Overview and Learning Objectives

This module takes a closer look at long-term care (LTC) insurance premiums, underwriting, claims procedures, and consumer tips.

At the conclusion of this module, you will be able to:

- Explain the key factors influencing the cost of coverage at various ages;
- List the various options consumers have for paying their premiums and things to think about as they decide;
- Explain the consumer protection features around LTC insurance premiums;
- Explain the options consumers have in the event of a rate increase;
- Describe the criteria that LTC insurance policies use to determine eligibility to receive benefits;
- Explain the key steps in the process of handling a claim, including the consumer's right to appeal the insurer's decision to deny a claim;
- List the most common reasons for denial of a claim;
- Describe the typical exclusion and limitations that policies impose and how they work;
- Explain the primary conditions that might make someone uninsurable for LTC coverage; and,
- Describe the underwriting approval techniques that insurance companies use.

Self-Assessment

- What does it mean that premiums are "designed to remain level?" How is this different than other types of insurance? On what basis can an insurance company raise premiums in the future?

- What are the various "consumer protections" in place around LTC insurance premiums? How can consumers determine whether a policy has these protections or not?

- What coverage features have the greatest impact on the cost of coverage?

- What are the advantages and disadvantages of "limited pay" policies?

- How would you help a consumer who is comparing two policies, when one has significantly lower premiums? What questions do you need to help them ask?

- What are the two criteria for qualifying for benefits under a tax-qualified (TQ) policy? Why are these criteria appropriate?

- What are the most common reasons for denial of a claim and what should a consumer do if their claim is denied?

- What are the most common "exclusions" in today's policies?

- What are the primary reasons someone might not be able to obtain LTC coverage, based on their current health? What conditions might applicants have and still be able to obtain coverage?

- Why do insurance companies use an in-person assessment in some situations to determine if someone is eligible for coverage?

- How can you help applicants whose application for coverage is rejected? How and when should they appeal?

Premiums: An Overview

Many other types of insurance have premium costs that increase each year as an individual gets older. Health and term life are examples of such insurance. In contrast, long-term care (LTC) insurance premiums are based on the age of the buyer at the time the policy is purchased. As a result, it is wise to purchase coverage at a younger age. When people buy many years in advance of when they will need the insurance, there is time for the premiums they pay in (which are set aside in "reserves") to build up with investment and inflation. That way, consumers can pay much less than if they began paying into the policy for coverage much closer to the time that care is needed.

While the vast majority of insurance companies have raised rates, they also cannot guarantee that they will not do so. Some have imposed premium increases, but the right of insurers to raise rates after a buyer has taken out a policy is limited. The circumstances under which they can typically raise rates are:

- The increase is actuarially justified based on claims experience for an entire class of insured individuals. A class refers to a group of individuals with the same characteristics, such as age, geographic location, and similar benefit classifications.

- No one person can be singled out for a rate increase based on age or health.

- The increase must be reviewed by the Texas Department of Insurance.

Rate Stability Guidelines

Stability of rates is a central issue in LTC insurance. No insurer wants to be in a position of having to raise rates. However, the information and technology available to price LTC insurance is not perfect, and the mortality and morbidity landscape against which policies must be priced is continually changing. Because it is a long-term product, insurers must make predictions for 20, 30 and even 40 years into the future about life expectancy, service use, the role of informal family caregiving, interest rates, and many other factors critical to determining the price of a policy.

Most insured blocks have never had a rate increase. Rate increases among the top eight insurers (representing about 80 percent of covered lives) have been modest and infrequent.[1] Some of the earliest experience with rate increases emerged because of poor underwriting practices or deliberate under-pricing to gain market share. Insurance companies today understand the importance of careful underwriting to ensuring rate stability and, therefore, invest in the time and technology necessary. Studies suggest that insurers, for the most part, are pricing correctly with respect to mortality and morbidity experience. In fact, claims experience for insurers who have invested in the time and technology to underwrite correctly has been better than expected, overall.

More recently, however, there has been concern about insurers' assumptions about policy lapse rates (the number of people who will keep or drop their policies over time) and interest rates. Premium increases could be necessary if insurers' assumptions about lapse rates prove incorrect. Even small differences between actual and expected rates on these critical assumptions are important. With the current downturn in the economy and lower interest rates, these concerns become even more important.

[1] Changes in Long-Term Care Industry: No Cause for Alarm. Kiplinger's Retirement Report. June 2000.

To address these important concerns, the National Association of Insurance Commissioners (NAIC) has adopted model "rate stability" guidelines, which do the following:

- Require insurers to disclose to prospective buyers any prior rate increases they have made;

- Make it more difficult for insurers to obtain a rate increase, including imposing fines and penalties, as a means of encouraging more conservative assumptions for initial pricing; and,

- Require insurers to certify that their premiums will be adequate under "moderately adverse" circumstances.

While the newest generation of LTC products may offer consumers somewhat higher premiums than previous products, these measures are designed to give consumers more confidence in the rate stability behind those premiums.

Coping with a Rate Increase

What options do consumers have if there is a rate increase? It depends on the administrative practices of the insurer and on provisions in the policy. Some policies will describe some of the options consumers have in the event of a rate increase. Other policies may not include such language but still might offer those options at the time of the increase. The first thing consumers should do, then, is to (1) check the policy and (2) call the company to ask if the following options are available:

- **Contingent Nonforfeiture.** Contingent nonforfeiture is described in Module 6. Policies sold after 7-1-2002, include this provision, which offers a limited amount of coverage in the event of a rate increase, even if consumers do not wish to continue to maintain their coverage by paying the increase.

- **Nonforfeiture Option.** Also described in Module 6, this optional rider provides similar (limited) coverage if a consumer chooses to drop the policy rather than accept the rate increase.

- **Decrease Coverage.** Some policies allow a consumer to give up some elements of coverage in return for keeping the premium affordable. For example, consumers might reduce the daily benefit amount or shorten their lifetime maximum coverage to offset the amount of the premium increase. The easiest change to make is to reduce the daily benefit amount since a 10 percent decrease in that feature is roughly equal to a 10 percent premium savings. It is important to ensure that consumers understand that the new decreased coverage should still provide meaningful protection. Certain changes may be more appropriate than others, given the consumer's situation and preferences.

When an insurer increases rates, it makes sense to find out whether the insurer has had other rate increases and to evaluate the size of the current increase in the context of past increases. A current increase might be a one-time adjustment that an otherwise conservative insurer is making to avoid future rate increases. Or, it might be "one of many" that the insurer must make. It may make sense to advise the consumer to retain the policy if the insurer is otherwise doing the right things and trying to mitigate the impact of the rate increase for its insured by offering coverage decrease options, or basing the new increased rates on "rate stability guidelines" to avoid future increases.

If, however, the consumer does not want to accept the rate increase under any circumstances, and does not like any other options available with the current insurer, then it may be advisable to seek alternative coverage. This should be a last resort strategy and it is critical that, before consumers drop coverage, they determine the following:

- Whether they are still insurable.

- The cost of new coverage at their current age.

It is important to advise the insured not to drop existing coverage until they are approved and issued an acceptable level of alternative coverage.

Factors Affecting Premiums

Consumers may ask help in selecting coverage features that they can afford. In order to help them, it is important to understand what types of coverage options are most desirable and appropriate for them given their particular needs. There is no such thing as a "one size fits all" policy. Some people want very comprehensive coverage (e.g., lifetime coverage that pays for home care at 100 percent of the nursing home daily amount) and others are comfortable with paying some costs directly to providers, if as a result the premiums are more affordable. For this type of consumer, a 50 percent or 75 percent home care benefit and a shorter lifetime coverage amount (e.g., "3 years" or "5 years") may make sense. Also, someone who expects to have family or friends who are willing to help supplement the care available under their policy may want to select less "comprehensive" coverage.

Some coverage features have a significant impact on premium cost while others do not. Consumers trying to decide on coverage should think more about the features that are significant in driving costs up, rather than about those that impact costs less. Also, if a feature does not add significantly to the premium cost (e.g., restoration of benefits rider), then it is also likely it does not add much value in terms of coverage. It is important for consumers to think twice about some of these "bells and whistles" to determine if they are really worth the additional premium cost.

Sometimes the impact on premiums with various coverage features differs with age. The presentation shows the impact on premiums, at various ages, of some of the most common coverage choices. (Please note that these premium impacts are based only on one insurer's rate structure; other companies may have different relationships within their pricing.) These impacts are summarized here:

- Choosing coverage that includes both facility care and home care, as opposed to facility care alone, has a significant impact on premium cost.

- Choosing a 100 percent home care benefit, as compared to a 50 percent home care benefit, increases premiums approximately 20 percent.

- Choosing a $150/day nursing home benefit, instead of a $100/day benefit, increases premiums about 50 percent.

- The difference in cost between "lifetime/unlimited" coverage and a "3-year" benefit maximum is about 65 percent, but this depends on age.

- The feature that most significantly impacts premiums is inflation protection. At age 55, including 5 percent compound automatic inflation protection almost doubles premium costs, compared to a plan with only periodic upgrades for inflation. At age 75, the increase is about 50 percent.

- Features that have a smaller impact on premiums include the elimination period amount (about 20 percent difference for 30 days versus 90 days) and spousal benefits, such as a surviving spouse premium waiver (15 percent) or a shared care rider (8 percent).

Payment Options

Most policies are designed to be "lifetime payment". This means that consumers continue to pay premiums until they begin to receive benefits. At this time, premiums are waived as long as they continue to receive benefits.

Some policies offer "limited pay" options. In this case, consumers pay premiums for a limited amount of time. The amount of each payment is higher, but it is possible for consumers to "pay up" before they would begin to receive benefits.

The "limited pay" options are:

- **Paid up at age 65**. The consumers continue to pay premiums until age 65. Consumers who are over age 65 (or close to it) at the time they buy a policy would not have this option.

- **Twenty (20) Pay**. A consumer pays premiums for the first 20 years of coverage. After that, a consumer is fully "paid-up" and no longer needs to pay premiums to keep coverage active. If consumers begin to receive benefits before the 20-pay period is reached, they would also stop paying premiums for the time they are receiving benefits. However, if consumers recover (and have not yet paid in), they would have to resume payments.

- **Ten (10) Pay**. This option is the same as the Twenty (20) Pay option, except consumers only pay premiums for 10 years.

- **Five (5) Pay**. This option is the same as the Twenty (20) Pay option, except consumers pay premiums for 5 years.

- **Single Pay**. Single Pay is the most expensive option. Consumers pay a single, large premium and are then fully "paid-up." Consumers never have to pay additional premiums to maintain coverage.

The primary attraction of the limited pay policies is that they limit consumers' exposure to possible future rate increases. Once a consumer is "paid-up", the insurance company cannot charge any additional premiums for coverage. (Once a Five and Ten Pay are paid in full the policy becomes a noncancellable policy. A single premium policy is known as a noncancellable policy)

The disadvantage of limited pay policies is that they cost much more than the amount a consumer would likely pay over a lifetime for a lifetime pay policy. In addition, not all companies offer limited pay policies. So, if consumers want to purchase a limited pay policy, they may have less choice. Some states are concerned about "limited pay" policies because they offer significantly higher sales commissions. States fear that agents may push these types of policies on consumers so that they can increase their commission.

As a result, it is important to counsel consumers to find the best insurance company and policy for them. Only then should they inquire about a limited pay policy. Consumers should also seriously evaluate how they feel about paying more in the short-run to protect against possible rate increases versus the amount and timing of premium costs as they age.

It is possible for consumers who had bought a limited pay policy to switch later to a lifetime pay policy, so that the premium they pay each year is reduced. However, consumers might not receive any credit for the amount they paid on the limited pay portion. In short, consumers should think carefully before buying a limited pay policy.

Premium Rate Classes

Some companies charge the same rate for everyone insured. Some have different rate classes based on health status. For instance, some companies have a discounted rate (usually 10-15 percent) for those in a "preferred" (or excellent) health status, while charging a uniform, higher rate for everyone else. Other companies have one rate for everyone, except for those in "substandard" (or poor) health. These policies might charge 20 percent to 100 percent more for people with certain high-risk health conditions.

Another practice is to accept a high-risk applicant, and not charge a higher premium. Instead, the company might limit the coverage the consumer can purchase (e.g., the insurer will only approve the consumer for a 90 day deductible instead of the 30 day deductible the consumer has requested, or the insurer will approve the consumer for 5 years of coverage instead of lifetime coverage). This type of barter is called a counter-offer. That is, the insurance company agrees to insure the consumer, but only for a different amount or type of coverage than requested.

Other companies have multiple rate categories: standard rates, preferred rates, and sub-standard rates.

Some considerations for a consumer when choosing among companies with different rate classes include the following:

- Consumers in less than standard health might find a better premium with an insurance company that does not have a preferred rate. Such consumers might have a lower premium in a plan with one rate for all policy members, than if they buy from a company that has preferred rates for which they do not qualify.

- Consumers should determine for which rate category they qualify before committing to buy a certain policy. If consumers are quoted a preferred or standard rate, but then only qualifies for the additional cost of a substandard rate, they might be better off buying from another company. A health condition that one insurer considers substandard could be considered standard by another. Consumers should always shop around and not pay the added cost of a substandard rate unless it is the only way they can obtain coverage.

- Not all companies offer rate classes. Consumers should compare the rates of one company that has rate classes with one that does not. Consumers in average or superior health may pay lower premiums with a company that does not have rate classes than with a company that does.

Underwriting

The purpose of underwriting is to assess the current functional and cognitive abilities of applicants and their risk of future disability. Premiums for an LTC product are based upon accepting individuals who are currently functional, independent, and have reasonable prospects of remaining that way for several years. The goal is to approve as many applicants as possible, while managing the risk effectively so that the premiums that have been established can remain fair and sustainable over time.

Because medical conditions alone often do not relate to a person's risk of becoming disabled and needing LTC insurance, underwriting for LTC takes into account more than simply the presence or absence of certain medical conditions. The underwriting criteria generally focus on a combination of medical, functional and cognitive conditions or the interaction of conditions, which are known to represent a high-risk for needing LTC.

Criteria can also vary from one insurer to the next. Some insurers decline to offer coverage to people with conditions that might require more investigation in order to determine the extent of their illnesses. Other insurers take additional time to look into applicants' health conditions; this tends to make them more likely to accept someone with a given health condition, if that condition is otherwise stable and well managed.

Typical Uninsurable Conditions

Some medical conditions will disqualify someone from being accepted into the program because of their usual and predictable progressive course. These conditions include chronic degenerative conditions such as Parkinson's disease, multiple sclerosis, and dementia. Other medical conditions, such as cancer or heart attacks, may or may not disqualify an individual, depending in large part on other factors. Additional information on medical treatment, physical functioning and cognition is often needed to make a final determination in these situations. Taking the time to obtain additional information often means that the insurance companies can accept someone that they might have otherwise been inclined to decline, based solely on their medical condition. So, this additional underwriting information is important to benefit both the applicant and the insurance program.

Every insurance company has a list of conditions that the company considers uninsurable. Uninsurable conditions are specific conditions that have a strong predictive value for unstable or failing health and carry an equally strong probability of resulting in significant limitations in one's ability to carry out activities of daily living (ADLs) in the next 48 to 60 months.[2] An uninsurable condition can be a single condition that indicates the current need for LTC, such as an Alzheimer's-type dementia, or a condition such as Parkinson's disease that might currently be stable, but where there is a significantly elevated risk of functional decline in the future. Finally, there are also combinations of medical conditions that present an increased risk of future disability, such as a history of poorly controlled diabetes, hypertension and stroke. Insurers differ in terms of the conditions that they consider uninsurable. The definition of uninsurable also depends upon whether an insurer offers only one rate class, or if it has a sub-standard risk category. A sub-standard risk category may allow an insurer to take applicants with conditions that another carrier might decline.

[2] The six ADLs are: eating, dressing, toileting, transferring (from bed to chair), maintaining or caring for continence and eating

The most common uninsurable conditions include:

- Current or recent use of LTC services;
- Help required with ADLs;
- Height and weight outside "acceptable" ranges;
- Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC);
- Alzheimer's type dementia, organic brain syndrome and all other forms of dementia and cognitive dysfunction;
- Amyotrophic Lateral Sclerosis (i.e., Lou Gehrig disease or ALS);
- Diabetes with complications such as renal failure, amputation, severe neuropathy, Transient Ischemic Attack (TIA) or stroke;
- Progressive neurological conditions such as Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis or Parkinson's Disease;
- Stroke or TIA within the past 12 to 24 months or history of multiple strokes or TIAs;
- Metastatic cancer;
- Use of certain adaptive devices such as a wheelchair, walker, four-pronged or quad cane, motorized scooter, Hoyer lift or hospital bed.

Insurers also carefully consider the type and amounts of medication the applicant takes, as this can play an important role in assessing an applicant's insurability. There are specific medications that are commonly used to treat uninsurable conditions, while other medications may indicate a high-risk level of disease severity or instability. The applicant's medication history is carefully evaluated during the underwriting process, so it is important that all of the applicant's medications be listed on their application.

Underwriting Tools

The decision to accept or decline an applicant is generally made based on information from a variety of sources. In general, insurers will collect more information on older applicants, since they are likely to have more medical and other conditions that must be fully explored before making an appropriate decision. The tools that are used to collect underwriting information are as follows:

- Application;
- Medical Records (also called Attending Physician Statement);
- Phone History Interview (PHI);
- Face-to-Face assessment (F2F).

Insurers do not require a medical exam or laboratory work in evaluating an application for LTC insurance. (However, if the applicant has no recent medical records and has not seen a doctor within two years, the insurance company may require the applicant to have a physical exam.)

The chart below shows how these evaluation tools are typically used. Each underwriting tool is described in more detail below.

Applicant Age	**APS**	**PHI**	**F2F**
Under 65	For specific conditions	All applicants	For specific conditions
65-74	All applicants	All applicants	For specific conditions
75 and older	All applicants	No	All applicants

Application. Some insurers have one application version for all applicants, while others may have different versions based on the age or employment status of the applicant. In general, the individual insurance tends to have a "one size fits all" application called a long form. The long form includes a detailed section exploring medical conditions and health history. For employer-group policies, insurers are likely to have a short form or an abbreviated application (a modified guaranteed issue) for employees who are actively at work and under age 65 or 70. In the employer-group market, spouses of employees may also have a more abbreviated application form, but parents and retirees are likely to complete the same long form application that is typically used in the individual market.

Attending Physician Statement (APS). Most insurers also request a copy of medical records from an applicant's primary care physician and sometimes they may also obtain records from one of the applicants' specialists. Insurers typically request medical records from the past three years, but some review records as far back as five years. Often, the physician records provide additional insight into the stability, nature, and severity of medical conditions. This additional insight may enable insurers to accept someone whom they might otherwise decline. Sometimes the medical records will reveal a medical condition that was not disclosed on the application but which raises an insurability concern. If this happens, the condition would be investigated further before an underwriting decision is made.

The insurer generally pays any expense associated with obtaining medical records. Once they have given their authorization to release their medical information to the insurer, applicants are not required to take any further action. If applicants have not been seen by a physician in the last two years, they may be asked to have a physical exam by a physician of their choosing, the cost of which will be the responsibility of the applicants.

Phone History Interview (PHI). Many insurers also use a telephone interview as an effective way to verify or clarify information provided on the application. This tool is generally focused on a certain age group (e.g., all applicants age 65 to 74 years may receive a Phone History Interview). This brief interview is conducted by a specially trained nurse and scheduled at a time convenient to the applicant. The nurse will ask questions about medications, medical conditions and the beneficiary's ability to function independently in everyday tasks such as bathing and dressing. The interview follows a structured format and generally requires about 20 minutes.

Face-to-Face Assessment (F2F). This is an in-person interview with a specially trained nurse, social worker, or paramedical worker. Many insurers use the F2F assessment as a critical underwriting tool for the older age applicants. It has proven to be a very cost-effective tool for identifying high-risk applicants with respect to cognitive or functional loss, who might otherwise be accepted and present early claims. It also helps to more fully evaluate older applicants with multiple medical conditions who are otherwise good risks because of the nature, stability and limited functional impact of those conditions. Without seeing the individual face-to-face, it would be too risky for the insurance company to accept them, based on medical history alone. Including a F2F assessment generally improves the risk pool and increases the acceptance rate.

The assessment takes place in the applicant's home or other location, if the person's own home is not convenient. It is not a physical exam. There is no blood or urine testing required during the in-person interview. The assessment is essentially a personal interview and it requires about 45 minutes. The interviewer asks the beneficiary about specific medical conditions, medications, and the beneficiary's ability to function independently in routine tasks such as bathing, dressing, taking transportation, or meal preparation. The assessment also includes a brief memory test to evaluate cognitive abilities and may include some simple medical screening, such as blood pressure readings and weight and height.

Acceptance and Decline Rates

Underwriting acceptance rates vary significantly across insurance companies due to differences in their philosophy and experience, the types of products they market, their target markets (e.g., young applicants versus very old applicants), and their distribution systems (e.g., direct mail, group presentation or direct agent sales). All of these factors significantly influence the risks that will present themselves to insurers, how they evaluate the risk and the acceptance and denial rates.

The chart below illustrates representative industry acceptance rates, although individual company experiences will vary.

Age of Applicant	Accept
< 65 years	91% - 99%
65- 74 years	79% - 95%
75-84 years	64% - 92%

Source: Long Term Care Group (LTCG) Underwriting Analysis, 2002.

If You Are Declined

Any consumer that is declined for insurance is entitled to know the reasons why. The insurance company may communicate the reasons to the applicant directly or the company may release the information to the applicant's physician.

Applicants retain the right to appeal or request reconsideration of a decline. They must make the request for an appeal in writing. Any information the consumers can gather to address the request is helpful. Consumers might ask their physician to write a letter clarifying information about their current condition or perhaps provide additional information, which the insurance company may not have evaluated. If the decision to decline the request for coverage was based solely on the application, the consumer might ask for a telephone or in-person interview or provide a copy of medical records so that the insurer has a clear and more complete picture of the consumer's health.

Consumers are, however, responsible for the costs associated with obtaining any additional medical information that they choose to provide to the insurance company to support the request for reconsideration.

Preferred and Substandard Risks

Most companies simply make a "yes" or "no" decision about whether an applicant qualifies for insurance coverage. Other companies, however, will identify some applicants as a preferred risk and give them a premium discount. Other companies may issue coverage to someone with some health conditions, which the insurer defines as sub-standard, and charge an additional premium for this person.

The criteria that might make someone a preferred risk vary across companies but might include the following:

- No uninsurable conditions;
- No use of mechanical devices;
- Does not require help with instrumental activities of daily living;
- No medical condition with likelihood of progression;
- No tobacco use within the last 1 to 5 years; and,
- Height and weight within preferred range limitations.

Similarly, the definition of a substandard risk category varies greatly among the companies that employ rate category. Some companies issue standard coverage to someone with a condition that another company would classify as sub-standard with an added premium charge. Some possible conditions that might cause someone to be rated substandard include the following:

- Congestive heart failure, stable and controlled with medication;
- Angina (post-heart attack but stable);
- Fibromyalgia;
- Seizure disorder (well-controlled);
- Lupus (in remission);
- Cirrhosis (mild or moderate and controlled on medication);
- Diabetes (onset less than 35 years or greater than 10 years from first diagnosis); and,
- Malignant lymphoma (five years post-diagnosis).

Qualifying for Claims

Type of Loss. People need LTC when they cannot perform their everyday ADLs without the help of another person or when they suffer from problems with memory or orientation (defined as cognitive impairment). For these reasons, all tax-qualified LTC policies use the following criteria for receiving benefits:

- **Need the help of another person with a specified number of ADLS.** The 6 ADLs are: bathing, dressing, toileting, transferring (from bed to chair), maintaining or caring for continence and eating. Needing help refers to both hands-on and stand-by help (supervision).

- **Severe Cognitive Impairment.** This refers to problems with memory and orientation to person, place, or time. It is measured by objective tools and tests. Alzheimer's disease is an example of severe cognitive impairment.

Tax-qualified policies pay benefits when the insured individual needs help with two or more ADLs for at least 90 days or has a severe cognitive impairment and a Plan of Care prescribed by a Licensed Health Care Practitioner.

Non-tax qualified policies pay benefits when the insured individual needs help with 2 or more ADLs or has a cognitive impairment. In Texas, non-tax qualified plans can be written more favorably. Some policies may include seven ADLs and some may also include medical necessity as an additional or alternative benefit criterion.

Medical necessity is an older and ill-defined term that does not correlate well with the need for LTC. If someone has a "medical need" for LTC (e.g., they are paralyzed or have severe movement restrictions due to phlebitis or arthritis), then they are most likely also to be unable to perform their ADLs. Some older policies and policies that are not tax-qualified may use medical necessity as a condition for receiving benefits. It is important to review how that term is defined in the policy and who can evaluate when medical necessity exists.

Degree of Loss. Most policies have a single threshold for all benefits – typically loss in two or more of the six ADLs or severe cognitive impairment. Some policies may pay a higher amount for a higher degree of loss for nursing home benefits (e.g., unable to perform three of six ADLs).

There is a significant difference in care needs when a beneficiary has two versus three ADL limitations. The chart below shows the nature of care needs at each level. The addition of the third ADL loss – the ability to get to and from and use the toilet on one's own – is critical in changing the type and frequency of care needs.

# ADL Losses	Which ADLs are Lost	Nature of Care Needs
2 ADLs	Bathing & Dressing	Care needs can easily be scheduled. Might need care once a day or less often.
3 ADLs	Bathing, Dressing and Toileting	Care must be "on call" as needed several times a day.

Imposing a higher benefit criterion for nursing home benefits probably has little impact on access to benefits since most people in nursing homes already have at least three or more ADL losses or a cognitive impairment. In fact, the average number of ADL losses among nursing home residents is 3.3.

Processing Claims

The claims process generally begins with a phone call to a special claims or customer service line the insurance company has specified. Customer service staff may do some "intake" over the telephone to understand the insured's care needs. The staff may also send the policyholder a claim form and an authorization form to release medical records from a provider that can provide more detailed information about care needs. Some insurers begin the claims process without a claim form, thus minimizing the burden of paperwork on the policyholder. Some insurers follow a more traditional route and require the policyholder complete a claim form to start the process.

The insurer gathers the information it needs to verify if the policyholder is eligible for benefits. The insurer may perform an in-person assessment interview (conducted by a trained nurse or social worker) to learn more about the policyholder's needs. The person completing the assessment collects information and passes it along to the insurer; they do not make a benefit decision.

It can take two to four weeks for the insurer to obtain all the information it needs to evaluate a claim. If approved, benefits can begin retroactive to the first day the policyholder was eligible, even if it takes some time for the insurer to process the claim request.

Handling Claim Denials

While the experience across insurers may vary, the most common reasons for denying a claim request are:

- The condition for which the claim is being made does not meet the definition of ADL or cognitive loss;
- Policy coverage has lapsed;
- The service is not a covered service;
- There is a duplicate claim for the same event; and,
- The claim amount exceeds the coverage amounts in the policy.

If a claim is denied, the policyholder is entitled to know the reason for denial and has the right to an appeal or reconsideration. It is important for the policyholder to understand the reason for the denial. The policyholders should also be familiar with the language of the policy so that they are aware of the extent of their coverage under the policy.

Exclusions and Limitations

Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the 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.

(8) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

Mental/Nervous. a neurosis, psychoneurosis, psychopath, psychosis, or mental or emotional disease or disorder of any kind.

Pre-Existing Condition Exclusion

"Pre-existing condition" is a condition for which medical advice was given or treatment was recommended by, or received from, a physician within 6 months before the effective date of coverage. Sometimes people confuse "underwriting" with this provision, but they are different. Underwriting refers to reviewing an applicant's health at the time of application and deciding whether or not coverage can be issued. A pre-existing condition exclusion is a limitation that might be put on coverage after it has been issued, but which pertains to a health condition the policyholder had prior to applying for coverage.

The Pre-Existing Condition Exclusions in a policy would postpone or delay coverage and not pay for care until after the first 6 months of coverage, if the need for care emerges within the first 6 months and is due to the pre-existing condition. Coverage for this condition would begin in month seven;

Outline of Coverage

The outline of coverage (OOC) is a summary of policy definitions, covered services, benefits, exclusions, and other policy provisions. It is a vitally important consumer disclosure document. Insurers are required to follow a state-mandated format and use specific language to explain coverage features in the OOC. Similarly, insurers are required to provide a potential buyer with the OOC before the agent can present an application to the potential applicant. This requirement is intended to encourage the individual to read the OOC and learn what is covered and what is not covered before they buy a policy. It is also designed to help consumers compare policies across insurance companies. This is why having a standardized approach to the information in the OOC is so important.

Some key elements are included in the Outline of Coverage:

- Policy Designation
- Purpose of Outline of Coverage
- Terms Under Which The Policy Or Certificate May be Returned and Premium Refunded
- Medicare Supplement Insurance Disclaimer
- Long-Term Care Coverage
- Benefits Provided by this Policy
- Eligibility of Benefits
- Limitations and Exclusions
- Pre-existing conditions
- Relationship of Cost of Care and Benefits
- Terms Under Which the (Policy) (Certificate) May Be Continued In Force and Is Continued
- Alzheimer's Disease, other Organic Brain Disorders…
- Premium
- Texas Department of Insurance's Consumer Help Line
- Denial of Application
- Offer of Inflation Protection
- Offer of Nonforfeiture Benefit
- Contingent Benefit
- Disclosure Regarding Federal Tax Treatment of Long-Term Care Insurance
- Additional Features

Consumer Tips

When is Long-Term Care Insurance the Right Choice?

When helping beneficiaries to determine whether LTC insurance is the right choice to finance their long-term care needs, keep these considerations in mind:

A good candidate:

- Has assets to protect or leave to others, or that have sentimental value
- Is able to afford monthly premiums
- Is unable or unwilling to pay out-of-pocket for a long duration of LTC
- Is not currently disabled or seriously ill, has a family history of longevity, and does not have a health history/lifestyle suggesting increased risk for disabling disease or injury
- Wants to ensure independence and control over money and assets
- Has an income level too high to qualify for Medicaid

An unlikely candidate:

- Has few or no assets to protect
- Is unable to afford insurance premiums, now or in the future
- Is already disabled or has serious health problems
- Has an income level that meets Medicaid eligibility limits
- Has enough assets to be self-insured and chooses that option
- Has no surviving loved ones to leave assets to

Things to Consider Before Buying

Perhaps the beneficiary is a good candidate for buying LTC insurance. Other considerations to keep in mind before signing an application are:

- What is the need and/or motivation for LTC insurance? Consumers should not buy out of fear or emotion. The purchase should be made because it is a sound financial decision and affordable.

- Is there enough income to pay a portion of care costs and then rely on a smaller LTC policy for the remainder? Consumers should not buy more than they think they might need. If consumers are concerned about the cost of the premium and do not mind paying some care costs on their own, they may buy a smaller policy and still benefit from coverage.

- Is enough coverage being purchased? Buying too little means the consumer is only slightly delaying the time when their own assets or income will be needed to pay for care. The consumer should think about how they feel about having care costs that extend beyond the period for which they buy coverage.

- Additionally, consumers should analyze the features available and select the features appropriate for them. There is no "one size fits all" policy.

- Long-term care costs increase annually. Consumers should plan for charges besides room and board, such as supplies, medications, linens, and other auxiliary expenses that may not be covered by the policy. It is important to check the policy language to see if it pays only for room and board in a facility, or if other expenses are covered. The consumer must ask himself/herself the question "Is the daily benefit selected adequate to include these auxiliary costs? If not, would it be feasible to pay for them out of pocket?

- It costs less to buy coverage at a younger age. As a result, the younger the consumer is at the time the policy is purchased, the better off they are financially.

- The consumer should make sure LTC insurance fit within their budget before purchasing a policy. The Suitability Personal Worksheet from the insurance company is a place to start, but ultimately the consumer must make their own decision about whether LTC coverage is affordable.

Shopping Tips

This list of shopping tips can help the consumer make an informed buying decision. Counselors should encourage consumers to do the following while interviewing insurance agents and companies.

1. Ask Questions – Many questions can be asked about the agent, insurance company and policies. Consumers should record answers so that they may verify if needed. Consumers should also ensure that the agent understands the specifics of their situation. The agent should listen carefully when trying to determine the amount and type of coverage that best meet an applicant's needs.

2. Comparison Shop – Consumers should -review more than one company's coverage: comparing benefits, types of facilities where coverage is provided, the limitations of coverage, the exclusions, and premiums. They should be careful to compare apples to apples, as there may be important differences to keep in mind. Also, consumers should make sure the insurance company is approved in the state in which they reside. They may apply for more than one policy and then compare the policies for which they are approved.

3. Compare Outlines of Coverage – Consumers should take their time and compare the outline of coverage. They should not buy the policy the first time an agent tries to sell it. Consumers should be wary of pressure or scare tactics on the part of the agent. The agent should provide the outline of coverage at the initial visit; if they do not, the agent should be avoided.

4. Understand the Policies and Premium – The consumers must understand what the policy does and does not cover, and how much it will cost. They should discuss it with a friend or relative. In addition, they should avoid any sales solicitation that claims the policy can be offered only once.

5. Do Not Be Misled By Advertising – Celebrity endorsements are done by paid actors who are not insurance experts. Consumers must rely on information in

the marketing material, brochures, policy language, and the Outline of Coverage to lay out what is and is not covered in the policy. They should insist on seeing a copy of the actual (specimen) policy, as it provides more detail on coverage than the Outline of Coverage. Insurers are not required to provide a sample policy but every agent selling coverage possesses one in order to know what is covered by the policy. A reputable agent should review the actual policy language with consumers to help them with their decision.

6. Do Not Buy Multiple Policies. One policy is sufficient.

7. Do Not Believe that Medical History is Not Important Disclosing medical history is very important. Applicants should ensure that the application materials are complete and accurate. They should not sign an application completed by the agent until it is reviewed and medical information is correct. If the health information is incorrect, the company can refuse to pay claims or may cancel the policy.

8. Never Pay in Cash – Consumers should always write a check payable to the insurance company.

9. Get the Agent's Information – Applicants should always obtain the name, address, and local and toll-free number of the agent and company.

10. Contact Company/Agent if Policy Not Received Within 60 Days – Consumers should keep the policy handy and tell a friend/relative where it is.

11. Review the Policy During the Free-Look Period – Policy can be canceled during this time and money will be refunded.

12. Reread the Application – This becomes part of the policy. If it is incorrect, the policyholder should notify the insurance company.

13. Consider Paying Premiums through Automatic Bank Draft – This will help to ensure that the policy will not lapse should the insured forget to pay the policy.

14. Check the Insurance Company's Financial Stability – Several private companies or rating agencies conduct financial analyses of insurance companies and grade them. While these ratings carry no guarantee of accuracy, they can

provide information on how some analysts view the financial stability of the company. Some rating agencies are:

A.M. Best Company
(900) 420 – 0400 (toll call)
www.ambest.com

Standard & Poor's
(212) 208 – 1527
www.standardandpoors.com

Duff & Phelps, Inc.
(312) 368 – 3157
www.bankwatch.com
Moody's Investor Service
(212) 553 – 1653
www.moodys.com

Fitch Investor Services
(212) 908 – 0500

Additional tools that can help a consumer determine whether LTC insurance is the best choice include:

- Suitability Personal Worksheet (see Module 5)
- Personal Value Assessment (see below)
- Identification of Resources to Fund LTC (see below)

Selecting an Insurance Company

Besides selecting a carrier with high ratings (A or better) from rating companies that have billions in assets, a consumer should ask a number of other questions:

- How long they have been in LTC, and do they have a dedicated unit? A dedicated unit indicates corporate support for a LTC product. Some newer companies can be very good but those that have been around longer have more data, extensive experience, and, larger risk pool.

- Has the company's business grown mostly through acquisition of other companies' LTC business or through sales growth? The former is a concern since the insurer's risk pool might not be as strong if they bought companies that were exiting the market due to pricing, underwriting, or other problems.

- How thorough is the company's underwriting process? A detailed application with use of other information like an Attending Physician's Statement and face-to-face assessments are indications of careful underwriting which is important to rate stability.

- Are the premiums based on the NAIC 2000 model for rate stability? While this may be difficult to find, it is a plus if they can determine this. The newest policies are more likely to comply, as are the policies currently for sale in the 20 or so states that have adopted the NAIC 2000 rate stability guidelines. Ask the agent to verify in writing whether the pricing for the product complies or not.

- What is the insurer's history of rate increases? What are the reasons for the increases? If the increases were on older policy forms that are designed and underwritten differently than what is currently being sold, this may not be an issue.

- Does the insurer offer a policy with options in the event of a rate increase, i.e. decrease in coverage to maintain current premium, or Contingent Non-forfeiture?

- Is credit of the applicant's past insured status given if applicant decides to increase or decrease coverage in the future? Some insurers allow this, others

make you drop the current coverage and buy the new coverage at the new age. Careful, this means paying higher premium amounts and the applicant may not pass underwriting.

Commonly Asked Questions

Q. The insurance company is increasing premiums. Can they do that?

A. Remind the consumer that the insurer has the right to raise rates on class basis and explain what that means and where that is disclosed in the insurers' information. Find out if the policy mentions the right to decrease coverage and/or has contingent non-forfeiture. Even if the policy does not mention the right to decrease, many insurers allow this anyway, so ask the company about it. The consumer might be able to keep the premium the same by making some small adjustments to existing coverage. For example, a 15% premium increase can be offset by taking a 15% decrease in daily benefit amount.

Q. How to find out if the company will be around 20 years from now?

A. The best bet is to pick a company with strong financial characteristics. Insurance agent should have a booklet that gives information about the insurance company's financial information and ratings. Look for a company with assets in the billions of dollars and with an "A" rating. Consult a rating service such as A.M. Best or Standard and Poor's. The marketing literature includes information on the insurance company's current ratings and assets. If not, ask the insurance agent to supply this or call the Department of Insurance (DOI) get this information.

Q. I've never heard of this company. Is it licensed?

A. With the exception of a few self-insured LTC plans, which are only available to members or employees of the organization offering the coverage, no entity is allowed to sell LTC insurance without being a licensed, DOI-approved insurer. So, even if the consumer has not heard of the company, the marketing literature should indicate the company's ratings and identify the company name. Consumers should call the DOI if there are any reasons to think that the company may not be licensed to sell LTC insurance.

Q. How often has my insurance company increased their rates in the last five years?

A. In Texas, insurers are required to disclose their history of rate increases, if any, before applicant makes a purchase.

Q. How much is a policy going to cost?

A. Beneficiary should ask for information on costs and rates. The beneficiary's agent may have prepared an illustration of costs for a few plan options, based on a discussion of his/her needs. If the consumer wants to see costs for other options, ask the agent to do additional illustrations or to provide a copy of the rate guide. Since there are many different benefit combinations, the complete rate guide may be a little overwhelming to review. However, the agent can explain the policy cost associated with different coverage choices.

Q. How many and what kind of complaints have been made against the company?

A. The Department of Insurance has information on formal complaints filed against a LTC insurance company, since insurance companies are required to track and report complaints. Advice consumers to contact the state DOI for complaints. Better Business Bureau, and Attorney General's office are two other organizations that the consumer can contact to.

Q. My claim was denied. Do I have any recourse?

A. Have the consumer describe the reasons given for a denied claim. The company has to state why the claim was denied. If they have not, find out. It could be that the deductible has not been met yet, they do not meet benefit triggers, or the claim was submitted for a service that isn't covered. Have consumer review policy language to compare reasons insurer gave with policy.

If the consumer believes they were unjustly denied, they can appeal the decision. The policy language usually explains the appeal process and the number of days the insurer has to review the request and respond. Call or write the insurer to

indicate plans to appeal. The consumer is responsible for the cost to obtain additional information from physician or whomever to support appeal.

Q. I want to cancel my policy. Is there a specific procedure I should follow?

A. If the consumer is dissatisfied with the policy, it should be returned to the company, not the agent. The consumer should do the following:

- Send the policy along with a brief letter asking for a refund.
- Send both the policy and letter by certified mail and obtain a mailing receipt.
- Keep a copy of all correspondence.

The refund process usually takes four to six weeks. A full refund of premium is only available if coverage is canceled within the 30-day free look period that begins as soon as the policy is first delivered to the purchaser. After that, he/she may be entitled to a return of "unearned" premium. "Unearned premium" is payment made in advance for a period of coverage after the date on which a cancellation request has been submitted. Note that the insurance company is not obligated to return past premiums - outside of these timeframes.

Q. Should I switch from one policy to another policy?

A. Before switching, consider whether the switch is beneficial. The new policy should improve the coverage. Also, consumers should consider how long they have had the old policy; how much are the premiums at their new age; can they afford the new premium; and will they pass underwriting for the new policy? Do not cancel any policy until a new policy is in place.

Module 7 Test

1. Which of the following correctly describes the conditions under which an insurance company can raise your premium rates after you have purchased coverage?

    a. When you get older, develop a high risk health condition or use lots of benefits.
    b. When you have a life status change (e.g., divorce, retire, etc.)
    c. When the insurer's administrative expenses increase or when they want to increase their profit margin.
    d. When the insurer can justify that the experience of an entire class of covered persons with similar coverage, of the same age, is different than what was originally predicted in the rates the insurer filed with the Department of Insurance.

2. Which of the following are a key component of the NAIC's Rate Stability Guidelines?

    a. Rates must be sufficient to be adequate even under "moderately adverse" circumstances.
    b. Rates must be guaranteed never to increase.
    c. Rates must be guaranteed never to increase beyond a certain amount specified when you buy the policy.
    d. If there is a rate increase, the consumer is guaranteed a return of premium equal to at least 30 times their daily benefit amount.

3. What options does a consumer have in the event of a rate increase?

    a. There really isn't anything they can do except pay the increase or drop their coverage.
    b. They can usually accept the increase or decrease coverage to an amount that would maintain their prior premium.
    c. They can complain to the Department of Insurance and get the rate increase overturned or waived if they can show just cause.
    d. None of the above.

4. Which of the following provisions has the largest impact on the cost of coverage?

    a. Elimination period
    b. Premium waiver
    c. Home care benefit amount
    d. Inflation protection features

5. Which of the following best describes a 20-pay limited pay policy?

    a. After you have made 20 premium payments, your policy is paid in full.
    b. After you have paid premiums for 20 years, your policy is paid in full.
    c. Once you have paid a total amount of premiums equal to 20 times your initial premium payment, no further payments are required.
    d. None of the above.

6. Most long-term care policies give discounts for certain types of individuals. Which of the characteristics from the list below does NOT qualify someone for a premium discount on long-term care insurance?

    a. Being married
    b. Being in excellent health
    c. Being male
    d. Being a member of a group sponsoring a policy

7. Although underwriting practices vary across insurers, which of the following is NOT generally a condition to decline someone applying for long-term care insurance?

    a. Need help with activities of daily living.
    b. Have mild arthritis, hypertension and a variety of other minor medical conditions.
    c. Recent history of stroke or multiple strokes.
    d. Chronic degenerative condition like Parkinson's disease or Lou Gehrig disease.

8. Which of the following is typically not used in evaluating your health when you apply for long-term care coverage?

    a. In-person assessment interview
    b. Telephone assessment interview
    c. Application
    d. Medical records (attending physician statement)
    e. Medical exam including blood and urine samples

9. In general, when does a long-term care policy pay benefits?

    a. When your doctor determines that you need care.
    b. When your family can no longer care for you on their own.
    c. When you are about to be discharged from the hospital but still need follow-up care.
    d. When you need help from another person with 2 or more Activities of Daily Living (ADLs) or when you have a cognitive impairment such as Alzheimer's disease.

10. Which of the following is not a typical policy exclusion for long-term care insurance?

    a. Care outside the United States
    b. Care in a nursing home with less than 25 residents
    c. Care provided by family or for which no expense is made
    d. Care required due to war, felony or riot

11. Which of the following statements is TRUE about pre-existing condition exclusions in long-term care policies?

    a. Most policies today exclude benefits for any condition emerging during the first 6 months of your coverage, if you had that condition previously.
    b. Most policies today exclude benefits for any condition that you had prior to applying for coverage.
    c. Most policies today have reduced the pre-existing condition exclusion to only 3 months, not 6.

d. A policy with a pre-existing condition exclusion must start paying in the seventh month.

12. When do consumers typically receive the Outline of Coverage?

    a. Before the agent can accept their application.
    b. After they have applied and while they are awaiting a decision from the insurer.
    c. Once they are approved for coverage.
    d. Only when they request it.

13. What steps should a smart shopper be sure to include as they consider long-term care insurance?

    a. Carefully read the outline of coverage and understand what is and is not covered. Consider and compare coverage from more than one company.
    b. Don't buy from any company that does not have reinsurance.
    c. Don't buy from any company that has been in the business for less than 10 years.
    d. Don't buy from any company that will take more than 20 days to issue coverage.

14. Which of the following eligibility statements is not true of a non-tax qualified policy?

    a. 2 of 6 ADL's
    b. Medical Necessity
    c. Plan of Care
    d. Cognitive Impairment

15. Which of the following is used to determine the cost of a LTC policy?

    a. Level of coverage
    b. Age
    c. Rider(s)
    d. All of the above

Module 7 Test Answers

1. Which of the following correctly describes the conditions under which an insurance company can raise your premium rates after you have purchased coverage?

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    d. None of the above.

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    b. Most policies today exclude benefits for any condition that you had prior to applying for coverage.
    c. Most policies today have reduced the pre-existing condition exclusion to only 3 months, not 6.

d. Most policies sold today do not have any pre-existing condition exclusions.

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    c. Once they are approved for coverage.
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