they decline additional coverage, they may still be able to accept future offers;
- The FPO usually ends when an individual begins to receive benefits. This means that the insurer will not issue additional offers to increase benefits;
- The increase offers also may end at a specified age (e.g., 85) or after an individual has declined a certain number of offers (e.g., 2 or 3 offers).

While the compound inflation protection costs more than the FPO approach initially, it can be more cost-effective in the long run. But which approach "costs more" really does depend upon the age at which you buy, how long you have your coverage and your age at the time you need benefits. (See the chart below). As with other things, there is no "one size fits all."

Periodic Benefit Increase vs. Automatic Inflation Protection



The FPO was the predominant approach to inflation protection in the employer group market. However, large employer groups such as the California Public Employees' Retirement Program's (CalPERS) Long Term Care Program and the Federal Long Term Care Insurance Program (FLTCIP) have begun to offer compound inflation protection as a choice to employees with impressive results – more than 80 percent of employees have elected coverage with the compound inflation protection. A growing number of employer-sponsored LTC insurance programs will include an offer of compound inflation protection.

The chart below summarizes the key differences between Compound Inflation Protection and the Future Purchase Option.

Table 3. Comparing Compound Inflation and Future Purchase Option

	Automatic Inflation Protection	Future Purchase Option*
How much will coverage increase?	5% per year, compounded	The amount care costs since the previous option
How often will coverage increase?	Yearly, automatic	May be yearly but might be every 2 to 3 years.
Do premiums increase as coverage increases?	No	Yes
When will coverage increases end?	Continue for the life of the coverage.	When one starts to receive benefits, or after declining two upgrade offers.

*Some FPOs will work differently than this.

Nonforfeiture Provisions

Nonforfeiture Provision

Nonforfeiture (NFO) is a benefit which individuals can add to their LTC coverage for an additional premium cost. It provides a continuation of coverage, on a limited basis, in the event that an individual ceases paying premiums resulting in a lapse in coverage. This limited amount of additional coverage might give time to make "transition plans" for how to pay for continued care needs if the coverage has lapsed due to non-payment of premium and if the individual does not wish to reinstate the coverage.

All individual policies are required to offer NFO to each applicant and receive a rejection in writing from the applicant. Group policies can let the group policyholder (e.g., the employer or association) decide whether and how to include NFO in the policy. Written rejection from the group policyholder is also required.

Most NFOs provide coverage equal to 30 times the nursing home daily benefit amount, or 100 percent of premiums paid to date (minus claims) at the time an individual stopped paying premiums and lapsed in coverage, whichever is greater. This would provide about one month's worth of continued coverage, or more, depending on the amount of premiums paid to date. Generally, a policy in force must be in-force for at least 3 years before the nonforfeiture provision applies.

Example: Assume Jane's premiums are $1,200/year. Jane has maintained her coverage for 5 years. Her current nursing home daily benefit amount is $150.
If Jane lets her coverage lapse by not paying premiums anymore, the value of her nonforfeiture benefit (assuming she had chosen to include this optional feature in her coverage initially) is:
The greater of $1,200 x 5 years = $6,000 or 30 x $150/day = $4,500

Contingent Nonforfeiture

Newer policies (sold after July 2002) automatically include, at no charge, a Contingent Nonforfeiture benefit. This provides the same protection as the nonforfeiture option described above, except that it is triggered by a "substantial increase" in premiums, which causes someone to stop paying premiums. There is generally a state-mandated schedule defining the amount of the premium increase that is considered "substantial" enough to trigger the contingent nonforfeiture benefit. The amount of benefit is the same as described above – the greater of 30 times the daily benefit amount or 100 percent of premiums, whichever is greater.

The schedule of "substantial premium increases" by age, which would trigger this benefit, is shown below.

Table 4. Triggers for a Substantial Premium Increase

Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium
<29	200%	64	54%	75	30%
30-34	190%	65	50%	76	28%
35-39	170%	66	48%	77	26%
40-44	150%	67	46%	78	24%
45-49	130%	68	44%	79	22%
50-54	110%	69	42%	80	20%
55-59	90%	70	40%	81	19%
60	70%	71	38%	82	18%
61	66%	72	36%	83	17%
62	62%	73	34%	84	16%
63	58%	74	32%		

Helping People Decide

If a policy includes a contingent nonforfeiture option, or if the policy allows an individual to decrease coverage in the event of a rate increase, then the additional protection of an optional nonforfeiture provision is very limited. It adds to the policy cost without providing additional "protection" beyond what is already provided.

Keep in mind that the coverage amounts available under both the contingent and the optional nonforfeiture provision are very limited – only about one month's worth of care. The best strategy is to help consumers select a policy that they can be confident they can continue to afford over time. If the policy has a "right to decrease" coverage in the event of a rate increase (or whenever the insured's preferences change) that often provides more protection than an additional cost provision such as the nonforfeiture option.

Elimination Period

Similar to other types of insurance, LTC coverage includes an elimination period or "deductible." This refers to the initial time period or amount of expenses incurred before the policy begins to pay benefits. The purpose of an elimination period is to help keep coverage more affordable and focused on care needs.

The elimination period in LTC insurance is the number of days after an individual is eligible for benefits (e.g., needing help with ADLs or having a cognitive impairment), but before benefit payments begin. Unlike the deductible found in auto or home insurance, LTC policies specify a given number of days, not a dollar amount.

Health insurance usually has a deductible that must be met each calendar year. Many LTC policies today require that the elimination period be satisfied once in an individual's lifetime. Older policies and some others may require meeting the elimination period for each episode of care. For these, "per episode" policies, generally, if 180 days pass without needing any care, a "new" episode of care will begin.

Calendar Days or Service Days

Some policies count each day in which an individual receives specific services that would otherwise be covered under the policy (e.g., each day an individual receives home health care or care in a nursing home). This is called a Service Day Elimination Period.

Other policies simply count each day someone is "disabled," whether or not they received any paid care. This is called a Calendar Day Elimination Period.

An individual can generally choose the elimination period you prefer, including: 0, 30, 45, 60, 90, 100, 120, 180, or 365 days. The choices offered vary by insurance company and by state. Most people select a 60 or 90 day elimination period to help keep premiums affordable while still minimizing possible "out-of-pocket" expenses during the elimination period.

Elimination period expenses are smaller and more predictable expenses that can be planned for. The "worst case" is paying all the expenses for care in the most

expensive setting of care for the entire elimination period. The "best case" is having no out-of-pocket expenses. This would be true if the elimination period for the policy only counts "calendar days" and family or friends can provide care during that time, or if other insurance or Medicare pays LTC expenses during the elimination period. The most likely scenario is somewhere in between the "best case" and "worst case."

Most policies do not require satisfying the elimination period in order to receive Respite Care, Hospice Care, or Care Coordination Services. Some policies also waive the elimination period requirement for Hospice Care Services. Otherwise, unless you choose a "zero day" elimination period, you will have to meet this requirement for most other services covered under the policy.

Most people who need LTC begin by receiving care at home a few times a week. At the outset, when satisfying the elimination period, expenses are likely to be lower than if care was received each day in a nursing home. Most people immediately assume that they will be paying the "maximum" costs as if they were in a nursing home each day while they are satisfying their elimination period. Thinking about this and having a "calendar day" elimination period can help people better understand how to choose a more affordable elimination period and how to plan for possible expenses during that time period.

Helping People Decide

Many people prefer the premium savings of a longer elimination period (e.g., 90 days). Counselors should help consumers think about how they feel about paying out-of-pocket for some initial expenses in order to have lower premiums. The structure of the elimination period also may make it easier to satisfy. The easiest ones to meet are:

- Once per lifetime;
- Calendar day;
- Allow days to accumulate over time (not consecutively);
- Count any day on which you have a covered expense, regardless of the amount; and
- Count days when other insurance or Medicare may pay.

Consumer Protection Provisions

The following important provisions are required in any tax-qualified LTC policy. Texas requires these provisions be included in all LTC policies:

- **Guaranteed Renewable.** Coverage can never be cancelled by the insurance company, nor can the company refuse renewal, as long as an individual continues to pay premiums and the maximum benefit under the policy has not been exhausted.

- **Free-Look Period.** A 30-day period following the receipt of the policy during which an individual may return it for any reason for a full refund of any premiums paid. It is strongly recommended that consumers keep accurate records reflecting receipt of the policy, which starts or triggers the 30 day free-look period. It is also strongly recommended that consumers choosing to return the policy during the 30-day free-look period return the policy by certified mail, return receipt requested. This will insure that the consumer has an accurate record of return within the period.

- **Third-Party Designee.** An individual has the right to designate another person to receive notice of premiums due and payments missed so that a premium will not be accidentally missed if an individual is ill, traveling, or has for some other reason not paid the premium..

- **Grace Period.** An individual has up to 65 days after the date that the premium payment is due to make that payment. Coverage cannot be cancelled for non-payment until after the grace period has expired and until after the "third party designee" has also been notified.

- **Added Protection against Lapse (Extended Reinstatement).** If coverage lapses for non-payment of premium because you were "disabled" at the time (e.g., functional loss or cognitive impairment), you can automatically restore coverage if this is done within 5 months of the missed premium due date).

- **Continuation/Conversion for Group Coverage.** Most group policies continue unchanged if an individual leaves the group but wants to maintain his or her coverage and "take it with you." There is usually no change to the premium or

the coverage. Some policies allow "conversion" to the same coverage on an individual basis. If premiums were being paid through a means that is no longer available due to leaving the group (e.g., payroll deduction from a former employer), it can be switched to being billed directly. A spouse insured through an employer group plan, maintains coverage even if there is a divorce and no longer married to the covered employee.

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Other Typical Coverage Features

This section describes some other typical coverage features included in LTC insurance. Most policies include the following:

- **Bed Reservation.** Pays expenses to "reserve" the nursing home or assisted living facility bed while an individual is temporarily absent for a hospital stay or other reason.

- **Caregiver Training.** Pays expenses to train an informal caregiver (family member or friend) to safely and appropriately provide personal care or similar services.

- **Hospice Care.** Short-term, supportive care for the terminally ill person with a life expectancy of six months or less.

- **Respite Care.** Intended to provide time off for those informal caregivers who ordinarily care for you on a regular basis. Typically 14 to 21 days of care per year.

- **Caregiver Training (Family Care).** Some policies pay expenses incurred in paying family or friends that provide care. Other policies will give a cash payment each day an individual is disabled and receives care from an "informal caregiver" even if there are no expenses incurred. Coverage is usually limited to a percent of the total daily benefit and may have a lifetime limit. Since most families do not charge for the care they provide, most people do not incur expenses when they receive informal care.

- **Waiver of Premium.** For most policies, individuals may stop paying premiums once they start to receive benefits. This is called "premium waiver." Some policies begin premium waiver on the first day in which benefits are received. Other policies begin premium waiver after having received benefits for a certain number of days (e.g., 90 days).

- **Restoration of Benefits.** This feature "restores" the total coverage amount or lifetime maximum to its full original amount even if benefits have been used, as long as the insured goes 180 days without any disability or care, following the

use of benefits. Since it is unlikely that someone who has used a significant amount of their benefits will recover to the point of being independent for 180 days and then subsequently require care, this benefit provision provides illusory coverage.

- **Alternate Care.** Allows the policy to pay expenses not typically covered by the policy for alternative care or services that may emerge in the future or be unique to a location or situation. This provision helps coverage purchased today keep pace with a rapidly changing LTC service delivery setting. Services that did not exist today and are not written into the policy can still, on a case-by-case basis, be paid for under the policy in the future. The insurer does not "impose" alternate care on individuals – it is an optional feature provided if you, your physician, and the company agreed upon.

Care Coordination

A growing number of policies today include care coordination. These policies not only pay for care, but help people identify the services they need and arrange for care, if desired. Care coordination is not managed care. It is a voluntary, value-added component of many of LTC policies.

Objectives. The goals of care coordination is to help consumers receive the most value from their coverage by identifying appropriate and lower cost care options and to provide valuable support for family caregivers. When the time comes that an individual needs care, often it is difficult to know what to do, what the options are, or where to get help. Care coordination can provide options, answers, guidance, and reassurance. It can also help identify specific providers in the community that can meet an individual's care needs.

How it Works. A trained Care Advisor (a nurse or social worker experienced in LTC) meets with consumers by telephone or in person and gathers information about their physical, mental, social, and medical situation. The Care Advisor suggests a "Plan of Care" based on specific care needs and family situation. The Plan of Care often suggests specific services and providers, although these suggestions are not "mandatory". It generally provides the option for both care at home or in a facility, depending on individual preferences and circumstances.

Finally, the Plan of Care is not put into effect unless the individual and their family are comfortable with it, and it is modified as needs change.

Different Approaches. Insurers may both pay for and provide care coordination services, or they may just pay for these services and require consumers to find the "care coordinator" on their own. Many insurers that provide this service have a contract with the national network of care advisors in all parts of the country, so that they can find a trained professional who knows the services and providers in their area.

Some insurers only have telephonic support for care coordination, provided by a nurse or social workers on their staff in a central location. This type of care coordination is more impersonal when compared to service provided by someone on-site and local who can meet in person to better understand an individual's care needs.

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Other Coverage Options (Additional Premium Charge)

There are a number of other coverage options that are available for an additional premium charge. Not all insurers offer these options, but some of the more typical optional benefit riders are:

- **Refund of Premium.** This option is often for younger buyers or buyers in the employer market. This option costs more but it is ideal for people worried about losing the value of all their premiums if they end up never needing LTC.

- **Shared Care.** This provision allows a married couple (or domestic partners) to share either an additional coverage amount or the entire amount of coverage they each have. This helps a couple obtain coverage in light of the uncertainty about which of them will need care and for how long.

- **Paid-up Survivor**. If one spouse dies and the other pays premiums for 10 years then they will have a paid-up policy. This rider can work several different ways. Some policies require both spouses to live for the full 10 years without any claims before one spouse dies before the policy is paid up.

- **Dual Premium Waiver.** This provision provides a waiver of premium for one spouse when the other spouse begins to receive benefits, assuming that both have maintained coverage under the policy for a specified time period (e.g., 10 years).

Module 6 Test

1. A nursing home operating in Texas shall be defined as?

    a. One that has group meals as well as kitchens in individual living units
    b. One that accepts only fully independent individuals
    c. One that has 24-hour staffing available and provides care and services to support people who are unable to perform Activities of Daily Living (ADLs) or has a cognitive impairment
    d. One that has a license as a nursing home

2. What phrase best describes care that is designed to give "time-off" and support to family caregivers who are normally providing LTC?

    a. Hospice care
    b. Respite care
    c. Supportive care
    d. Home health care

3. Which of the following services are covered under a Home Health Care policy?

    a. Home health aide
    b. Nursing home care
    c. Adult day care
    d. a and c

4. What phrase best describes care for individuals who are both terminally ill and who need long-term care to assist them with activities of daily living?

    a. Hospice care
    b. Respite care
    c. Supportive care
    d. Home health care

5. Which of the following most accurately describes how LTC insurance policies pay for home care relative to facility care?

   a. Home care benefits are paid at 50% of the nursing home amount
   b. Home care benefits are paid at 75% of the nursing home amount
   c. Home care benefits are paid at 100% of the nursing home amount
   d. Most policies give a variety of choices for how much can be paid for home care

6. Most policies today offer a lifetime coverage maximum (or total coverage amount) best described as follows:

   a. A specified number of years (e.g., 3 years) during which time you must use your benefits.
   b. A specified number of years (e.g., 3 years) times 365 days per year. That defines the total number of days on which you can receive benefits.
   c. A specified dollar amount, derived by multiplying some number of years times 365 days per year times the daily benefit amount you select. This dollar amount applies to all covered services under the policy.
   d. Same as c. above, except that there are separate dollar pools for facility care and for at-home care. If you use up the lifetime maximum dollar amount for home care, then you have no more benefits unless you receive care in a facility.

7. If you receive care everyday in a nursing home, how long will your $109,500 LTC policy last, assuming that your daily benefit amount for facility care is $100/day?

   a. At least 3 years, and possibly longer if your care costs less than $100/day
   b. Exactly 3 years
   c. Less than 3 years, if your care costs more than $100/day
   d. None of the above

8. Which of the following statements below are TRUE with respect to **<u>Compound Inflation Protection?</u>** (Circle ALL that apply):

   a. Coverage increases periodically (e.g., every 2 or 3 years) by a specified amount.
   b. Coverage amounts increase each year by 5% of the previous year's amount.
   c. Coverage amounts increase each year by 5% of their original amount.
   d. Coverage increases are automatic.
   e. No increases in coverage are available once you are receiving benefits.
   f. Daily benefit amounts increase, but the lifetime maximum does not increase.
   g. Increases in coverage end at age 85.
   h. You pay an additional premium for the amount of increased coverage each time there is an increase.
   i. The premium is designed not to change over time, even though the coverage amounts increase each year.
   j. In the long-run, this is the most cost-effective approach.
   k. This approach is best for younger buyers.

9. Which of the following statements below are TRUE with respect to **<u>Simple Inflation Protection?</u>** (Circle ALL that apply):

   a. Coverage increases periodically (e.g., every 2 or 3 years) by a specified amount.
   b. Coverage amounts increase each year by 5% of the previous year's amount.
   c. Coverage amounts increase each year by 5% of their original amount.
   d. Coverage increases are automatic.
   e. You decide whether or not to elect each increase when it is offered.
   f. No increases in coverage are available once you are receiving benefits.
   g. Daily benefit amounts increase, but the lifetime maximum does not increase.
   h. Increases in coverage end at age 85.
   i. You pay an additional premium for the amount of increased coverage each time there is an increase.
   j. The premium is designed not to change over time, even though the coverage amounts increase each year.
   k. In the long run, this is the most cost-effective approach.
   l. This approach is best for younger buyers.

10. If you purchase a $100 a day nursing home benefit and the nursing home charges you incur are $80 a day and the policy pays $100, the benefit payment method is known as?

    a. Disability
    b. Reimbursement
    c. Indemnity
    d. None of the above

11. Which of the following correctly describes Contingent Nonforfeiture?

    a. A policy provision which provides a limited amount of coverage (e.g., 30 days worth) if your policy lapses due to non-payment of premium following a "substantial" increase in your premiums based on your age at the time you bought the policy.
    b. A policy provision which provides a limited amount of coverage (e.g., 30 days worth) if your policy lapses due to non-payment of premium for any reason.
    c. A policy provision which provides a limited amount of coverage (e.g., 30 days worth) if your policy lapses due to non-payment of premium because you were cognitively impaired at the time of the premium lapse.
    d. None of the above.

12. Which of the following correctly describes an Elimination Period?

    a. The period of time you must wait before the insurance company determines whether you can be approved for coverage.
    b. The period of time after your coverage becomes effective but before you can be eligible for any benefits.
    c. The period of time after you are eligible for benefits and begin to receive covered services but before the policy will pay benefits.
    d. The period of time you must wait to receive a refund of premium if you decide to cancel your policy within the first 30 days.

13. Which of the following correctly describes the concept of premium waiver?

    a. You are not required to pay premiums while you are receiving benefits.
    b. Once you begin to receive benefits, you never again have to pay premiums.
    c. Once you become disabled and need care, you stop paying premiums, even if you have not yet started to receive services.
    d. After you pay premiums for 20years, your policy is "paid-up" and you don't have to continue to pay premiums.

14. The "free-look" refers to the initial number of days you have your coverage in which you can decide to cancel without any obligation and receive a refund of any premiums you have paid. How long is this "free-look period in Texas?"

    a. It varies from state to state.
    b. 10 days
    c. 20 days
    d. 30 days

15. How many days does a Texas LTC policyholder have to make a premium payment from the date the payment is due?

    a. It varies from state to state.
    b. 10 days
    c. 30 days
    d. 65 days