

# California

## 8-Hour Long-Term Care

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# 8-Hour Long-Term Care

## I. Introduction and Overview

### A. Introduction and Topic Objectives

This section develops the various topics associated with the idea of long-term care and explains relevant services and facilities. It also examines the methods used to finance long-term care. The California Department of Insurance does consider each of the topics in this book to be important to insurance professionals and consumers.

### INTRODUCTION TO LONG-TERM CARE (THE LONG-TERM CARE CRISIS)

With the aid of technology and today's advanced healthcare systems, more people are living to age 80, 90 or beyond. This reflects the truth behind the marketing phrase "60 is the new 40". Now, with on-going scientific programs beginning to offer hope of truly understanding the genetics of aging, we may soon see additional increases in life expectancy. Longer life expectancy increases a person's need to plan for long-term care.

What is long-term care? Essentially, it is the inability to care for oneself due to a chronic (long-term) medical condition. Every day more than 5,000 people in this country turn 65. More than 2.5 million are 85 or older. And the likelihood of chronic illness increases with age. The chance of a person currently age 65 being confined to a nursing home at some time in the future is now one in three. According to the U.S. Census Bureau, the over-85 population is the fastest growing segment of the U.S. population, and one out of four people in that age group today lives in a nursing home. Approximately 75 percent of nursing home residents are women.

The programs that many believe cover chronic long-term care events are not necessarily designed to do so. Medicare and Medicare Supplements primarily pay for the costs associated with acute (as opposed to chronic) medical conditions. And, while Medi-Cal (Medicaid) does provide long-term care benefits for many senior citizens, they must first exhaust most of their income and assets to qualify. It is no secret that many seniors are paying a growing proportion of their income in out-of-pocket costs for health care and long-term care services at home due to limited or no insurance coverage. Every day people move into Medi-Cal/Medicaid facilities because they have run out of money from paying these out-of-pocket expenses for home health care or assisted living facility care.

The long-term care problem is made even more complex by the ever-rising cost of services. The Genworth Cost of Care study for 2017 noted that the semi-private nursing facility cost of long-term care in the U.S. is \$235 per day or \$85,775 per year and the median cost for "hands-off" homemaker services is \$131 per day. Are Americans planning for the costs associated with long-term care? Surveys and information gleaned from focus groups discovered the following:

- *Uninsured medical expenses (including long-term care) are the top financial worry among men and women age 55 and older.*
- *People are over five times more worried about being a burden on their family than dying.*

- *Almost two-thirds of people will actually require some long-term care, such as home care, assisted living or nursing home care after they reach age 65, but only 35 percent of people believe they will need such care.*
- *People greatly underestimate the financial, social and lifestyle impact of caregiving responsibilities.*
- *When someone needs long-term care, a wide circle of primary caregivers, secondary caregivers, other family, friends and community members often provide the care and are impacted by the responsibilities.*

The answer is that consumers are concerned about long-term care issues and are looking for credible guidance from insurance agents, financial advisors and other sources.

Long-Term Care Insurance (LTCi) is a category of coverage designed to address these growing problems. Obviously, the ideal time to purchase long-term care insurance would be the day before you need it, but as we know, life doesn't work that way. A 2012 study by the Life Insurance Marketing Research Association (LIMRA) indicated that the number one reason people purchase long-term care insurance is for asset and income protection in retirement. Policyholders also obtain peace of mind, secure their independence and preserve their assets by having coverage.

The concepts of long-term care and long-term care insurance are presented in this outline in basic terms as we unfold a story that is important to consumers, insurance agents and financial advisors as well as employers. The reality is that long-term care has become one of the greatest health-care issues for older persons and their families and one of the most common catastrophic health-care expenses.

## **Defining Long-Term Care**

The California Insurance Code sees long-term care like this; Long-Term care can be defined as diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, which are provided in a setting other than an acute care unit of a hospital. This would include institutional care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility, or personal care home. Home care would include home health care, personal care, homemaker services, hospice, or respite care. Community-based care includes adult day care, hospice, or respite care. (Sec. 10231.2 of the California Insurance Code (CIC))

**Clinically-** Long-term care is basically custodial care. It is important for people to realize that purely custodial care is the type of care most persons in nursing homes require. The only nursing home care that Medicare covers is skilled nursing care or skilled rehabilitation care provided in a certified skilled nursing facility.

**Custodial vs. Acute Care-** Treatment and care for people with chronic conditions require a host of non-medical services, from installing bathtub railings to finding supportive housing. The best ways to provide these services often are not by medical specialists or in medical institutions. In fact, the services that keeps people with chronic conditions independent for as long as possible are frequently those that emphasize assistance and caring, not curing.

**Acute care on the other hand**, is active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.

Examples include setting broken limbs, receiving stitches for lacerations, and sundry emergency room visits. In medical terms, care for acute health conditions is the opposite from chronic care, or longer term care.

**Define Long Term-** Long-term care policies intended to qualify for tax benefits use this criterion; a health care practitioner must certify that the insured will need assistance with activities of daily living (ADLs) for at least a period of 90 days. **ADLs include eating, dressing, toileting, bathing, continence, and transferring (getting from one place or position to another).**

Some non-tax-qualified policies may provide benefits for serious illnesses of less than 90 days. The phrase "long-term" is not differentiated from "short-term" on a time line somewhere. Only for tax purposes is there an arbitrary cut-off point. A look at another vocation can illustrate the differences. In accounting terminology, the difference between "short-term" and "long-term" investments lies in the nature and purpose of the investment. Investments which are readily marketable and which can be sold without disrupting corporate policies or impairing the operating efficiency of the business should be classified as current assets. Investments that are made for the purpose of fostering operational relationships and which do not meet the test of ready marketability are long-term in nature.

## **B. Risk Factors Associated With Long-Term Care**

This book limits its discussion on the matter to the long-term care needs of senior citizens. Because of the diverse perceptions that can be caused by the idea of "long-term care", the State of California, along with many other states and the federal government, have codified the concept of long-term care in order to standardize terminology, facilitate comparisons, and promote availability of products designed to ease the financial hardships brought on by the need for long-term care among today's aging population in California.

According to the U.S. Dept. of Health and Human Services, about 60 percent of individuals over age 65 will require at least some type of long-term care services during their lifetime. Over 40 percent will need care in a nursing home for some period of time. Factors that increase your risk of needing long-term care are:

- Gender - Women are at a higher risk than men, primarily because they tend to live longer.
- Age - The risk generally increases as you get older.
- Marital Status/Domestic Partner Status - Single people are more likely to need care from a paid provider.
- Availability of Family Caregivers - Family caregiving can be substantial. Demands of the situation place caregivers at high risk for injury and adverse events. Also, family caregivers are unpaid providers who needing skills to protect the care recipient from harm.
- Medical History - Poor diet and sedentary habits can increase risk. Family history of health issues can also be a precursor of problems.
- Financial Factors - The financial circumstances of the elderly are highly diverse, although elderly persons at the highest risk of needing long-term care are more likely to be poor or near-poor.



## **C. The LTC Services and Facilities That Provide Care**

### **Long-Term Care Services**

Many entities and resources have the potential to help with care. Information is key in utilizing long-term care services in an efficient and economical manner.

#### **Home Health Care**

The services and a brief description of each are provided. Naturally, services above this level can be included in a long-term care policy. Section 10232.9 of the California Insurance Code (CIC) enumerates the following services. Long-term care policies that offer this type coverage must provide at least the following:

- Home health care- skilled nursing care or similar professional services in the residence
- Adult day care- involves care on a less than round-the-clock basis. It is accomplished in a licensed facility, not the home, and can be medical or non-medical in nature, such as help with ADLs
- Personal care- Either a skilled or nonskilled person who helps with the activities of daily living. Examples of this include fixing meals, housekeeping, laundry, and taking medicines. It shall be provided under a plan of care developed under medical supervision.
- Homemaker services- this includes skills necessary for a person to remain in their home, involving a plan of care developed under medical supervision
- Hospice services- Services intended to ease the physical and mental distress of terminally ill patients. These services are not paid for by Medicare. They are administered by skilled or unskilled personnel under an approved medical plan
- Respite care- This type care is designed to relieve a principal caregiver for a short period of time. It can be provided at home, in a community-based program or an institution. "Short term" has to be defined so as not to be misconstrued. This type coverage is a separate benefit with unique benefits and conditions.

#### **Public Programs**

It is important to understand the differences among the public programs that offer long-term care services. Each program has its own rules for what services it offers and eligibility requirements. Many public programs determine eligibility for services according to a person's need for help with activities of daily living (ADLs); more on that later.

#### **Multipurpose Senior Service Program (MSSP) -**

Local Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

Clients eligible for the program must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement.

### **In-Home Supportive Services (IHSS) -**

The IHSS Program will help pay for services provided to someone so that he or she can remain safely in their own home. To be eligible, a person must be over 65 years of age, or disabled, or blind. Disabled children are also potentially eligible for IHSS. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.

The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

### **Program of All-Inclusive Care for the Elderly (PACE) -**

The PACE model of care provides a comprehensive medical/social service delivery system using an interdisciplinary team approach in a PACE Center that provides and coordinates all needed preventive, primary, acute and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment

## **Facilities that Provide Care**

### **Formal Care**

#### **Nursing homes-**

These are what generally come to mind when thinking of long-term care for the elderly. Residents in these facilities often cannot walk and generally need help in performing at least one activity of daily living. These activities include eating, dressing, toileting, bathing, continence, and transferring (getting from one place or position to another—more on that later). People in this situation may also have substantial memory loss. At a nursing home, the staff consists of registered nurses and certified nursing assistants. Nursing facilities must also have physicians readily available. In some nursing homes there are facilities provided strictly for the care of people with psychiatric problems. Others may address the needs of people with some form of dementia, perhaps an Alzheimer's disease wing. This is one of the things over which an individual has no control. Alzheimer's and similar diseases that affect the functioning of the brain and nervous system often lead to the need for extended long-term care. Over half of nursing home residents experience a cognitive impairment like Alzheimer's disease. All nursing homes in California must be licensed by and meet the standards of the California Department of Public Health (DPH).

<http://www.cdph.ca.gov/PROGRAMS/LNC/Pages/LnCAboutUs.aspx>

#### **Continuing Care Retirement Communities**

Many senior citizens opt to move to continuing care retirement communities (CCRC's) such as senior apartments offering independent living in a large building where meals and weekly housekeeping are provided. Continuing care retirement communities can provide all levels of care and allow people to stay in the same facility throughout the

senior years. There are large facilities offering assisted living services. This is licensed care. These services are offered under various cost structures, often on a per visit basis. An aide can come in to help with medications, dressing, etc. but they are not available for an extended period of time. Such living conditions are for fairly independent residents. An emergency call system is in place but is not intended for repeated use. People who cannot walk, dress, or generally get about without assistance need a caregiver within closer range. A board-and-care home or private caregiver would better suit them.

### **Residential Care Facilities for the Elderly (RCFE's)**

A "Residential care facility" means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code (Sec. 10232.92(a) of the CIC). Portions of large residential facilities, CCRC's, often have an RCFE license. This assisted living option is designed for the more mentally alert resident who needs occasional assistance. The residents live in their own unit and have scheduled appointments for assistance with bathing, dressing or other ADL's. There are other RCFE facilities that are licensed to provide custodial care. All RCFE's are considered board-and-care facilities but when thinking of board-and-care homes, people commonly associate the term with smaller, custodial care facilities. See IV H for California Department of Social Services (CDSS) Community Care Licensing Division (CCLD) info on RCFEs.

Board-and-care homes offer assistance with ADL's as well as housekeeping, laundry, medication and the like. Charges are generally all-inclusive, not the per-visit type associated with independent living facilities. The care ratio runs about three residents to one caregiver, so more individual attention can be given than in a large retirement center. The RCFE's licensed to operate by the California Department of Social Services, Community Care Licensing, must also meet local regulations relating to fire and safety codes. Operating records of such homes are public record. As such, they are available from the proprietor or Community Care Licensing. These are not medical facilities and are not licensed as such. Medi Cal does not pay for care in these types of homes, but some homes may accept Supplemental Security Income as payment.

The reader will note that the terms 'Board and Care' and 'Assisted Living' have no legal standing in California law. References to the terms are always directed back to RCFE.

### **Adult Day Care Setting**

This type of care is outside the home and on a daily basis, as the name implies. These programs offer partial care programs. A good example of their use would be an older couple where the well spouse is the caregiver for the needy spouse. Such an arrangement allows the care giving spouse some time away from what could otherwise be a 24-hour job of caring for the ailing family member. The same logic holds if family members need to work outside the home but want to keep the senior adult in the home. Utilization of these centers can forestall institutionalization of the loved one who has physical or mental functional impairments. There are two types of adult day care services;

- Social model- These centers offer supervised social and educational activities, including exercise, special events, nutrition guidance, family counseling and arts. The primary focus is recreation and social stimulation. Centers like this are for adults who need a protected environment and trained staff.

- Health care models- Many of the social model services are offered, along with additional comprehensive medical services, and rehabilitation. Also offered are physical, occupational and other special therapies. This type may also offer care for people with special needs.

### **Senior Community Centers**

These facilities should not be confused with adult day care centers. Senior community centers have programs for active seniors, providing a social outlet for seniors not needing a protected environment or trained staff.

## **Alternative Living Settings/Arrangements**

### **Retirement Home Living Arrangement**

Such residential care facilities for the elderly provide assisted living arrangements. Residents are provided with a room, meals and activities. It is usually required that residents can act independently and be able to perform substantially all of the activities of daily living. Such facilities are not required to have doctors or nurses on staff. These types of facilities are licensed and inspected by the California Department of Social Services.

### **Life Care Communities**

These operate with life care contracts, a combination of health care housing and insurance for seniors. The insured signs a contract, which remains in effect as long as that person lives. Such homes require an entrance fee and regular monthly charges. Additional charges may be required for higher levels of service. Various levels of long-term care are offered along with nursing home-type care. The senior may start out with an independent living arrangement, move to an intermediate care facility, and then the facility's skilled nursing facility.

### **Fraternal, Religious and Other Organizations**

Some organizations provide, sponsor, or give a stamp of approval to retirement living arrangements. Discretionary groups are groups that do not fit into the category of trade or professional groups. A large museum patrons group, a religious organization, or an environmental group might fit in this category. Many church-published magazines have advertisements for senior living arrangements. A check of the Internet shows the United Methodists, Presbyterians, Lutherans, as well as Masonic Lodges support retirement facilities for their members. The not-for-profit nature of these facilities requires two things; that they limit eligibility to the facility to members of the organization, and that they solicit donations for any operational funding shortfall.

### **Family Care**

Family caregivers provide a wide variety of services to care recipients: administering medications and physical therapy, assisting with daily tasks, meeting with healthcare providers, coordinating treatment regimens and schedules, helping with financial and administrative aspects of medical care, health insurance and more. They can also provide emotional support for coping with disease.

A survey on family caregiving found most family caregivers feel more positive about their experiences than they did just before they took on the responsibility, with significant differences in expectation prior to becoming a caregiver and the actual experience. Among unpaid family members safety is a number one concern, especially

in care situations involving someone with a cognitive limitation. Four overlapping safety concerns usually top the list of caregiver worries: People with cognitive issues getting lost, responding to emergency situations, injuries and falls, medication errors

The American Red Cross has a Family Caregiving Program and a family caregiving reference guide to assist caregivers. The program has been designed to:

- Teach skills for caring for the elderly, chronically ill and disabled at home;
- Help organizations in the communities served by the American Red Cross provide services that benefit the growing senior population
- Prepare families to take on the responsibility and challenges of caring for a loved one at home.

The program consists of individual topic-based modules for caregivers. They can be taken separately or in combination. Topics include:

- Home Safety
- General Caregiving Skills
- Positioning and Helping Your Loved One Move
- Assisting with Personal Care
- Healthy Eating
- Caring for the Caregiver
- Legal and Financial Issues
- Caring for a Loved One with Alzheimer's Disease or Dementia

Interested parties can contact their local Red Cross or visit this webpage-

<http://www.redcross.org/portal/site/en/menuitem.d229a5f06620c6052b1ecfbf43181aa0/?vgnextoid=58d2914124dbe110VgnVCM10000089f0870aRCRD&vgnnextchannel=bf970c45f663b110VgnVCM10000089f0870aRCRD>

Alternatively, the Family Caregiver Alliance has a website with information concerning the role of friends and family in the long-term care process. The organization is headquartered in California and much of the information is specific to California.

The webpage is-

<http://www.caregiver.org/caregiver/jsp/home.jsp>

## **D. Locating Information on Services and Facilities that Provide Long-Term Care**

Services range from skilled services by highly skilled personnel like physical therapists, to a lower level of care delivered by unskilled personnel. Long-term care is also provided by; home care agencies, senior centers, adult day care centers, traditional nursing homes, and continuing care retirement centers. County departments of health oversee nursing homes, while county departments of social services have jurisdiction over the in-home social services programs, and the city and county area agencies on aging coordinate other long-term care services. In addition, private, for-profit home-care programs proliferate in many of the more affluent areas.

## **Where to Obtain Information on Long-Term Care Services and Facilities**

Long-term care services and facilities can be located through the network of Information and Assistance (I & A) programs throughout California. Such programs are funded through California's Area Agencies on Aging (AAA's). The AAA's are responsible for the planning and delivery of services for older persons and people with disabilities. Area

programs are designed to fit the needs of older people in each specific region. Information/location of AAA's can be found online at the California Dept. of Aging website;

[https://www.aging.ca.gov/ProgramsProviders/AAA/AAA\\_Listing.asp](https://www.aging.ca.gov/ProgramsProviders/AAA/AAA_Listing.asp)

Through the I & A program, anyone can find out about the location of senior centers, senior nutrition sites, adult social day care and adult day health care centers, Alzheimer's resource centers, "Meals on Wheels" programs, transportation, care management programs, home health agencies, hospice programs, legal services and health insurance counseling. Direct specific questions about care or facilities to the California Department of Social Services or the Department of Health Care Services-

California Dept of Social Services  
744 P St  
Sacramento, CA 95814- 6401  
Telephone- (916) 945-6951  
<http://www.cdss.ca.gov/cdssweb/default.htm>

California Dept of Health Care Services  
Long-Term Care Division  
PO Box 997413 MS 0018  
Sacramento, CA 95899-7413  
Telephone- (916) 552-9105  
<http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx>

For taxpayer-funded health insurance counseling, prospective insurance purchasers should call their local Health Insurance Counseling and Advocacy Program (HICAP). HICAP contacts are also listed in the front of the Yellow Pages phone directory under Senior Services, toll-free at 1-800-434-0222, or online at;  
<http://www.cahealthadvocates.org/HICAP/>

## **How Services are Provided and Funded**

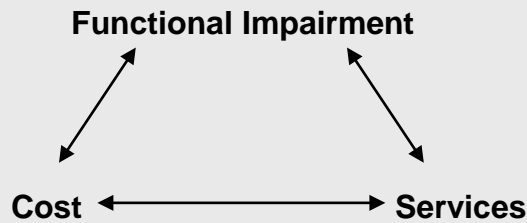
Long-term care includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living or in nursing homes; the particulars are discussed throughout this book. While there are a variety of ways to pay for long-term care, it is important for individuals to think ahead about how they will fund the care received. Generally, Medicare doesn't pay for long-term care. Other sources of payment include personal savings, long-term care insurance, life settlement, viatical settlement, accelerated death benefit, reverse mortgage, veterans' benefits, and Medicaid. These options are discussed in another part of the book.

## **E. The Availability of LTC Services and Facilities**

People need long-term care if they are unable to take care of themselves because of a prolonged (chronic) illness or disability. Where does one go to find such care? Do you find it in the yellow pages? The Internet? At church? Does the government help? When Uncle Carlos got to where he couldn't get around much anymore, Cousins Ray and Sandy seemed to deal with the situation pretty well. Do they have insight regarding the subject?

Where does one go for services? The answer is; to all of these resources. Information is the key to utilizing long-term care services in an efficient and economical manner. With long-term care, the critical thing to realize is the interrelationship between cost, services, and functional impairment.

That is, the less proficient an individual is at performing the six (or seven) activities of daily living (ADL's), the more intensive the services will be required. Remember that depending on how defined, ADL's include eating, dressing, bathing, toileting, ambulating, transferring, and continence. We will see in other sections of the text that what is included as an ADL is important.



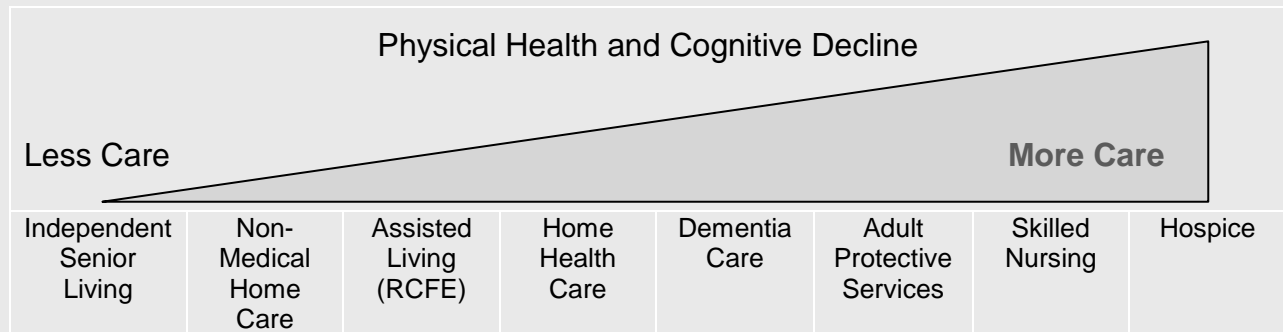
### **The Long-Term Care Continuum**

Long-term care services in California include an array of categorical programs offering medical, social, and other support services that are funded and administered by a variety of federal, state, and local agencies as well as through private sources.

Implementation of an effective program will help promote economic efficiency so that duplicative and confusing eligibility criteria, assessments, and service limitations will not inhibit consumer satisfaction, impede improvements in consumer health status, and result in the ineffective use of resources. It is in the interest of those in need of long-term care that a system exists that provides dignity and maximum independence for seniors, creates home and community-based alternatives to unnecessary out-of-home placement, and is cost effective. A long-term care continuum should include the following goals;

- Provide a continuum of social and health services that foster independence and self-reliance, maintain individual dignity, and allow those in need of long-term care services to remain an integral part of their family and community life.
- If out-of-home placement is necessary, it should be at the appropriate level of care, and prevent unnecessary utilization of acute care hospitals.
- When family caregivers are involved in the long-term care of an individual, to support caregiving arrangements that maximize the family's ongoing relationship with, and care for, that person.
- Deliver long-term care services in the least restrictive environment appropriate for the individual.

The continuum of care includes all levels of health care and personal care service available. It is normally defined as all levels of housing, supportive and health care services available to a person in a given locality. Long-term care continuum is often used to refer to the range of private and public providers of care to the incapacitated population. At one end of the continuum are providers of service to a largely able-bodied, cognitively-capable, and independent population. Independent senior living residences with occasional congregate meals and activities are examples of this level of long-term care. The other end of the continuum is hospice, providing care to persons at the end of life. A person can enter the long-term care continuum at any point, stay at any level for as long as needed, leave the continuum, or jump forward or backward, depending on need.



Many times the striving for optimum conditions results in higher cost. For example, the average costs associated with impairment in one kind of ADL may differ from the average costs associated with impairments in other types. The nursing home residents with impairments in "late-loss" ADL's such as bed mobility or eating were associated with higher average nursing costs than nursing home residents with impairments in dressing or grooming.<sup>1</sup>

### **Chronic Conditions, Delivery Care and Services Provided**

Long-term care is the kind of assistance a person needs when assistance is needed to help with personal care. A disabling or long-term (chronic) medical condition is what usually triggers the need for this type of assistance. Long-term care services can include in-home care, as well as nursing home or community-based care. The need for such services can happen to anybody. An accident or unexpected, severe illness can create the need for long-term care. So can the slow, steady onset of chronic diseases like arthritis, Alzheimer's disease or Parkinson's disease. Advancing age or feebleness can also contribute to the need for long-term care.

Coordinating the services and matching the unique needs of those requiring long-term care is, at best, difficult. Only recently did the state impose operations standards for board and care facilities that provide housing for individuals who might otherwise be institutionalized. An array of unconnected services heightens the critical importance of effective case management, information and referral services, and written understanding among state, county, and city agencies. In response to that need, Los Angeles County, for instance, has promoted cooperation across the city, county, and private sectors through long-term care task forces. Major expansions of long-term care services will impel fundamental reforms in service delivery and a major restructuring of existing programs. Like reforms in financing, those in service delivery are likely to be difficult. Legislation in the early 1980's proposing the coordination of services through a state long-term care corporation or through area agencies on aging generated significant and intense interagency disputes. Concurrent issues that will affect local service delivery include the availability and specialized training of health and long-term care personnel. In 2000, approximately 50% more physicians, nurses, occupational and physical therapists, geriatric social workers, case managers, gerontologists, and mental-health workers were needed than were available in 1990 in order to fully staff all forms

<sup>1</sup> Williams, B., Fries, B., et al., "Activities of Daily Living and Costs in Nursing Homes," *Health Care Financing Review*, Vol. 15, No. 5, Summer, 1994, pp. 117-135.



of health and long-term care services to the elderly.<sup>2</sup> While geriatricians are in short supply, the recent granting of board certification and the presence of selected geriatric medical programs at the state's medical schools may alleviate the problem.

## **II. Potential Resources for Paying for Long-Term Care Expenses**

### **A. Financing/Paying for Long-Term Care**

Preparing for the possible costs of future impairment and long-term care is a task that everyone faces as they age. A person preparing for possible future long-term care needs has several options from which to choose. An individual must set aside personal savings and assets and then supplement those personal resources with other programs. This section summarizes the current state of financing for long-term care, identifies some of the issues affecting it both now and in the future, and considers alternatives that address the mix of private and governmental sources of financing for LTC costs.

### **Funding Mechanisms for Long-Term Care**

#### **Savings**

Savings- It is defined as income not spent. At the end of any period, saving is equal to income in that period minus consumption. It is negative if expenditures exceed income. In an economic sense, saving is a passive concept and does not imply any decision about the form savings may take, such as a savings account, purchasing annuities, buying stocks or bonds, etc. Savings is encouraged in a market economy, forced in a command economy. However it comes about, the image of an older couple, relaxed, trim, and fit with money in the bank carefully husbanded from years of work is a strong and powerful image. Advertisers often play on this image. It looms large in the middle-class psyche.

The average savings rate, which plummets to basically zero in prosperous times, will rebound as people stress about their financial futures. It's pretty simple - when people are feeling good about their circumstances, they spend more. When people are worried about their futures, they save more. When the unemployment numbers stay high over an extended period, then it is easy to predict that the average personal savings rate will respond upward.

Private Investment- In common usage, "investment" is the expenditure on acquisition of financial or real assets. To the economist this is not investment, but the shifting of savings from one form (cash) to another. There are many types of private investment plans available, from savings and loan to the stock market. The fact that so many options exist may confuse and cow individuals into doing nothing at all with their potential savings. Add to this the scandals surrounding Wall Street, burst-bubble technology stocks, negative publicity about variable annuities, etc... and it's a wonder

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<sup>2</sup> California Employment Development Dept., 1990, *California Projections of Employment by Industry and Occupation: 1987-2000*

there are so many people willing to invest. Many savings vehicles have a minimum amount needed to open or maintain an account. This is viewed by some as a disincentive to save, especially for those on a tight budget.

As a reference point, the minimum wage rate in 2018 in California was \$11.00 per hour or \$22,880 for the 2080 hours in a typical work year. That minimum wage is 188% above the poverty level for the 1 person family unit and about 91% of the poverty level for a family of four. Annual wages of \$45,760; \$68,640; \$114,400; \$228,800 and \$2.288M correspond to 2, 3, 5, 10 and 100 times minimum wage respectively.

## **Home Equity**

When considering ways of meeting growing costs for long-term care services, there has been growing interest in the possibility that seniors without other financial resources could draw on their home equity to help pay for their own care. One mechanism for doing so is a "reverse mortgage," under which a lender advances money in return for a future claim on the home. This would allow people with functional disabilities to use proceeds from a reverse mortgage to meet costs for personal care, home modifications, or other assistance needed to remain in the home. Those not yet in need of assistance could use the funds to pay premiums for a private long-term care insurance policy.

## **Residential Reverse Mortgages Insured by HUD**

Here is general information on reverse mortgages (includes information on a current (and ongoing) demonstration project by U. S. Department of Housing and Urban Development (HUD)).

### Facts for Consumers from the Federal Trade Commission-

If you're 62 or older – and looking for money to finance a home improvement, pay off your current mortgage, supplement your retirement income, or pay for healthcare expenses – you may be considering a reverse mortgage. It's a product that allows you to convert part of the equity in your home into cash without having to sell your home or pay additional monthly bills.

The Federal Trade Commission (FTC), the nation's consumer protection agency, wants you to understand how reverse mortgages work, the types of reverse mortgages available, and how to get the best deal.

In a "regular" mortgage, you make monthly payments to the lender. In a "reverse" mortgage, you receive money from the lender, and generally don't have to pay it back for as long as you live in your home. The loan is repaid when you die; sell your home, or when your home is no longer your primary residence. The proceeds of a reverse mortgage generally are tax-free, and many reverse mortgages have no income restrictions.

How Reverse Mortgages Work- A reverse mortgage is a type of home equity loan that allows you to convert some of the equity in your home into cash while you retain home ownership. RMs works much like traditional mortgages, only in reverse. Rather than making a payment to your lender each month, the lender pays you. Unlike conventional home equity loans, most RMs do not require any repayment of principal, interest, or servicing fees for as long as you live in your home. Funds obtained from an RM may be used for any purpose, including meeting housing expenses such as taxes, insurance, fuel, and maintenance costs.

**Requirements and Responsibilities of the Borrower-** To qualify for an RM, you must own your home. The RM funds may be paid to you in a lump sum, in monthly advances, through a line-of-credit, or in a combination of the three, depending on the type of RM and the lender. The amount you are eligible to borrow generally is based on your age, the equity in your home, and the interest rate the lender is charging.

Because you retain title to your home with an RM, you also remain responsible for taxes, repairs, and maintenance. Depending on the plan you select, your RM becomes due with interest either when you permanently move, sell your home, die, or reach the end of the pre-selected loan term. The lender does not take title to your home when you die, but your heirs must pay off the loan. The debt is usually repaid by refinancing the loan into a forward mortgage (if the heirs are eligible) or by using the proceeds from the sale of your home.

### **Types of Reverse Mortgages**

There are three types of reverse mortgages:

- *single-purpose reverse mortgages*, offered by some state and local government agencies and nonprofit organizations
- *federally-insured reverse mortgages*, known as Home Equity Conversion Mortgages (HECMs) and backed by HUD
- *proprietary reverse mortgages*, private loans that are backed by the companies that develop them

Single-purpose reverse mortgages are the least expensive option. They are not available everywhere and can be used for only one purpose, which is specified by the government or nonprofit lender. For example, the lender might say the loan may be used only to pay for home repairs, improvements, or property taxes. Most homeowners with low or moderate income can qualify for these loans.

HECMs and proprietary reverse mortgages may be more expensive than traditional home loans, and the upfront costs can be high. That's important to consider, especially if you plan to stay in your home for just a short time or borrow a small amount. HECM loans are widely available, have no income or medical requirements, and can be used for any purpose.

Before applying for a HECM, you must meet with a counselor from an independent government-approved housing counseling agency. Some lenders offering proprietary reverse mortgages also require counseling. The counselor is required to explain the loan's costs and financial implications, and possible alternatives to a HECM, like government and nonprofit programs or a single-purpose or proprietary reverse mortgage. The counselor also should be able to help you compare the costs of different types of reverse mortgages and tell you how different payment options, fees, and other costs affect the total cost of the loan over time. To find a counselor, visit [www.hud.gov/offices/hsg/sfh/hecm/hecmelist.cfm](http://www.hud.gov/offices/hsg/sfh/hecm/hecmelist.cfm) or call 1-800-569-4287. Most counseling agencies charge around \$125 for their services. The fee can be paid from the loan proceeds, but you cannot be turned away if you can't afford the fee.

How much you can borrow with a HECM or proprietary reverse mortgage depends on several factors, including your age, the type of reverse mortgage you select, the appraised value of your home, and current interest rates. In general, the older you are, the more equity you have in your home, and the less you owe on it, the more money you can get.

The HECM lets you choose among several payment options. You can select:

- a "term" option – fixed monthly cash advances for a specific time.
- a "tenure" option – fixed monthly cash advances for as long as you live in your home.
- a line of credit that lets you draw down the loan proceeds at any time in amounts you choose until you have used up the line of credit.
- a combination of monthly payments and a line of credit.

You can change your payment option any time for about \$20.

HECMs generally provide bigger loan advances at a lower total cost compared with proprietary loans. But if you own a higher-valued home, you may get a bigger loan advance from a proprietary reverse mortgage. So if your home has a higher appraised value and you have a small mortgage, you may qualify for more funds.

### **Loan Features**

Reverse mortgage loan advances are not taxable, and generally don't affect your Social Security or Medicare benefits. You retain the title to your home, and you don't have to make monthly repayments. The loan must be repaid when the last surviving borrower dies, sells the home, or no longer lives in the home as a principal residence.

In the HECM program, a borrower can live in a nursing home or other medical facility for up to 12 consecutive months before the loan must be repaid.

If you're considering a reverse mortgage, be aware that:

- Lenders generally charge an origination fee, a mortgage insurance premium (for federally-insured HECMs), and other closing costs for a reverse mortgage. Lenders also may charge servicing fees during the term of the mortgage. The lender sometimes sets these fees and costs, although origination fees for HECM reverse mortgages currently are dictated by law. Your upfront costs can be lowered if you borrow a smaller amount through a reverse mortgage product called a "HECM Saver."
- The amount you owe on a reverse mortgage grows over time. Interest is charged on the outstanding balance and added to the amount you owe each month. That means your total debt increases as the loan funds are advanced to you and interest on the loan accrues.
- Although some reverse mortgages have fixed rates, most have variable rates that are tied to a financial index: they are likely to change with market conditions.
- Reverse mortgages can use up all or some of the equity in your home, and leave fewer assets for you and your heirs. Most reverse mortgages have a "nonrecourse" clause, which prevents you or your estate from owing more than the value of your home when the loan becomes due and the home is sold. However, if you or your heirs want to retain ownership of the home, you usually must repay the loan in full – even if the loan balance is greater than the value of the home.
- Because you retain title to your home, you are responsible for property taxes, insurance, utilities, fuel, maintenance, and other expenses. If you don't pay property taxes, carry homeowner's insurance, or maintain the condition of your home, your loan may become due and payable.
- Interest on reverse mortgages is not deductible on income tax returns until the loan is paid off in part or whole.

### **Getting a Good Deal**

If you're considering a reverse mortgage, shop around. Compare your options and the terms various lenders offer. Learn as much as you can about reverse mortgages before

you talk to a counselor or lender. That can help inform the questions you ask that could lead to a better deal.

- If you want to make a home repair or improvement – or you need help paying your property taxes – find out if you qualify for any low-cost single-purpose loans in your area. Area Agencies on Aging (AAAs) generally know about these programs. To find the nearest agency, visit [www.eldercare.gov](http://www.eldercare.gov) or call 1-800-677-1116. Ask about "loan or grant programs for home repairs or improvements," or "property tax deferral" or "property tax postponement" programs, and how to apply.
- All HECM lenders must follow HUD rules. And while the mortgage insurance premium is the same from lender to lender, most loan costs, including the origination fee, interest rate, closing costs, and servicing fees vary among lenders.
- If you live in a higher-valued home, you may be able to borrow more with a proprietary reverse mortgage, but the more you borrow the higher your costs. The best way to see key differences between a HECM and a proprietary loan is to do a side-by-side comparison of costs and benefits. Many HECM counselors and lenders can give you this important information.
- No matter what type of reverse mortgage you're considering, understand all the conditions that could make the loan due and payable. Ask a counselor or lender to explain the Total Annual Loan Cost (TALC) rates: they show the projected annual average cost of a reverse mortgage, including all the itemized costs.

### **Be Wary of Sales Pitches**

Some sellers may offer you goods or services, like home improvement services, and then suggest that a reverse mortgage would be an easy way to pay for them. If you decide you need what's being offered, shop around before deciding on any particular seller. Keep in mind that the total cost of the product or service is the price the seller quotes plus the costs – and fees – tied to getting the reverse mortgage.

Some who offer reverse mortgages may pressure you to buy other financial products, like an annuity or long-term care insurance. Resist that pressure. You don't have to buy any products or services to get a reverse mortgage (except to maintain the adequate homeowners or hazard insurance that HUD and other lenders require). In fact, in some situations, it's illegal to require you to buy other products to get a reverse mortgage.

The bottom line: If you don't understand the cost or features of a reverse mortgage or any other product offered to you (or if there is pressure or urgency to complete the deal) walk away and take your business elsewhere. Consider seeking the advice of a family member, friend, or someone else you trust.

### **Your Right to Cancel**

With most reverse mortgages, you have at least three business days after closing to cancel the deal for any reason, without penalty. To cancel, you must notify the lender in writing. Send your letter by certified mail, and ask for a return receipt. That will allow you to document what the lender received and when. Keep copies of your correspondence and any enclosures. After you cancel, the lender has 20 days to return any money you've paid up to then for the financing.

## **Commercial Reverse Mortgages**

Income-producing property types, such as apartment complexes, office buildings and complexes, ranches, farms, residential or commercial acreage, mobile home parks and RV parks all qualify for reverse mortgage loans. There is no age restriction for commercial property reverse mortgages. What is needed is a viable reason for the use of funds from the commercial reverse loan. Long-term care is a viable reason. A commercial reverse mortgage is given on the basis of property type, need for funding and value of the commercial property involved.

## **Life Settlements**

Life settlements are basically a form of cashing out an insurance policy. It is the sale of an existing life insurance policy by a policyowner to a third party. The owner of a life insurance policy receives more than its cash value and less than its face value. The policyowner receives a discounted sum of cash, usually 55 to 85% of the face value, upon surrender of the life insurance to a third party. Policy assignment is as old as the insurance industry, the contract being considered personal property of the owner.

## **Viatical Settlements**

A viatical settlement is a similar transaction but involves insureds with shorter life expectancies. The viatical settlement industry took its name from the Latin, *viaticum*, a noun that means "provisions for a journey." So says one of the Internet sites touting this product. The transitive verb, "viaticate," is only recently (since 2012) to be found in online dictionaries.

People want to sell policies for several reasons. Viatical settlements seem to be mostly associated with AIDS. They became popular with people stricken with other terminal diseases and, with chronically ill people in need of long-term care. Any such illness is a heavy financial burden. Freeing up cash to help pay bills is one of the benefits of a life settlement. Or, it could be done in order to continue receiving quality health care, to afford the basic comforts of life and meet daily living expenses, to distribute gifts to family members or friends, to make a special trip or pilgrimage, or just to have financial independence.

In order to negotiate a policy, here are some requirements that will probably be considered by the life settlement company;

- ◆The policy must not be contestable by the insurance company; this usually means that the policy must have been in force for at least two years.
- ◆The policy must be issued by a highly rated company ("A" or better, depending on the rating service).
- ◆The named insured must be diagnosed as having a shortened life expectancy
- ◆There is a dollar value band of consideration. Some policies are too small, say below \$10,000, to be worth the trouble to consider. Others may be too large a risk to cover by the companies operating in this fledgling industry.
- ◆All parties with ownership or interest in the policy are required to sign a release of interest in the policy.

The underwriting process for such a transaction involves obtaining and verifying medical and insurance information for review. This can take from two to four weeks. Requests for information are sent out and the primary physician completes a questionnaire. When all documents have been received and all questions answered, the file is reviewed, a

projection of life expectancy made, and all other potential risks associated with the policy are weighed. Then an offer on the policy is made. In many cases, the processing time from receipt of a complete application to the date that funds are received is four to eight weeks. This seems a considerable time span for someone counting months to live. All types of individual policies and many group policies can be reviewed for purchase. Group policies must have an irrevocable beneficiary, absolute assignment, waiver of premium feature, or certain convertibility options. There are other alternatives available to a policyholder with a life threatening illness. The person may be able to borrow against the life insurance policy. If the policy has any cash surrender value, the owner may be able to cash out of his or her policy. A third alternative is the offer of an accelerated benefits option by the insurance company.

Taxation can be an issue. Under current Federal and some state tax laws, the sale of a life insurance policy may be taxable. Persons who are subject to taxation under the California Revenue and Taxation Code should be aware that, generally, section 17131.5 of that Code provides that, for taxable years beginning on or after January 1, 1991, gross income does not include any amount received by a person owning a life insurance policy (whether in a single sum or otherwise) under contract supplemental thereto, if the amounts are paid pursuant to the sale of his or her life insurance policy under California Insurance Code Section 10113.1. That provision of the Insurance Code deals with the sale of a life insurance policy on the life of a person with a life threatening illness. Anyone considering going the life settlement route should consult with a legal or financial professional before doing so to determine what, if any, taxes will be levied.

Life settlements are addressed under the Health Insurance Portability and Accountability Act (HIPAA). This Act states that any portion of the death benefit under a life insurance contract on the life of an insured that is sold or assigned to a life settlement provider shall be treated as an amount paid under the life insurance contract by reason of the death of the insured. A person meets the requirements for sale of the policy if he or she is terminally or chronically ill.

"Terminally ill individual" means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of certification.

"Chronically ill individual" has the meaning given by Section 7702B(c)(2)<sup>3</sup> of the Internal Revenue Code. Summed up, it is the inability to perform two of six activities of daily living (ADLs) or the presence of severe cognitive impairment. This meaning is discussed further in the section of this book titled "Definitions Under IRS Notice 97-31."

The several states have enacted laws to protect life settlers. California has passed legislation allowing licensed insurance agents to act as life settlement brokers. This could raise the possibility of a conflict of interest. An agent may be called upon to help acquire accelerated death benefits on an existing insurance contract. This pays little or no commission. The same agent may also advise the policyholder to look into a life settlement, a sale likely to generate a generous sales commission.

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<sup>3</sup> U.S. Code Title 26, Internal Revenue Code, Subtitle F, Procedure and Administration, Chapter 79, Definitions

## **Insurance Products That Contain Long-Term Care Benefit Options**

Individual life insurance products that have a long-term-care or critical-care component are called "combination products." Life or annuity policies can be sold with long-term care riders. This works like any other type of rider to a policy. An increase in premium accompanies the rider. Examples can be seen in the long-term care insurance consumer rate guide.

### **Stand-Alone Long-Term Care Insurance Products**

A stand alone long-term care policy offers long-term care benefits only. This type insurance is often expensive and the cost of LTC depends on the type of policy purchased (size of benefit, length of benefit period, care options).

The purpose of long-term care insurance is to pay for some of the insured's expenses when assistance is needed with basic activities of living. Because of a chronic illness or disability, such things as bathing, eating, and toileting may require help. Long-term care insurance is any insurance that pays for the following;

- **Care in a facility that is NOT an acute care unit of a hospital-** such as a nursing home, a residential care facility, convalescent facility, extended care facility, custodial care facility, skilled nursing facility or personal care home
- **Home care-** including home health care, personal care, homemaker services, hospice or respite care
- **Community-based care-** such as adult day care or hospice

Premium cost is also based in large part on age at the time of purchase. Unlike life insurance, long-term care does not have an easily quantifiable probability of paying benefits. In order to receive benefits under a long-term care policy an insured must be considered chronically ill and unable to perform certain activities of daily living. The consumer decision-making process is complicated by the options and choices available in the market. Different options make economic sense for some and do not for others. A partnership policy makes little sense for a high-net-worth individual since the Medicaid asset protection likely has no value. Market suppliers care more about getting to the bottom of the emotional motivation for clients in this case to help facilitate rational decision-making. This argument is why insurance products containing long-term care benefit options makes sense for consumers.

### **Policies and Annuities with Long-Term Care Benefits**

The Pension Protection Act of 2006 (PPA) enhanced the status of policies that combine annuities or life insurance with long-term care coverage. When the policyholder needs care, the long-term care benefit payments from the annuity or life policy are received on a tax-free basis.

Policies that combine life or annuity coverage with long-term care features predate the enactment of the PPA. Life insurance policies were combined with a promise to pay part of the death benefit (generally 2% to 4% monthly) if a qualifying event such as disability, critical illness, cancer, terminal or chronic illness occurred. Their sales did not attract much interest. A possible reason for slow sales was doubt about the tax treatment of payments from the policies to pay for long-term care expenses. The LTC portion of combination policies may not have fit the definition of qualified policies, so benefits would have been considered taxable by the IRS.



The 2006 PPA law stated that funds withdrawn from annuities or from life insurance policies to pay for LTC would not be taxable. The law also made clear that annuities and life insurance would retain their tax advantages even when packaged with LTC riders. The change was a simple one; withdrawals taken from the policies to pay for long-term care became tax free beginning in 2010. The change made the tax status of the combination policies clear and should make them more attractive to consumers. It is important to note that the long-term care benefits must be consistent with HIPAA; the benefits must be for tax-qualified long-term care insurance.

### **Product design**

A typical product design for a single premium deferred annuity (SPDA/LTCI) combo product will provide a long-term care benefit that is generally a multiple of the annuity account value. The payout will be delivered over a certain number of months, 24, 36 or 48. Policies will vary by insurance carrier, age and health conditions. As an example assume that the insured wants \$6,000 per month of benefit for 48 months (\$6,000 X's 48 = \$288,000). To get that \$288,000 benefit, the policy holder may have to place \$100,000 into the SPDA combo product. A risk charge will be taken from the accumulation of the product to provide the additional \$188,000 of coverage.

The first money out of the SPDA to pay the long-term care benefit will be the insured's initial premium to the plan. If the policyholder dies before their contribution is exhausted a beneficiary will receive the difference. Once benefits are paid beyond the initial premium the insurance company will continue to pay benefits until they are exhausted. The risk charge for the benefit beyond the premium will generally be between one-half to 1.25 basis points. In other words, if a typical SPDA was paying a return of 5.5%, the combo plan may only pay 4.5%. The long-term care benefit under the program qualifies under IRC section 7702B so the cost of the long-term care benefit will not be a taxable event to the insured. Long-term care benefit payments will reduce the basis of the annuity for income tax purposes. This may create a larger tax burden on heirs of the annuity owner after death.

### **Accelerated Death Benefits, Riders and Annuities**

An accelerated death benefit is a feature of some annuity and life insurance policies or it can be added as a rider. Such benefits cannot be marketed as health, accident or long-term care insurance. Agents cannot unnecessarily replace a long-term care insurance policy with an accelerated death benefit policy and certain notices must be issued when a life or long-term care policy is replaced. Such benefits must also provide that if a health-care practitioner makes a determination (exceptions apply) that an insured does not meet the definition of "chronically ill individual," the insurer must notify the insured that he or she is entitled to a second assessment by a licensed health-care practitioner, upon request, who will personally examine the insured.

### **What an Annuity Does**

The annuity contract which is sold by life insurers, allows the "scientific" liquidation of an estate, accompanied by the promise that the annuitant cannot outlive the stream of income produced by the liquidation. The insurer can make its guarantees based on the basic set of insurance principles; pooling of many similar exposures to loss, premiums paid in advance, and predictability based on the law of large numbers.

An annuity is generally defined as a stream of regular payments. An annuity insurance policy is a contract in which the insurer promises the insured, called the annuitant, a

regular series of payments, called rent. The basic insurance principles that underlie an annuity insurance operation are the same as those that underlie all insurance operations. That is, the insurance company combines many individuals exposed to the same peril. It uses the law of large numbers to predict in advance the payments it must make. Then it charges each insured a fair share of all losses. By charging a premium of all the individuals exposed to the peril, the insurance operation transfers money from all the people exposed to the peril to those who will experience the loss.

Many Americans acquire annuity protection from their employers as a result of participation in a pension plan. When the employer agrees to provide retirement income, the income represents an annuity promise to the retiree. In addition to pension plans, privately purchased annuities may be obtained from life insurers. Annuities have come and gone from the public's investing consciousness. Total annuity sales for 2017 decreased 8 percent to \$203.5 billion compared with 2016, according to the LIMRA Secure Retirement Institute's website.

The "loss" insured against with an annuity is living a long time. This sounds like a loss that most people would not dislike. However, old age without money can be a tragedy. An annuity insurance operation transfers funds from those who die at a relatively early age to those who live to relatively old ages. That is, some annuitants will live to take out much more than they paid in as a premium. Other annuitants will not live long enough to take out as much as they paid in. Every annuitant pays a fair premium to enter the annuity insurance pool. In exchange for the premium, the annuitant obtains the right to receive regular payments from the insurance pool as long as he or she is alive. An insurance company earns interest on all the money in the pool. Therefore, the annuity payments received by an annuitant will come from three sources: (1) liquidation of the original premium payment, or principal, (2) interest earned on the principal, and (3) funds made available by the relatively early death of some annuitants.

It is interesting to note that the mortality table used by annuity insurers to predict the amount of payments they will make is not the same one used for life insurance calculations. People who purchase annuities live longer than do those who do not purchase annuities. While mortality tables used for life insurance calculations end at age 100, the 1983 individual annuity mortality table and Annuity 2000 mortality table continue to age 115. The reason for this is *adverse selection*.

Adverse selection in life insurance means that those people with a greater than average likelihood of premature death try to purchase life insurance at regular rates. Life insurers try to prevent adverse selection by requiring medical examinations in addition to other underwriting precautions. It is more difficult to prevent adverse selection by people purchasing annuities. Theoretically, an insurer could require a medical examination and then reject the "superhealthy" as "poor risks." However, this generally is not a sound approach to take with the public. Therefore, the insurer recognizes that people who purchase annuities are probably in above-average health. This explains why they use a mortality table that reflects this better than average mortality.

### **Other Catastrophic Benefits**

A trend in providing catastrophic benefits features so-called linked-benefit products that join catastrophic long-term care coverage with traditional annuity or life policies. If it is used to pay for long-term care costs, the payout may be exempt from income taxes, creating a tax benefit as well providing insurance. This type policy allows for both

longevity and unexpected chronic conditions. Many consumers are reluctant to buy long-term care insurance because they fear that their investment will be wasted if they do not use it. Some insurance companies have attempted to solve this problem by combining catastrophic benefits with another product. The idea is that policy benefits will always be paid, in one form or another. These products are relatively new and the features are changing as the product evolves. The amount of the catastrophic coverage benefit is often expressed in terms of a percentage of the value of the underlying life or annuity benefit. Given the dual coverage feature and the value of the catastrophic coverage, the linked plans offer a viable option to stand-alone long-term care insurance proposals. Of the population of those who desire long-term care coverage, underwriting will exclude some, and not all who can afford long-term care insurance will want to buy it. Adding a catastrophic benefit to another product could boost purchase of long-term care; knowing they would get linked coverage until they became eligible for Medicare would probably lead some younger people to buy coverage, to reduce their risk of failing underwriting and to obtain lower premiums.

## **Medi-Cal**

Medi-Cal is also discussed in other sections of this book. The reader is directed to Attachment I – Medi-Cal Requirements.

Medicaid was established as Title IX of the 1965 Amendment to the Social Security Act. Medi-Cal is California's adaptation of Medicaid; a health insurance program for certain low-income people. These include: certain low-income families with children; aged, blind, or disabled people on Supplemental Security Income; certain low-income pregnant women and children; and people who have very high medical bills. Medicaid is funded and administered through a state-federal partnership. Although there are broad federal requirements for Medicaid, states have a wide degree of flexibility to design their program. States have authority to establish eligibility standards, determine what benefits and services to cover, and set payment rates. All states, however, must cover these basic services: inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing and home health services, doctor's services, family planning, and periodic health checkups, diagnosis and treatment for children.

Long-term care recipients of Medicaid come almost exclusively from the aged, blind and disabled group of eligible beneficiaries but very few of those are actually receiving SSI (Supplemental Security Income). SSI is a welfare payment for certain disabled or handicapped individuals who are unable to work, have no assets and have no extended family financial support. Certain provisions of the enabling Act, as well as congressional amendments since 1965 have allowed the aged, blind and disabled who don't qualify for SSI to receive Medicaid under an alternate set of eligibility rules.

Medicaid enrollment doubled over the period of 1990 to 2018 from about 25 million U.S. recipients to about 67.2 million in 2018. Over the decade 2000-2010, enrollment growth averaged 2.7 percent.

Nearly two-thirds of Medicaid beneficiaries are enrolled in private managed care plans that contract with states to provide comprehensive services, and others receive their care in the fee-for-service system. Managed care plans are responsible for ensuring access to Medicaid services through their networks of providers and are at financial risk for their costs. In the past, states limited managed care to children and families, but they are increasingly expanding managed care to individuals with complex needs. Close to

half the states now cover long-term services and support through risk-based managed care arrangement. Most states are engaged in a variety of delivery system and payment reforms to control costs and improve quality including implementation of patient-centered medical homes, better integration of physical and behavioral health care, and development of “value-based purchasing” approaches that tie Medicaid provider payment to health outcomes and other performance metrics. Community health centers are a key source of primary care, and safety-net hospitals, including public hospitals and academic medical centers, provide a lot of emergency and inpatient hospital care for Medicaid enrollees.

Medicaid covers a continuum of long-term services and supports ranging from home and community-based services (HCBS) that allow persons to live independently in their own homes or in other community settings to institutional care provided in nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF-IDs). HCBS was 57 percent of total Medicaid LTSS in FY 2016. This percentage has climbed an average of two percentage points per year starting in FY 2013. This is a dramatic shift from 1995 (two decades earlier), when institutional settings accounted for 82 percent of national Medicaid LTSS expenditures.

One major worry for older adults is that costs for long-term care will exhaust their life savings. Some fear that if their assets are depleted by a long-term illness the dignity, security and independence they worked a lifetime to attain will also dissipate. Among the population 65 or older, 55 percent are expected to have total lifetime use of a nursing home of at least one year and 21 percent will have a total lifetime use of nursing home services for five or more years.

While California sets rules for Medi-Cal eligibility, federal guidelines must be followed since the federal government provides over 70 percent of Medi-Cal funding. (California Healthcare Foundation, 'Medi-Cal Facts and Figures,' <http://www.chcf.org>).

The California legislature allocates funds for the remaining portion.

To be eligible for Medicaid, an applicant must fall within a category of persons entitled to participate in the program. Criteria that must be met include:

- being age 65 or older, blind or disabled by Social Security standards or receiving Supplemental Security Income (SSI) or Social Security disability
- a permanent U.S. resident; a California resident; and
- having a Social Security number.

The person must also be admitted to a nursing facility under a doctor's orders and meet medical need criteria for nursing home care. Lastly, the person must meet financial need requirements under the assets and income tests as determined by the California Department of Health and Human Services (DPHS). Any resources owned by the applicant are evaluated for accessibility, value and exclusion status when making Medi-Cal eligibility determinations.

There are several organizations that promote "Medi-Cal Planning," as a means of sheltering assets of an individual going (or expecting to go) into a long-term care facility. An Internet search engine request for "Medi-Cal Planning" brings up several sites devoted to this topic. Without Medi-Cal planning, nursing home expense can deplete an estate very quickly. Families need to decide whether Medi-Cal planning is in their best interest.

## **Agents and consumers must understand there is a difference between Medicare and Medi-Cal.**

**MEDICARE** is a federal health care program funded by federal tax dollars. Because it is related to the Social Security Program, eligibility is based on a person's work history or relationship with another individual with a work history (i.e., spouse or dependent child). Medicare was designed to pay for physician and hospital care for people who are elderly or disabled. As described in "Taking Care of Tomorrow, A Consumer's Guide to Long-Term Care," produced by the California Department of Aging, which must be provided by the agent to every consumer at the time of solicitation;

"Most long-term care delivered in nursing homes is provided to people with chronic, long-term illnesses or disabilities. The care they receive is personal care, sometimes still referred to as custodial care. Medicare does not pay for this kind of care."

Medicare pays only some 14% of all nursing home costs.<sup>4</sup> The "Taking Care of Tomorrow" publication goes on to say;

"To qualify for the limited Medicare nursing home benefit, you must first have spent three full days in a hospital within 30 days of your admission to a nursing home. You must also need skilled nursing care that only a licensed professional can provide, every day of your stay. If you meet these requirements Medicare will only pay the full cost of nursing home care up to the first 20 days of a covered stay. After the first 20 days, if you still require daily skilled care, Medicare will pay part of the nursing home bill. You will have to pay a co-payment for each day of the next 80 days that Medicare continues to pay for your stay. Medicare will not continue to pay after it has paid for your nursing home care for 100 days within a benefit period."

***Will Medicare Pay if I Need Care in My Home?*** "Taking Care of Tomorrow" answers:

"Yes, but only if you meet certain stringent requirements of the Medicare program . . . You must be homebound and require skilled nursing or rehabilitation services at least several times weekly that only a licensed professional can provide. The services you receive must be from a home health care agency that participants in Medicare.

You may also receive some personal care services along with any skilled care you require. However, Medicare does not pay when personal care is all you need, and it does not pay for general household services such as laundry, shopping or other services you receive in your home."

**Medi-Cal** is funded by both federal and state tax dollars and provides health care coverage for millions of eligible beneficiaries. Medi-Cal is designed to provide services for people with low incomes and few assets. The program provides health care services to people on public assistance and to others who cannot afford to pay for their health care. Medi-Cal pays for hospital, medical, prescription drug, and "medically necessary" nursing home care. California does not consider a person's impairment in their ability to perform Activities of Daily Living in determining eligibility for Medi-Cal's nursing home benefit.

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<sup>4</sup> Kaiser Commission on Medicaid and the Uninsured, analysis of 2011, <http://kff.org/other/state-indicator/residents-by-primary-payer-source/>

## ***How Can I Pay For Long-Term Care If My Finances Are Limited?*** "Taking Care of Tomorrow" answers:

"Medi-Cal can pay for hospital and medical care approved by your doctor, prescription drugs if you don't have Medicare, and nursing home care. It can also cover some home care services known as In-Home Supportive Services (IHSS)...

IHSS provides non-medical services to eligible aged, blind, and disabled persons who are unable to remain in their homes safely without this assistance."

### **Medi Cal Home and Facility Care**

SB483 (Kuehl) of the 2008 California Legislative Session incorporated the Department of Health Care Services provision for implementing the Deficit Reduction Act (DRA) changes to the Medicaid rules. The federal legislation gave time to the states to make changes to state laws and SB 483 was needed to make those changes.

### **Income and Asset Limits**

Limits are tied to countable asset levels<sup>5</sup>. Individuals may have up to \$2,000 in assets or \$3,000 in assets as a couple. Some personal assets are not considered when determining Medi-Cal coverage. For example, assets that do not count are:

- Your primary home
- One vehicle
- Household goods and personal belongings
- Life-insurance policy with a face value of \$1,500 per person
- Prepaid burial plan (unlimited if irrevocable or up to \$1,500 if revocable) and burial plot

If the asset requirements are met, income determines the Medi-Cal program for which a person qualifies.

### **Medi-Cal Programs – Income Qualification at a Glance**

#### **Program / Requirements**

#### **Monthly Income**

Supplemental Security Income (SSI)

Single: up to \$866.40/mo.

- 65 or older, blind or disabled

Couple: up to \$1,462.20/mo.

Note: Higher income levels apply for individuals who are blind.

**Aged & Disabled Federal Poverty Level Program**

Single: up to \$1,188/mo.

- 65 or older, blind or disabled

Couple: up to \$1,603/mo

**Medi-Cal with a Share of Cost (SOC)**

Single: over \$1,188/mo.

- 65 or older, blind or disabled

Couple: over \$1,603/mo.

**250% California Working Disabled (CWD)**

- Have work
- Meet Social Security's definition of disability
- Pay small monthly premium

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<sup>5</sup> The data in this section are from: California Department of Health Care Services, *Medi-Cal General Property Limitations*, 2012, [www.dhcs.ca.gov](http://www.dhcs.ca.gov). and California Health Advocates, <http://www.cahealthadvocates.org/low-income/medi-cal.html>

Equity in the exempt homestead is limited to \$750,000. This equity value increases with the Consumer Price Index. In addition, "equity interest" is defined as the lower of the assessed value or the appraised value, minus encumbrances. The home equity limits will not apply if the individual's spouse, minor, blind, or disabled child is living in the home or if denial of eligibility would result in a demonstrated hardship. (Sec. 14006.15(c) Welfare and Institutions Code)

The appraised value of the principal residence will be determined by a qualified real estate appraiser who has been retained by the applicant or beneficiary, less any encumbrances of record. (Sec. 14006.15(a)(2) Welfare and Institutions Code)

### **Hardship Exception**

This exception will apply if denial of eligibility would result in a demonstrated hardship. An undue hardship exists if;

- The deprivation of medical assistance causes the individual's endangerment
- Denial of medical assistance would result in eviction from a nursing home.
- The individual is otherwise eligible for the Medi-Cal
- Denial of medical assistance would cause the individual to be unable to remain at home or in the community and would hasten or cause the individual's entry into a medical or long-term care institution.
- The individual would be deprived of food, clothing, shelter, or other necessities of life.

If none of these exceptions satisfy, then the citizen has a right to a hearing for appeal of the matter. (Sec. 14015.1 and 14015.2 Welfare and Institutions Code)

### **Look-back Period**

In the context of this section it is recognized that assets transferred by the applicant or beneficiary prior to the look-back period established by the department preceding the date of initial application were not transferred to establish eligibility or reduce the share of cost. These assets are not considered in determining eligibility. The look-back period is currently 60 months. (Sec. 14015(c) Welfare and Institutions Code)

### **Annuity Requirements**

Medi Cal applicants are required to disclose any interest the applicant or applicant's spouse has in an annuity and requires the Department to inform applicant and beneficiaries that the state will become a remainder beneficiary in certain annuities. (Sec. 14006.41(b) Welfare and Institutions Code)

The State is required to inform the Medi Cal applicant and beneficiaries that the state will become a remainder beneficiary in certain annuities. (Sec. 14006.15(a)(2) Welfare and Institutions Code)

### **Agents Should Be Aware**

The purchase of a long-term care policy will not necessarily ensure that someone will avoid Medi-Cal when they need long-term care. Whether that is to their advantage or not depends upon the particular circumstances. People who are unlikely to be able to afford premiums, unable to absorb even a moderate increase are not appropriate purchasers, and the safety net of Medi-Cal may be their only option.

# How Medicare Interrelates With Paying for Long-Term Care Expenses

## Medicare

Most long-term care is furnished in nursing homes to people with chronic, long-term illnesses or disabilities. The care they receive is personal care, often called custodial care. Medicare does not pay for custodial care. As stated previously, Medicare pays only about 14% of all nursing home costs.<sup>6</sup>

## Medicare LTC Provisions

The Medicare.gov website tells us that generally, Medicare does not pay for long-term care. Medicare pays only for medically necessary skilled nursing facility or home health care and an individual must meet certain conditions for Medicare to pay for these types of care. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Medicare doesn't pay for this type of care called "custodial care". The following information, facts and figures on the Medicare program comes from the Medicare.gov website.

## Part A: Hospital Insurance

Part A covers inpatient hospital stays (at least overnight), including semiprivate room, food, tests, and doctor's fees. Part A covers brief stays for convalescence in a skilled nursing facility if certain criteria are met:

1. A preceding hospital stay must be at least three days, three midnights, not counting the discharge date.
2. The nursing home stay must be for something diagnosed during the hospital stay or for the main cause of hospital stay.
3. If the patient is not receiving rehabilitation but has some other ailment that requires skilled nursing supervision then the nursing home stay would be covered.
4. The care being rendered by the nursing home must be skilled. Medicare part A does not pay for custodial, non-skilled, or long-term care activities, including activities of daily living (ADL) such as personal hygiene, cooking, cleaning, etc.

The maximum length of stay that Medicare Part A will cover in a skilled nursing facility per ailment is 100 days. The first 20 days would be paid for in full by Medicare with the remaining 80 days requiring a co-payment (as of 2017, \$164.50 per day). Many insurance companies have a provision for skilled nursing care in the policies they sell. If a beneficiary uses some portion of their Part A benefit and then goes at least 60 days without receiving facility-based skilled services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period.

## Part B: Medical Insurance

Part B medical insurance helps pay for some services and products not covered by Part A, generally on an outpatient basis. Part B is optional and may be deferred if the beneficiary or their spouse is still working. There is a lifetime penalty (10% per year) imposed for not enrolling in Part B unless actively working. Part B coverage begins once

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<sup>6</sup> See Kaiser, footnote 4



a patient meets his or her deductible, then typically Medicare covers 80% of approved services, which the remaining 20% is paid by the patient.

Part B coverage includes physician and nursing services, x-rays, laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportation, immunosuppressive drugs for organ transplant recipients, chemotherapy, hormonal treatments, and other outpatient medical treatments administered in a doctor's office. Medication administration is covered under Part B only if it is administered by the physician during an office visit.

Part B also helps with durable medical equipment (DME), including canes, walkers, wheelchairs, and mobility scooters for those with mobility impairments. Prosthetic devices such as artificial limbs and breast prosthesis following mastectomy, as well as one pair of eyeglasses following cataract surgery, and oxygen for home use are also covered.

Complex rules are used to manage the benefit, and advisories are periodically issued which describe coverage criteria. On the national level these advisories are issued by CMS, and are known as National Coverage Determinations (NCD). Local Coverage Determinations (LCD) only apply within the multi-state area managed by a specific regional Medicare Part B contractor, and Local Medical Review Policies (LMRP) were superseded by LCDs in 2003.

### **Traditional Medicare Supplements (A-N)**

Medigap offerings have been standardized by the CMS into ten different plans, labeled A through (currently, but not consecutively) N, sold and administered by private companies. Each Medigap plan offers a different combination of benefits. The coverage provided is roughly proportional to the premium paid. However, many older Medigap plans offering minimal benefits will cost more than current plans offering full benefits. The reason behind this is that older plans have an older average age per person enrolled in the plan, causing more claims within the group and raising the premium for all members within the group. Since Medigap is private insurance and not government sponsored, the rules governing the sale and offerings of a Medigap insurance policy can vary from state to state. Some states such as Massachusetts, Minnesota, and Wisconsin require Medigap insurance to provide additional coverage than what is defined in the standardized Medigap plans.

Medigap or Medicare Supplement refers to various private supplemental health insurance plans sold to Medicare beneficiaries in the United States that provide coverage for medical expenses not or only partially covered by Medicare. The term 'Medigap' is derived from the notion that it exists to cover the difference or "gap" between the expenses reimbursed by Medicare and the total amount charged.

Medicare Supplemental is not a long-term care policy. These plans cover some or all of Medicare's deductible, co-payments, and coinsurance, which can be substantial. Depending on the plan that a person has, he or she may find that a Medicare supplemental plan will cover long-term care for a certain number of additional days. Unfortunately, that extended coverage only lasts for a relatively few days; not months or years. After these days get used up, neither Medicare nor a Medigap policy will cover the bills. Another health insurance policy must take over the burden, or a person must exhaust all of his or her resources. Once an individual's resources are exhausted, a person that requires long-term care may find themselves covered by the state's Medi

Cal program. Having a supplemental insurance policy can still be a good idea, any strategy that cuts expenses will free up capital for other uses; long-term care coverage, for example.

### **Products available**

Some people elect to purchase a type of supplemental coverage, called a Medigap plan, to help fill in the holes in Original Medicare (Part A and B). These Medigap insurance policies are standardized by CMS, but are sold and administered by private companies. Some Medigap policies sold before 2006 may include coverage for prescription drugs. Medigap policies sold after the introduction of Medicare Part D on January 1, 2006 are prohibited from covering drugs. Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy. Medigap Policies may only be purchased by beneficiaries that also receive benefits from Original Medicare (Part A & Part B).

### **Part C: Medicare Advantage plans**

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as "Medicare Advantage" (MA) plans. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships. In exchange for these extra benefits, enrollees may be limited in the providers they can receive services from without paying extra. Typically, the plans have a "network" of providers that patients can use. Going outside that network may require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members' annual out-of-pocket spending on medical care, providing insurance against catastrophic costs over \$5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if you want to use the provider included in the plan's network or "panel" of providers.

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD. Since 2004, the number of beneficiaries enrolled in private plans has more than tripled from 5.3 million to 17.6 million in 2016. This represents 31% of Medicare beneficiaries. A third of beneficiaries

with Part D coverage are enrolled in a Medicare Advantage plan. Medicare Advantage enrollment is higher in urban areas; the enrollment rate in urban counties is twice that in rural counties (22% vs. 10%). Almost all Medicare beneficiaries have access to at least two Medicare Advantage plans; most have access to three or more. Eight out of ten beneficiaries (82%) now have access to six or more Private Fee-for-Service plans.

## **Part D: Prescription Drug Plans**

Medicare Part D went into effect on January 1, 2006. Anyone with Part A or B is eligible for Part D. It was made possible by the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. In order to receive this benefit, a person with Medicare must enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD). These plans are approved and regulated by the Medicare program, but are actually designed and administered by private health insurance companies. Unlike Original Medicare (Part A and B), Part D coverage is not standardized. Plans choose which drugs (or even classes of drugs) they wish to cover, at what level (or tier) they wish to cover it, and are free to choose not to cover some drugs at all. The exception to this is drugs that Medicare specifically excludes from coverage, including but not limited to benzodiazepines, cough suppressant and barbiturates. Plans that cover excluded drugs are not allowed to pass those costs on to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases. Note that for beneficiaries who are dual-eligible (Medicare and Medicaid eligible) Medicaid may pay for drugs not covered by part D of Medicare, such as benzodiazepines, and other restricted controlled substances.

Neither Part A nor Part B pays for all of a covered person's medical costs. The program contains premiums, deductibles and coinsurance, which the covered individual must pay out-of-pocket. Some people may qualify to have other governmental programs (such as Medicaid) pay premiums and some or all of the costs associated with Medicare.

## **Premiums**

Most Medicare enrollees do not pay a monthly Part A premium, because they (or a spouse) have had 40 or more 3-month quarters in which they paid Federal Insurance Contributions Act taxes. Medicare-eligible persons who do not have 40 or more quarters of Medicare-covered employment may purchase Part A for a monthly premium of:

- \$227.00 per month (2017) for those with 30-39 quarters of Medicare-covered employment, or
- \$413.00 per month (in 2017) for those with fewer than 30 quarters of Medicare-covered employment and who are not otherwise eligible for premium-free Part A coverage.

All Medicare Part B enrollees pay an insurance premium for this coverage; the standard Part B premium for 2017 is \$134.00 per month. A new income-based premium plan has been in effect since 2007, wherein Part B premiums are higher for beneficiaries with incomes exceeding \$85,000 for individuals or \$170,000 for married couples. Depending on the extent to which beneficiary earnings exceed the base income, these higher Part B premiums are \$187.50, 267.90, or 348.30 for 2017, with the highest premium paid by individuals earning more than \$214,000, or married couples earning more than \$428,000. Part C and D plans may or may not charge premiums, at the programs'

discretion. Part C plans may also choose to rebate a portion of the Part B premium to the member.

## **Deductible and coinsurance**

**Part A** - For each benefit period, a beneficiary will pay (in 2017):

- A Part A deductible is \$1,316.
- A \$329 per day co-pay for days 61-90 of a hospital stay.
- A \$658 per day co-pay for days 91-150 of a hospital stay, as part of their limited Lifetime Reserve Days.
- All costs for each day beyond 150 days.
- Coinsurance for a Skilled Nursing Facility is \$164.50 per day for days 21 through 100 for each benefit period.
- A blood deductible of the first 3 pints of blood needed in a calendar year, unless replaced. There is a 3 pint blood deductible for both Part A and Part B, and these separate deductibles do not overlap.

**Part B** - After a beneficiary meets the yearly deductible of \$183.00 (in 2017), they will be required to pay a co-insurance of 20% of the Medicare-approved amount for all services covered by Part B with the exception of most lab services which are covered at 100%. The copay for outpatient mental health which started at 50% was gradually stepped down over several years until it matched the 20% required for other services. They are also required to pay an excess charge of 15% for services rendered by non-participating Medicare providers. The deductibles and coinsurance charges for Part C and D plans vary from plan to plan.

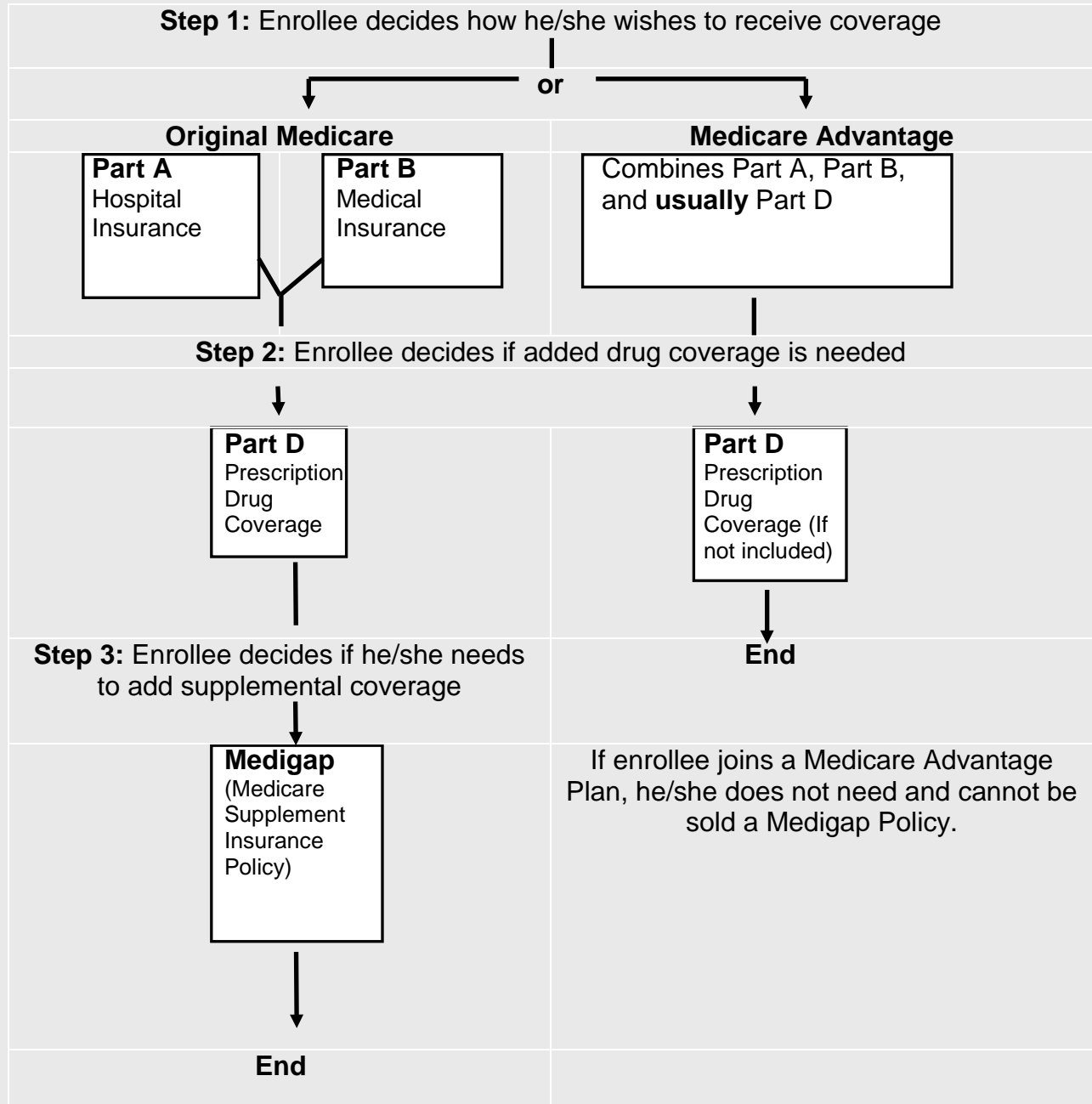
## **Payment for services**

Medicare contracts with regional insurance companies who process over one billion fee-for-service claims per year. In 2010, Medicare accounted for 13.5% (\$452 billion) of the federal budget. In 2016 it accounted for 17% (\$565.5 billion) of the total expenditures. For the decade 2013-2023 Medicare is projected to nearly double from \$592 billion to \$1.1 trillion.<sup>7</sup>

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<sup>7</sup> Kaiser Foundation, Medicare Info, <http://kff.org/medicare>

**Chart II-1 Medicare Basics**



Source: "Choosing a Medigap Policy: A guide to Health Insurance for People with Medicare," Centers for Medicare & Medicaid Services

### **III. Federal Legislation and Long-Term Care**

As part of this section the reader is directed to see Attachment II – Tax Treatment of Long-Term Care Insurance and Expenses

#### **A. Health Insurance Portability and Accountability Act (HIPAA) Definitions that Apply to Long-Term Care Expenses and Insurance**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) Public Law created a framework by which costs incurred for chronic illness would be treated as medical expenses under IRC Sec. 213(d) and by which long-term care insurance policies that meet certain requirements would be considered "tax-qualified" allowing for tax free benefits and tax deductible premiums under certain circumstances

The legislation was designed partly to provide favorable tax treatment to "federally qualified" long-term care insurance policies. Policies sold before Jan. 1, 1997, are generally considered to be tax-qualified. Policies sold after Dec. 31, 1996, were required to meet new standards to be considered qualified. While these standards include a number of consumer protections, they also specify the criteria that a covered individual must meet before any benefits can be paid. In some instances, tax-qualified policies may require an individual to meet disability criteria that are more restrictive than many non-tax-qualified policies.

HIPAA addressed the tax rules for qualified policies, but the benefits of non-tax-qualified policies are still debated. As a result, there is disagreement about the relative merits of tax-qualified and non-tax-qualified policies. Insurers offered non-tax-qualified policies if the offered tax-qualified products.

Fewer non-tax qualified policies are available for sale. One reason is that consumers want to be eligible for the tax deductions available when buying a tax qualified policy. The tax issues can be more complex than the issue of deductions alone, and it is advisable to seek good counsel on all the pros and cons of a tax qualified policy versus a non-tax qualified policy, since the benefit triggers on a good non-tax qualified policy are better. By law, tax qualified policies carry restrictions on when the policy holder can receive benefits. One survey found that sixty-five percent of purchasers did not know whether or not the policy they bought was tax qualified.

#### **Qualified Long-Term Care Services/Chronically Ill Individual**

The broad and expanding nature of long-term care expenses made it difficult to stipulate a "laundry list" of qualified services. The IRS defines "qualified long-term care services" as:

*Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.*

This is a wide-ranging universe of potential services. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a threshold for initiating benefits by tying services to a state of disability defined as a

*chronically ill individual.* A chronically ill individual must be certified by a licensed health care practitioner, within the previous 12 months, as meeting one of the following tests:

- The individual is unable, for at least 90 days, to perform at least two activities of daily living (ADL's) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. (See Internal Revenue Service Notice 97-31, issued May 6, 1997 or California Insurance Code (CIC) section 10232.8(e)(1 – 6) for the definitions of the ADL's.)
- The individual requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Federal and State laws require the certification of the insured's status as a "chronically ill individual" to be renewed annually. It is only when an insured meets this definition that favorable tax treatment for the cost of long-term care services will be granted.

### **Licensed Health Care Practitioner**

The Internal Revenue Service defines licensed health care practitioner (LHP) in very general terms. It may include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. California Insurance Code section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and "shall not be compensated in any manner that is linked to the outcome of the certification".

### **90-Day Certification for Activities of Daily Living**

Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it could have had the unintended consequence of allowing taxpayers to deduct expenses associated with short-term disabilities due to the broad nature of the definition of qualified *long-term care service*.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be recertified by the LHP (licensed health professional) at least annually.

IRS Publication 502 stipulates that the 90-day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

## **Substantial Assistance**

For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both *hands-on assistance* and *standby assistance*.

- Hands-On Assistance: means the physical assistance of another person without which the individual would be unable to perform the ADL.
- Stand-By Assistance: means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

## **Severe Cognitive Impairment and Substantial Supervision**

Notice 97-31 defines a *severe cognitive impairment* "as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning." Note that the 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be recertified every 12 months to ensure that they still qualify for benefits. Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

## **B. Tax Qualified Long-Term Care Insurance**

### **Introduction**

Prior to HIPAA, neither long-term care insurance premiums nor benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as accident and health insurance or disability insurance for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free.

HIPAA requires that long-term care insurance policies comply with its guidelines to be considered "qualified" long-term care insurance. As such, qualified long-term care insurance policies are accident and health policies and the tax treatment of their benefits are generally the same as other A & H plans.

Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance. However, HIPAA was silent as to the tax treatment of benefits received from non-qualified policies issued after January 1, 1997. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

### **Benefits**

Congress created a generalized structure to which qualified LTCi products must adhere. For purposes of HIPAA, a qualified long-term care insurance policy must pay benefits



using no less than 5 or no more than 6 of the following activities of daily living: eating; toileting; transferring; bathing; dressing; and/or continence.

Tax qualified long-term care insurance is generally treated the same as an accident and health insurance policy. Some of the rules include:

1. Reimbursement method long-term care insurance benefits pass tax-free
2. Per diem and cash method policy benefits received are subject to an annually adjusted limit amount of \$360/day in 2017 (indexed upwards annually by approximately 5 percent)
3. Premiums are generally deductible
4. Premiums paid by an employer for an employee are 100 percent deductible and do not count as income to the employee
5. Certain tax deductibility limitations apply to individuals, sole proprietors, owners of S-corporations, and LLP's
6. Individuals with Health savings accounts can utilize these funds to pay for qualified long-term care insurance subject to limitations discussed below
7. Qualified long-term care insurance cannot be included in a Section 125 Cafeteria Plan or flexible spending arrangement
8. Qualified long-term care insurance policies may not use "medical necessity" as a benefit trigger and must coordinate benefit payment with Medicare

## **Required Consumer Protection**

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of Senate Bill 1943, Chapter 1132, Statutes of 1992, that included protections related to the following: guaranteed renewal or non-cancellation of the policy; prohibitions on exclusions and limitations; extension of benefits and conversions; replacement; unintentional lapse; post-claim underwriting; requirement to offer inflation protection and rejection by consumer; restrictions on preexisting conditions and probationary periods; disclosure; and, non-forfeiture provisions.

## **IRS Reporting Mechanism**

HIPAA also establishes a reporting mechanism for benefits received under all long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an IRS 1099 LTC Form issued by the carrier. Benefits reported on the 1099 must also be disclosed on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does indicate the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional questions to the taxation of non-qualified benefits because it provides a vehicle for these benefits to be taxed. Despite continuing confusion, neither the Department of the Treasury nor Congress has clarified this matter.

## **C. Tax Treatment of Pre-1997 Long-Term Care Insurance Policies**

### **Introduction**

Policies issued prior to January 1, 1997, created a challenge under HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for "grandfathered" policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting "long-term care insurance requirements of the State in which the contract was ... issued" would be grandfathered in for the purposes of tax qualification unless the policyholder made a "material change" to the policy.

### **Definition of "Material Change"**

Although the interim directive did not define "material change", the final regulations issued in December 1998 identified criteria for which a "material change" would result in a policy losing its tax qualified status. The following are treated as "material changes" and considered issuance of a new contract with the resulting loss of tax qualified status:

- A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company;
- A substitution of the insured under an individual contract;
- A change (other than a non-material change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract.

The following, however, are actions that are not considered "material changes" and will not jeopardize the policy's grandfathered status:

- Regarding premiums: a change in the mode of premium payment; an increase or decrease in premiums for all contracts that have been issued on a guaranteed renewable basis; a reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family; a reduction in premium due to a reduction in coverage made at the request of a policyholder; a reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status); the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder.
- Regarding riders: the addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract; the deletion of a rider or provision of a contract (called an HHS – Health and Human Services – rider) that prohibited coordination of benefits with Medicare.
- Other actions include: the effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract; the substitution of one insurer for another in an assumption reinsurance transaction; the expansion of coverage

under a group contract caused by corporate merger or acquisition; the extension of coverage to collectively bargained employees; the addition of former employees.

**Note:** *The critical message for consumers is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised. A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90-day certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for long-term care.*

## **D. Long-Term Care Insurance Premium Deductibility**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent Department of the Treasury rulings have created four primary deductibility scenarios for tax qualified long-term care insurance. They are: health savings accounts; individual deductibility; deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) and limited liability corporations (LLC); and, deductibility for employee/owners of C-corporations. The tax incentives that allow for premium deductibility may help the self-employed and employees of companies that provide employer-paid long-term care insurance. To a lesser extent, some individual taxpayers, who are not self-employed may benefit from the premium deductibility allowed by HIPAA.

### **IRS Notice 97-31**

#### **Definitions Under IRS Notice 97-31**

As a means of understanding the precise meanings of the definition of contract provisos, the California Insurance Code refers to the Internal Revenue Service Code. This is done to avoid any conflicting interpretations and to preserve the tax benefits sought under these policies.

Internal Revenue Service Bulletin No. 1997-21 dated May 27, 1997, provides definitions of the following terms when used in connection with long-term care contracts;

*ADL Trigger.* For purposes of the ADL trigger, taxpayers may rely on all or any of the following safe-harbor definitions-

- 1.) **"Substantial assistance"** means hands-on assistance and standby assistance.
- 2.) **"Hands-on assistance"** means the physical assistance of another person without which the individual would be unable to perform the ADL.
- 3.) **"Standby assistance"** means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual's throat if the individual chokes while eating).

*Cognitive Impairment Trigger.* For purposes of the Cognitive Impairment Trigger, taxpayers may rely on either or both of the following safe-harbor definitions-

- 1.) **"Severe cognitive impairment"** means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar

forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

- 2.) **"Substantial supervision"** means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

The California legislation incorporates these terms into the law in order that no mistake will be made concerning tax status of policies. Notice 97-31 was issued to provide interim standards for taxpayers in California and the rest of the country to use in interpreting the new long-term care provisions and to facilitate operation of the insurance market by avoiding the need to amend contracts.

### **Reimbursement Benefits are Tax Free**

A policy is considered tax qualified if the insuring clause of a LTC contract matches the requirements established by 97-31 and its definitions. Under long-term care insurance contract provisions amended to the Internal Revenue Code in 1996, certain payments and reimbursement benefits received on account of a chronically ill individual from a qualified long-term care insurance contract are tax-free exclusions from income.

### **Health Savings Accounts (Medical IRA Account)**

Health Savings Accounts (HSA) and their predecessor MSA's, were established under HIPAA and more recent reforms. Those consumers under age 65, who are willing to take on the responsibility of a larger medical insurance deductible in favor of lower premiums, are provided a tax incentive to do so. Simply stated, the consumer purchases a qualified high deductible medical insurance plan. They are then allowed to make a pre-tax contribution to their HSA account not to exceed (in 2018) \$3,450 (individual) or \$6,900 (family). "Catch-Up" contribution provisions allow HSA holders to add an additional \$1,000 to their account if they are age 55 or older. The money placed in the HSA account grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for unreimbursed medical expense allowed by IRC Sec. 213(d), deductibles and co-insurance. The money in the HSA can also be used to pay the premiums on a tax qualified long-term care insurance policy up to the age banded limits listed below.

HSA's are achieving acceptance in individual and group health insurance markets. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional "low-deductible" plans and the "high-deductible" plans that qualify for the HSA program. HSA's represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

### **Individual Deductibility**

Taxpayers who itemize their deductions may benefit from the deductibility of qualified long-term care insurance premiums. Based on the taxpayer's age, only a portion of the long-term care insurance premium is deductible. Taxpayers over age 60 with above average income and assets may be interested in long-term care insurance. These

individuals may itemize their deductions because they own property and the standard deduction is not in their best interest. Expenses for medical care and insurance premiums are deductible to the extent that they exceed 10% of adjusted gross income. Prior to HIPAA, most taxpayers in this circumstance would not exceed 10% of their adjusted gross income in unreimbursed medical expenses. However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy. However, unlike other accident and health insurance premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted. In 2018, the age "banded" amounts that may be applied towards the taxpayer's un-reimbursed medical expenses are:

Banded Age Limits	Individuals/Couples
Under Age 40	\$ 420/\$840
Ages 41 - 50	\$ 780/\$1,560
Ages 51 - 60	\$1,560/\$3,120
Ages 61 - 70	\$4,160/\$8,320
Ages 71 +	\$5,200/\$10,400

Individual taxpayers under age 61 who itemize their deductions may not get much of a tax relief by including the allowable long-term care insurance premium amount in their unreimbursed medical expenses. However, someone age 61+ may benefit. Individual taxpayers, who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The deductible premium amount allowed is limited by the age-banded amount in that tax year.

The following is a thumbnail example of how this may work for a hypothetical husband and wife, both ages 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of \$9,000. Assume, for the purposes of this example, that this couple has an adjusted gross income of \$100,000 therefore they must exceed \$10,000 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

- Amount Allowed For TQ-LTCi \$7,820
- Medicare Supplement Premiums \$5,000
- Medicare Part B Premiums \$3,000
- Other Allowable Medical Expenses \$3,000
  - (Rx, eyeglasses, dental)

➤ **Total \$18,820**

In this example, the taxpayers would be allowed to deduct \$8,820 (\$18,820 minus their \$10,000 threshold) of un-reimbursed medical expenses. If they are in a combined federal and state income tax bracket of 35%, their tax savings would equal \$3,087 (\$8,820 x 35%). This would amount to an approximately 35% premiums savings (\$3,087 ÷ \$9,000). The deductible amount allowed for long-term care insurance premiums is not enough to trigger a deduction for these taxpayers; neither are the stand-alone deductions for the other unreimbursed medical expenses. However, the combination of all of them provides this hypothetical couple with a savings. It is

important to note that most agents are not qualified tax advisors and as such need to be cautious in their recommendations. Clearly, if the agent inquires as to the unreimbursed expenses illustrated above they may spot a potential tax savings for the consumer and refer them to their tax advisor.

*Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses.*

## **Deductibility for the Self-Employed**

Premiums for qualified long-term care insurance paid by an employer on behalf of an employee are deductible to the employer as an accident and health insurance premium. That being said, if the employee is an owner of the business entity some limitations apply.

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships ("LLP") and limited liability corporations ("LLC"). An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only. The profit or loss from the business entity is passed through to the owners pursuant to their share of ownership. Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees. Spouses of owners of S-corporations, LLP's and LLC's are considered owners regardless of their direct or indirect participation in the business' activities. With respect to accident and health insurance coverage purchased by one of these entities for a non-owner-employee, premiums are fully deductible. There is no imputed income to the employee of premiums and the benefits pass tax free at the time of the claim.

Beginning in 2003 premiums for accident and health insurance are 100% deductible for owners of these entities. It is not necessary for these taxpayers to exceed 10% of adjusted gross income to benefit from the tax code for these expenses. Tax qualified long-term care insurance (considered accident and health insurance for these purposes), falls into this general rule and the 10% AGI threshold does not come into play. The amount allowable for deduction is limited by the previously discussed age-related schedule.

Consider a self-employed husband and wife, both age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of \$6,000 per year. They would be allowed to deduct \$2,620. If they are in the combined Federal and State tax bracket of 35% their tax savings would be \$917 or approximately 15% of premium. Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 15% of the premium paid. Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses.

*Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several examples provided in this Attachment that should be included in the course.*

## **Deductibility in Closely-Held C-Corporation**

The fine-line difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners. Therefore, premiums paid by the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees is deductible to the corporation. There is no imputed income to the employee stockholder for premiums paid and the benefits will pass tax-free at time of claim. Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive "like" benefits. Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits. Both are incorrect.

The Internal Revenue Code section 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable class of employees who are eligible for the benefit, is not allowed. The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as "officer employees" can be created for the corporation who are eligible for a specific accident and health insurance benefit.

However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and tax advisors to be judicious in recommending and establishing classes eligible for coverage. It is also important for the corporation to establish the plan in their Minutes and to clearly identify the classes of employees that are eligible for benefits. Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation. There is no income imputed to the employee and the benefits pass tax free at time of claim; however it is important to consult with a tax advisor.

## **E. Pension Protection Act of 2006**

This act included key provisions addressing the taxation of combination annuity plans featuring long-term care insurance. The rules apply only to nonqualified annuities (purchased with after-tax dollars) coupled with tax-qualified long-term care riders. The Act clarified that, effective Jan. 1, 2010; long-term care insurance benefits paid out of these plans (even if a portion of those serves to reduce account values in the underlying annuity) are paid as tax-free long-term care insurance benefits. This is a watershed event. Prior to that date there was no mechanism that allowed for gains in a contract to be paid out on a tax-free basis. In addition, the law also allows for 1035 exchanges into combination plans. This is noteworthy in light of the many trillions of dollars deposited in existing annuities.

Benefit payout structures under such plans are typically defined as accelerated benefits. The policy's qualifying event for benefits, that is, the definition of chronic illness must match the definition established in HIPAA. The long-term care benefit payments are made from the annuity account value while waiving surrender charges. This is usually combined with some form of tail benefit payable after account values are depleted. The benefit is paid monthly and is usually expressed as a percent of the annuity account

value at the time of initial claim. For example, 1/24 of the lifetime LTC benefit limit may be payable for 24 or more months from the account value, with a 12, 24, or 48 month extension of benefit "tail" as selected by the client. This creates the opportunity to convert what would have been partially taxable account values from the annuity into tax-free payouts that range from 150% to 300% of the account value as LTCI benefits.

## **New Trends: LTC Insurance, Life Insurance, Annuities and Benefit Riders**

The Pension Protection Act of 2006 (PPA), like HIPAA, is a significant piece of legislation that addresses hundreds of disparate issues. Also like HIPAA, a very small portion (section 844) deals with long-term care insurance and riders that are part of life insurance or annuity contracts. PPA affirms HIPAA as it pertains to life insurance contracts and accelerated benefit riders (ABRs). Over the years, accelerated benefit riders have appeared in various life insurance policies with a promise to pay part of the death benefit (generally 2% to 4% monthly) if a qualifying event other than death occurs; e.g. disability, critical illness, cancer, terminal or chronic illness.

Section 101(g)(1) of the Internal Revenue Code governs the accelerated payment of death proceeds on the life of a terminally or chronically ill insured. HIPAA added section 7702B to the IRC which specified the definition of 'chronic illness'. Essentially, if the qualifying event for benefits matches the chronic illness definition established by HIPAA, the early payout of the death benefit for long-term care expenses will not be taxed as income. However, the payments cannot exceed the per diem limits (\$360 in 2018) and must comply with other provisions of the NAIC Model for long-term care insurance. Per PPA, the premiums (or charges) for this coverage can be deducted from the internal growth of the annuity without a taxable event (income) to the annuitant. In addition, if the annuitant qualifies for care, the long-term care benefits payments from the annuity will be received income tax free. One of the central points is that the long-term care benefits must be consistent with the HIPAA--if it looks like qualified long-term care insurance, it is qualified long-term care insurance.

A typical product design for a single premium deferred annuity (SPDA/LTCI) combo product will provide a long-term care benefit that is generally a multiple of the annuity account value. The payout will be delivered over a certain number of months, 24, 36 or 48. While examples will vary by insurance carrier, age and health conditions, let's say that the insured wants \$6,000 per month of benefit for 48 months (\$6,000 X's 48 = \$288,000). To get that \$288,000 benefit, the policy holder may have to place \$100,000 into the SPDA combo product. A risk charge will be taken from the accumulation of the product to provide the additional \$188,000 of coverage.

The first money out of the SPDA to pay the long-term care benefit will be the insured's initial premium to the plan. If the policyholder dies before their contribution is exhausted a beneficiary will receive the difference. Once benefits are paid beyond the initial premium the insurance company will continue to pay benefits until they are exhausted. The risk charge for the benefit beyond the premium will generally be between one-half to 1.25 basis points. In other words, if a typical SPDA was paying a return of 5.5%, the combo plan may only pay 4.5%. Again, since the long-term care benefit under the program qualifies under IRC section 7702B, the cost of the long-term care benefit will not be a taxable event to the insured. Long-term care benefit payments will reduce the



basis of the annuity for income tax purposes. This may create a larger tax burden on heirs of the annuity owner after death.

Here are some key points for agents to think about when discussing "combo products" with consumers:

1. How insurance agents and financial advisors who have been working primarily in their narrow specialties will be able to help clients navigate this new world of long-term care planning choices. Benefits available with life and annuity/LTCI combos are likely to be limited as to benefits paid at time of claim.
2. Long-term care benefit qualification must be consistent with HIPAA in order for the combo plan to fall under the PPA guidelines. In order to solicit/sell long-term care insurance in California, Agents need to hold a current license as: Life Agent, Accident and Health Insurance Agent, or Life-Only Agent (only if it is a LTC rider on a full life policy).
3. What sorts of long-term care expenses will the life or annuity combo pay for-- nursing home only, assisted living, home care, or all of the above? Will the plan reimburse for incurred cost or provide some sort of indemnity (per diem) benefit based on a day of service incurred? What sorts of assessments and plans of care will the claims process require?
4. Underwriting criteria will lead to choices of deferral periods based on insured's health issues. This will be a special challenge to life insurance agents selling annuities, marketers and wholesalers not attuned to underwriting issues in the current SPDA environment.
5. 1035 exchange opportunities are likely to occur (moving cash values from life insurance and annuity contracts to those with LTCI benefits).
6. Which type of life insurance product, SPDA, fixed, indexed or variable, will be best suited to specific clients? What if they do not perform as anticipated? Will consumers who purchase a combo plan be faced with a lower level of benefits if the underlying life insurance or annuity contract pays the guaranteed rate as opposed to the current rate? Will there be "true-up" provisions which give the insured an ability to "reinforce" their long-term care pay-out in the event that product investment performance doesn't reach expectations.

## IV. Long-Term Care Insurance (LTCi)

### A. Types of Products

#### Stand Alone

The purpose of long-term care insurance is to pay for some of the insured's expenses when assistance is needed with basic activities of living. Because of a chronic illness or disability, such things as bathing, eating, and toileting may require help. Long-term care insurance is any insurance that pays for the following;

- **Care in a facility that is NOT an acute care unit of a hospital-** such as a nursing home, a residential care facility, convalescent facility, extended care facility, custodial care facility, skilled nursing facility or personal care home
- **Home care-** including home health care, personal care, homemaker services, hospice or respite care
- **Community-based care-** such as adult day care or hospice

In California, three types of long-term care policies may be sold:

1.) **Institutional Care.** These policies pay for skilled, intermediate or custodial care in a nursing home or similar facility. Some policies also cover care in a residential care facility for the elderly or a hospice.

2.) **Home care only.** These policies pay for care in the insured's own home. They are required to include home health care, adult day care, personal care, homemaker services, hospice and respite care. Some also include care management services and equipment prescribed for medical purposes.

3.) **Comprehensive long-term care.** These policies pay for long-term care provided at home or in the community as well as nursing facility care. All of the home and community services included in home care only policies must be included in a comprehensive policy as well.

## Products With Long-Term Care Riders

### Life with LTCi

Life insurance has a lump sum death benefit. If a serious illness strikes, for some types of policies a portion of it can be accessed to provide accelerated benefits for chronic illness rider. This is literally accelerating out part of the death benefit from the policy before dying.

There are two drawbacks for the insurance-buying public when considering the purchase of long-term care coverage;

- Whether or not the coverage will be used
- An increase in premiums makes the policy unaffordable

An accelerated benefit for chronic illness rider is a market response to these issues and has created policies that combine the benefits of life insurance and long-term care insurance. The basic concept is that if the insured does not use the money in the policy for long-term care costs, his or her heirs will receive a death benefit and the money is put to good use by the family. These policies can be funded by a large, single-premium deposit into a life insurance policy. If some of the death benefit is used for long-term care, the balance goes to the heirs. The purchase of a combo policy gives the insured leverage to get more long-term care coverage than simply self-insuring by keeping the money in savings.

Here is an example of that leverage:

A 55-year-old, investing \$100,000, could get \$240,000 in death LTC benefits, or \$9,600 a month for long-term care. At 65, that \$100,000 deposit would create \$180,000 in death benefits, and a \$7,200 monthly LTC benefit. The withdrawal for care costs is limited to 4 percent of the death benefit each month with an optional 3 percent or 5 percent inflation increase. That provides more money available to pay for care than could have been received if the insured simply saved the \$100,000 if the need for care arose. Policies may offer a lifetime LTC option for an additional premium.

Combining long-term care with the death benefit in a whole or universal policy costs more, but there is a payoff either way. If the insured goes into a nursing home, he or she will collect. If such care is not needed, there's still cash for heirs. Plus, whole and universal policies often establish a premium guaranteed to at least maintain the basic benefit, although it may not be enough to build cash value. That neutralizes the problem of rising rates on long-term care insurance. Those who want the lifelong coverage and

investment features of a whole or universal policy may find that the long-term care benefit adds little extra cost.

For individuals who have accumulated cash value in a life insurance policy but no longer need the coverage, consideration may be given to trading it in for a new one with the LTC rider. This can be accomplished through a tax-free swap. If the old policy were merely cashed in, the policy owner could be liable for taxes on the investment gains.

### **Annuity**

The combined annuity and qualified long-term care benefits addresses both longevity and catastrophe risk. The Pension Protection Act of 2006 enabled the tax-free aspect. The LTC annuity is simply two existing products, an annuity is overlaid with LTC insurance, but the tax code allows premiums to be deducted from the annuity's income stream without creating a taxable event. This effectively lowers the cost of the LTC insurance premiums, serving as an inducement for people to purchase these policies.

An annuity purchased for retirement is simple to understand; an investor pays a portion of his or her retirement assets in exchange for a guaranteed stream of income for life (the spouse's lifespan can be insured as well). Many people fear they will outlive their savings or make unwise investment decisions. A retirement annuity eliminates these concerns because it is a form of income insurance, as opposed to an investment that entails risk. The other half of an LTC annuity is long-term care insurance, providing protection against the costs of nursing homes and assisted living facilities. These policies offer comfort for those who fear depleting their assets on healthcare.

### **Disability Insurance**

Individuals typically purchase disability insurance with the idea in mind to replace income lost due to illness or injury until they reach age 65, when Social Security benefits would begin to be paid. A product which links disability income insurance with long-term care insurance through the use of a conversion option could be created. The combined product would permit the insured to convert the disability income policy into a long-term care policy.

The logic of an insurance product that combines disability insurance with long-term care insurance is that it would protect against the income-loss associated with developing a disability as well as the costs of needed services associated with becoming disabled. Some policies offer aspects of combined disability/long-term care coverage. In one example the policyholder can exchange the disability policy for a long-term care insurance policy without undergoing an underwriting review. The specific level of long-term care insurance premiums is based on the age at the time of conversion.

The availability of the long-term care conversion option would increase the cost of the underlying disability policy. The advantage to the consumer is that the additional premium is purchasing a right to convert to a long-term care policy rather than actual coverage for long-term care services. For a slightly higher premium, the conversion feature provides a younger person who has purchased a disability income policy with protection from being excluded from the long-term care insurance market due to a health condition that develops after the disability income policy is purchased.

## **Critical Illness Insurance**

With this insurance product the insurer is contracted to typically make a lump sum cash payment if the policyholder is diagnosed with one of the critical illnesses listed in the insurance policy. The policy may also be structured to pay out regular income and the payout may also be on the policyholder undergoing a surgical procedure, for example, having a heart bypass operation. The policy may require the policyholder to survive a minimum number of days (the *survival period*) from when the illness was first diagnosed. The survival period used varies from company to company, however, 14 days is the most typical survival period used. The contract terms contain specific rules that define when a diagnosis of a critical illness is considered valid. It may state that the diagnosis need be made by a physician who specializes in that illness or condition, or it may name specific tests, e.g. EKG changes of a myocardial infarction, that confirm the diagnosis.

Typical critical illness insurance products refer to policies where the insurer pays the policyholder a pre-determined lump sum cash payment if the policyholder is diagnosed with a critical illness listed in the policy. However, alternative forms of critical illness coverage provide direct payment to health providers to cover the high medical costs in treating critical illnesses such as cancer, cardiovascular procedures and organ transplants. The maximum amount is set out in the insurance policy and defined per episode of treatment. As with the disability insurance it is not difficult to envision a long-term care conversion feature added on to this type of policy.

## **Accelerated Death Benefit**

Life insurance companies that offer the option to accelerate the benefits of a policy limit such an option to individuals with life expectancies of less than 12 months. Such benefits, once received, may affect tax status and eligibility for state and federal means-based assistance programs. Basically, an accelerated death benefits rider allows insureds who are terminally ill or who suffer from certain catastrophic diseases to collect part or all of their life insurance benefits before they die, primarily to pay for the care they require. Benefits may also be payable if the insured is receiving long-term care. Accelerated death benefits riders are not uniform but they can be classified in the following ways;

- 1.) Terminal illness rider- This allows terminally ill insureds with a life expectancy of six months or a year to receive part or all of the policy proceeds. Many insurers allow the rider to be added without an extra premium, but any lump sums advanced are discounted for interest to reflect the time value of money. The face amount of insurance, cash values if any, and premiums are reduced after the payment is made. For example Mr. Williams, terminally ill with cancer, asks for 50% of his \$250,000 term insurance policy. The benefit is discounted for interest and Mr. Williams receives \$116,000. This is a rounded figure. The actual amount will depend on the interest rate and discounting assumptions made by the insurer. Once the payment is made, premiums are reduced 50% and the face amount if the policy is reduced to \$50,000.
- 2.) Catastrophic illness rider- Insured who have certain catastrophic diseases can collect part or all if the policy face amount with this type rider. Covered diseases normally include AIDS, life-threatening cancer, coronary artery disease, kidney failure, and similar devastating diseases.
- 3.) Long-term care rider-This type allows insureds that require long-term care to collect part of their life insurance prior to death. The rider may cover care in a skilled nursing facility, intermediate care facility, or custodial care facility. Some riders also

cover certain types of home care. As an example, assume that a policy rider allows a monthly benefit to be paid equal to 2.5% of the face amount of insurance up to a maximum of 50% of the face amount. On a \$250,000 policy, a maximum of \$6,250 could be paid on a monthly basis for up to 20 months

### **Other Products as They Become Available in the Marketplace**

Insurers are likely to seek certification for new products as they become available. Every wave of innovation, as it draws in new ideas and concepts, inevitably raises on its crest new products, sometimes personifying the accidental in an otherwise continuous causation. Occasionally the market will boil and send up steam, and the clouds of steam provide a halo for one particular product or another.

### **Hybrid Long-Term Care Policies**

A way to increase the appeal of long-term care insurance is the offering of "hybrid" products that combine long-term care insurance with other insurance products. Insurance for long-term care may be viewed as covering expenses similar to health expenses, but many policyholders will not make claims against their long-term care insurance until decades after the initial purchase of the policy. Rather than viewing their premiums as having paid for insurance against a catastrophic risk that never materialized, consumers may feel that they have "lost" or "wasted" all of their premium payments, even though they probably do not adopt similar perspectives towards home and car insurance. Hybrids may overcome some psychological barriers for those consumers, by incorporating another insurance product that they perceive to have value.

### **Life/Long-Term Care**

One simple type of hybrid of life insurance with long-term care insurance is an *accelerated death benefit* (ADB), which (if offered) is often an option or rider to a life insurance policy. This benefit permits the owner of the policy to "accelerate" all or part of the death benefit when of certain qualifying events or triggers occur. At the time of acceleration, the death benefit under the policy is reduced- if enough payments are disbursed under an accelerated death benefit, the death benefit may be completely eliminated. Typically, with an ADB one cannot expect substantial insurance payouts for both an expensive long-term care episode and death. The consumer must continue to pay the life insurance premiums while receiving the accelerated benefits. Accelerated death benefit options arose in the 1990s at the same time that viatical settlements (payments derived from sale of an insurance policy by a terminally ill policy holder) became more common. The option is generally associated with cash value life insurance, but may be available with term insurance. The trigger for an ADB can vary, including combinations of:

- Terminal illness, with death expected within 24 months;
- Acute illness, such as acute heart disease or AIDS, which would result in a drastically reduced life span without extensive treatment;
- Catastrophic illness requiring extraordinary treatment, such as an organ transplant;
- Long-term care needed because the policyholder cannot perform a number of daily living activities such as bathing, dressing, or eating; or
- Permanent confinement in a nursing home.

Therefore, not all ADB riders can really be considered as long-term care insurance. Indeed, one state insurance department states in a recent report that an accelerated death benefit "is not long-term care insurance" and has proposed regulatory language that states that "The policy or certificate shall not be advertised as long-term care insurance, nursing home insurance, [or] home care insurance...." (New York State Insurance Department, 2005). In some cases the level of benefits may be restricted to only a specified percentage of the life insurance coverage (e.g., 50 percent). Therefore, if the amount of life insurance is small, the coverage of long-term care may be relatively small compared to the costs of several years of long-term services and supports.

### **Annuity/Long-Term Care**

Hybrids of annuities with long-term care insurance are available in the marketplace. In some ways they are similar to the life insurance/long-term care insurance hybrids described above. One example is a single-premium deferred annuity that can be used to pay for long-term care expenses. It is offered by a company that states the age range of issue is from 50 to 85, but that the primary market is from 70 to 85. The product is designed to appeal to persons who attempt to "self-fund" for their risks of having long-term care expenses. Some potential sources of appeal, in comparison to other ways to self-fund, might lie in the following characteristics of this product:

- As with annuities in general, the money will compound tax-free within the annuity hybrid.
- There is simplified medical underwriting and typically no exams are required.
- A higher interest rate is used to calculate the total amount available to pay for long-term care expenses than the interest rate used in the annuity that determines the cash value that will be paid to the beneficiary.

The concept of a hybrid product of an annuity and long-term care insurance coverage was analyzed by Murtaugh, Spillman, and Warshawsky (2001). Their initial motivation to explore this hybrid product was to see if, by combining annuities and a form of long-term care insurance, the premium costs of the combined product might be significantly lower than the two products priced separately. This possibility exists because people more likely to require long-term care are for the most part less likely to live a long time. In other words, from the perspective of the insurance company the financial risks of a high payout for one product (either the annuity or the long-term care insurance) will tend to be offset for an individual by a lower financial risk of a high payout for the other product.

While hybrid premiums can be paid via monthly payments, they are most-often paid through a one-lump-sum premium. Regardless of the type of policy or premium payment (whether on-going or lump sum), the policy expense to the insured corresponds to the insurance company's assumptions of the risks involved, which include interest return on conservative investment of premium dollars, probable benefit usage and individual health underwriting/qualification.

### **Other Hybrid Products as They Become Available in the Marketplace**

A search of the Web produces many entries for "New" hybrid long-term care policies; many of which appear to be repackaging of the life and annuity combination products already discussed. Insurance professionals who offer long-term care products are wise to stay current with innovative new products entering the market.

A unique offering is a hybrid policy featuring a return of premium option so that clients can access the investment during life if they decide to use the funds for other purposes, thereby eliminating the risk that a client will lose his or her investment simply by being fortunate enough to never require long-term care. In order to make these hybrid products more affordable, insurers have begun promoting the option of paying for the contract in installments- spreading the payments over ten or twenty years- rather than buying the contract in a single lump sum payment, as has been the norm for annuity hybrids. Regardless of the payment term, these contracts guarantee that the level of premium will remain constant over the term, as opposed to traditional LTCI policies that have recently seen significant premium increases. Similarly, the level of benefits that the client becomes entitled to upon purchasing the contract is guaranteed and is often based upon a percentage of the funds that the client chooses to invest in the contract. It is now possible to purchase a single hybrid policy that covers a married couple, rather than only one spouse. This type of second-to-die policy, while common among solo products, is a newly emerging feature for hybrid LTCI policies.

## **B. Group Coverage**

"Group long-term care insurance" refers to a long-term care insurance policy which is delivered or issued for delivery in California (Section 10231.6 of the CIC). True group insurance is generally defined as an insurance contract made with an entity such as an employer, professional, or trade organization. It covers the people who have a relationship with the entity (employees, union members, etc.) purchasing the contract as well as their families/dependents. Premium payments may be split or paid by one side or the other. This type of insurance is typically written for life, health/accident/ annuities, and disability.

An employer can sponsor a multi-life plan. This consists of individual Long-term care insurance policies bundled to offer group discounts. The employee has a durable contract with the insurance company that will serve them well into the future. Additionally, HIPAA consumer protections on individual products do not apply to true group long-term care insurance. This is particularly an issue as it pertains to the mandatory offer of inflation protection and non-forfeiture benefits required with individual products.

Group long-term care is a policy delivered or issued for delivery in California for;

- ♦ Employer or labor organizations, such as a steel mill or an oil refinery, or a trust can be established for the benefit of the members of such organizations. It can be any combination of current and former employees or members.

- ♦ Professional, trade, or occupational associations like a used car dealers association or the professional women in journalism guild. Membership could consist of any combination of current or former members if the association meets both of these requirements;

- 1.) It is made up of people who are or were actively engaged in the same trade, profession or occupation. That is, the endeavor indicated by the name of the umbrella group.

- 2.) The association has been perpetuated in good faith for purposes other than that of obtaining insurance.

- ♦An "association" or group of associations that has come together for the purposes as outlined in the preceding section (not solely to acquire insurance). Also, must have at the outset a minimum of 100 persons as members, an active existence for at least one

year. The association must also have a constitution and bylaws with the following requirements uniformly realized;

- 1.) The association holds meetings on a regular basis, at least once a year, to further the interests of members.
- 2.) Dues or contributions are required of the membership. This does not apply to credit unions.
- 3.) Members vote and are represented on governing councils of the group.

The term "multi-life" for an association also indicates that more than one individual is being insured in a contract. In an employment setting this means that several people are eligible for insurance. Eligible candidates include owners, employees, or a combination of both. Multi-life long-term care insurance is attractive to association members because of the following features;

- Selectable features such as inflation protection and levels of coverage
- Spouse can be included as an insured
- Deductible nature of the policy for the individual
- Portability if a worker moves on to other employment

Before any advertising or policy marketing can take place, the association must file evidence with the insurance commissioner that the association consistently follows these requirements. Thirty days after filing these requirements, the organization is deemed to meet it unless the commissioner determines that such is not the case. In other words, the commissioner must investigate the group's relationship to the act of issuing insurance.

Long-term care insurance can be offered on a group basis. Continuation or conversion coverage must be a feature of all group long-term care insurance policies and certificates. Continuation/conversion coverage is not required in the following circumstances:

- 1.) If the insured does not make required payments,
- 2.) Terminating coverage is replaced within 31 days and- the replacement coverage provides identical or substantially equivalent coverage; the replacement coverage premium is calculated on the insured's age at the time of issue of the group certificate for the coverage which is being replaced.

**Group Continuation/Conversion-** Continuation or conversion applies if group coverage terminates for any reason except for those mentioned in the paragraph above, If those exceptions do not apply, the following obligations fall on the insurer;

Continuation coverage- This means an individual policy of long-term care insurance, issued by the insurer of the terminating group coverage, without considering insurability, with equal or substantially equivalent benefits. It applies to certificate holders as well as to an individual who is eligible for group insurance because of relationship, not membership, who may need to continue coverage after death of or divorce from the group member.

Conversion coverage- This means an individual policy of long-term care insurance must be made available to each certificate holder, without regard to insurability, and containing identical or substantially equivalent benefits to the group policy. The term 'substantially equivalent' must take into consideration the relative advantages of



managed care plans that use restricted provider networks, considering items such as service availability, benefit levels, and administrative complexity.

The premium for the converted policy shall be calculated on the insured's age at the time the group certificate was issued. If adequate notice is given to certificate holders, the insurer may require the following before issuing conversion coverage;

- 1.) The individual must have been continuously insured for at least six months immediately prior to termination
- 2.) Written application and payment for conversion must be submitted by the insured within a reasonable period after termination of the group coverage.
- 3.) A provision for a reduction of benefits can be contained in the conversion policy if the insured has existing long-term care insurance, payable on an expense-incurred basis, which, together with the conversion policy, would result in payment of more than 100 percent of incurred expenses. Such a provision shall not be included in the conversion policy unless the reduction in benefits is reflected in a premium decrease or refund.
- 4.) The conversion policy contains a provision limiting the payment for a single claim, spell of illness, or benefit period occurring at the time of conversion, to the amount that would have been payable had the group coverage remained in effect. (Sec. 10236.5 of the CIC)

### **Group Coverage Replacement**

If one long-term care group policy is replaced by another under the same master policyholder, the following obligations accrue to the replacing insurer;

- a.) Identical (or substantially equivalent) benefits to the terminating coverage shall be provided. If the commissioner determines such to be in the best interest of the beneficiaries, lesser or greater benefits may be provided.
- b.) To calculate the premium on the insured's age at the time of issue of the group certificate for the coverage this is being replaced. If the new coverage is replacing replaced insurance (the new is the third or subsequent insurance on the group) the newest replacement premium is calculated on the insured's age at the time the previous group certificate was issued. If new or increased benefits are added this way, the premium for those benefits is calculated on the insured's age at the time of replacement.
- c.) Must offer coverage to all persons covered under the replaced group policy on its date of termination.
- d.) Do not exclude coverage for preexisting conditions if the terminating group coverage would provide benefits for those preexisting conditions.
- e.) Cannot require new waiting, elimination, or probationary periods, or similar preconditions related to preexisting conditions. Time periods applicable to preexisting conditions shall be waived to the extent that similar preconditions have been satisfied under the terminating group coverage.
- f.) Cannot vary benefits or premiums based on the insured's health, disability status, claims experience, or use of long-term care services. (Sec. 10236.8 of the CIC)

When a group policy terminates, the insured needs to be made aware of these options;

- a.) A policy does not qualify for favorable tax treatment unless exchanged for a new policy designed specifically to comply with both federal and state tax law and current California insurance law.
- b.) Insurers usually promise purchasers that they will be given the option to convert once new policies become available.

c.) The decision to convert or retain an existing policy is done on a case-by-case basis. It depends on the circumstances of the insured.

## **Employer Group**

This term refers to any subgroup within an association consisting of an employer, his employees and their dependents, which purchase group health insurance as members of the association. It can also refer to multiple employers or labor organizations established for employees or former employees, alone or in a combination.

## **Trade Group**

A trade association or group is an organization founded and funded by businesses that operate in a specific industry. It can seek collaboration between companies on industry-wide standardization of components. Associations may offer other services, such as producing conferences, networking or charitable events or, in our case, offering insurance. Many associations are non-profit organizations governed by bylaws and directed by officers who are also members.

## **Association Group**

This is similar in concept to a trade group. An "association" or group of associations that has come together for the purposes as outlined in the preceding section (not solely to acquire insurance). The association must also have a constitution and bylaws with the following requirements uniformly realized;

- 1.) The association holds meetings on a regular basis, at least once a year, to further the interests of members.
- 2.) Dues or contributions are required of the membership. This does not apply to credit unions.
- 3.) Members vote and are represented on governing councils of the group.

Before any advertising or policy marketing can take place, the association must file evidence with the insurance commissioner that the association consistently follows these requirements. Thirty days after filing these requirements, the organization is deemed to meet it unless the commissioner determines that such is not the case. In other words, the commissioner must investigate the group's relationship to the act of issuing insurance.

## **Discretionary Group**

Other groups that do not meet the criteria as described above can issue or participate in a group insurance program if the following conditions apply;

- a.) Group policy issuance by the organization does not conflict with the best interests of the public as a whole.
- b.) The group policy's issuance will result in economies of scale as far as acquisition and administration are concerned. "Economies of scale" refer to factors that cause the average cost of producing a commodity to fall as output of the commodity rises. The commodity in this case is insurance. For instance, a firm or industry, which would less than double its costs, if it doubled its output, enjoys economies of scale.
- c.) Benefits are reasonable in relation to the premiums charged.
- d.) There is no deceptive or ulterior purpose in the name, true or fictitious, of the group or the policy for purposes of marketing.
- e.) The marketing of insurance is not the group's principal source of revenue

- f.) The group's marketing method to obtain new members is not connected to the solicitation of insurance.
- g.) Benefits or services of significant value other than insurance are provided to members.

Life care contract providers that operate in California can also issue group insurance contracts. "Life care contract" is described in the California Health and Safety Code as a continuing care contract under which routine care, including acute care, is provided to a resident for the duration of his or her life. This includes the services of physicians. The care must be provided in a continuing care retirement community. (Sec. 10231.6 of the CIC)

### **Group Policies Issued Outside California**

Group policies issued by out-of-state insurers cannot be sold to California residents unless they also meet the requirements in 'Discretionary Groups' above (Section 10231.6(d) CIC). Policy submittal, approval, and advertising regulations apply equally to these group policies.

## **C. Common Policy Benefits**

### **Coverage for Care in a Nursing Home**

Policies that limit benefits to the provision of institutional care shall be called a 'nursing facility and residential care facility only' policy and the words "Nursing Facility and Residential Care Facility Only" shall be prominently displayed on page one of the form and the outline of coverage. (Section 10232.1(b) of the CIC)

If a long-term care policy provides reimbursement for care in a nursing facility, it shall cover and reimburse for per diem expenses, as well as ancillary expenses, up to the policy's maximum lifetime daily facility benefit. (Sec. 10232.95 of the CIC)

California Insurance Code Section 10232.97 goes on to state that with every long-term care policy or certificate that covers care in a nursing facility, the threshold establishing eligibility for nursing facility care shall be no more restrictive than a provision that the insured will qualify if either one of two criteria are met:

- Impairment in two activities of daily living.
- Impairment in cognitive ability.

Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a "nursing facility and residential care facility only" policy or certificate and the words "Nursing Facility and Residential Care Facility Only" shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits. (Sec. 10232.1 of the CIC)

### **Coverage for Care in a Residential Care Facility for the Elderly (RCFE)**

In California, LTC facilities for adults are classified as either Residential Care Facilities for the Elderly (RCFE's) or Adult Residential Facilities. Adult Residential Facilities (ARF) are facilities of any capacity that provide 24-hour non-medical care for adults ages 18 through 59, who are unable to provide for their own daily needs. ARFs and RCFEs each differ from a nursing home and nursing homes are regulated separately. Any prospective resident should make sure that the LTC facility is properly licensed by the

state. Logically, if a place has no license, no one can monitor the care provided. Care in a residential care facility must be covered by a long-term care policy (Section 10232.95(a)).

**Assisted Living Option-** If a long-term care policy is offered for sale in California, the policy must offer coverage for assisted living care in a licensed residential care facility for the elderly (RCFE). The minimum benefit payable can be no less than 70% of the maximum benefit for institutional care. (Section 10232.92(b) of the CIC)

Necessary expenses incurred by the insured in the RCFE are to be covered, up to the maximum daily residential care facility benefit of the policy or certificate. There is no restriction on the provider of services as long as they are provided by the RCFE, exceed the daily maximum benefit, or conflict with federal law for tax-qualified consideration (Section 10232.92(c) of the CIC).

The assisted living benefit can take different forms. It can be payment for a caregiver to help out the insured in the home. The help can be in the form of custodial care, therapy or actual daily health care. Or, it can be in the form of payment for living in an assisted living facility for seniors. Either way, the purpose of assisted living is to keep the person requiring care in the friendliest most healthful and cost effective environment available: the home.

Further, any policy that limits benefits to the provision of institutional care shall be called a 'nursing facility and residential care facility only' policy and the words "Nursing Facility and Residential Care Facility Only" shall be prominently displayed on page one of the forms and the outline of coverage. (Section 10232.1(b) of the CIC)

## **Coverage for Home and Community Care**

There is a widely-held belief that the best plan for the elderly to remain in their own home for as long as possible. At some point that situation will no longer be tenable so, from the consumer's point of view, the most desirable policy is one with flexible provisions. That is, policies likely to pay under many different circumstances and a variety of care settings. Policies offered ten to twelve years ago cannot be offered today because of changes in insurance laws. For example, an older policy might require a hospital stay before paying benefits for a nursing home stay. This tends to trespass on benefits under Medicare. Such benefits are not offered today. Other policies may not have covered assisted living, offered inflation protection, favorable renewability provisions or comprehensive and understandable benefit triggers. State laws have done away with requirements for hospital stays before nursing home coverage begins. Also, all policies must be either guaranteed renewable or non-cancelable. (Sec. 10236 of the CIC)

## **Services Provided**

Section 10232.9 of the CIC enumerates these services;

Home care or community-based services- The services and a brief description of each are provided. Naturally, services above this level can be included in the contract. Long-term care policies that offer this type coverage must provide at least the following:

- Home health care- skilled nursing care or similar professional services in the residence

- Adult day care- involves care on a less than round-the-clock basis. It is accomplished in a licensed facility, not the home, and can be medical or non-medical in nature, such as help with ADLs
- Personal care- Either a skilled or nonskilled person who helps with the activities of daily living. Examples of this include fixing meals, housekeeping, laundry, and taking medicines. It shall be provided under a plan of care developed under medical supervision.
- Homemaker services- this includes skills necessary for a person to remain in their home, involving a plan of care developed under medical supervision
- Hospice services- Services intended to ease the physical and mental distress of terminally ill patients. These services are not paid for by Medicare. They are administered by skilled or unskilled personnel under an approved medical plan
- Respite services- This type care is designed to relieve a principal caregiver for a short period of time. It can be provided at home, in a community-based program or an institution. "Short term" has to be defined so as not to be misconstrued. This type coverage is a separate benefit with unique benefits and conditions. (Sec. 10232.9(b) of the CIC)

**No Limits-** These are no-no's, they are not to be used as prerequisites. Home health care benefits cannot be limited in the following ways;

- Requiring a need for care in a nursing home if home care services are not provided.
- Directing that skilled nursing or therapeutic services be used before or with unskilled services.
- Requiring the existence of an acute condition before services under the long-term care contract can begin.
- Limiting benefits to services provided by Medicare-certified providers or agencies.
- Limiting benefits under the policy to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.
- Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.
- Requiring "medical necessity" or similar standard as a criteria for benefits. (Sec. 10232.9(c) of the CIC)

Comprehensive long-term care policies that provide institutional and home care and that set daily, weekly, or monthly benefit payment maximums must pay a maximum benefit payment for home care that is at least half the maximum benefit payment for institutional care, and in no event less than fifty dollars per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision. Also, comprehensive long-term care policies that set a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, are to allow a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care. (Sec. 10232.9(d) of the CIC)

### **Minimum Benefits**

The home care benefit is calculated as a percentage of the institutional care benefit. While it may vary from insurer to insurer, a choice is often given of 50%, 75%, 100%

and 150% of the institutional benefit selected. The minimum is 50% of institutional benefits and in no event can home care benefits be less than \$50 per day. So, if a \$150 daily institutional benefit was selected and the policyholder chooses a 50% Home Care Daily Benefit, the policy would provide up to \$75 a day for home care. More home care coverage should be considered by those seniors whose intention it is to remain at home (Sec. 10232.9(d) of the CIC).

## **Benefit Eligibility Triggers and Definitions**

Long-term care is the kind of assistance a person needs when assistance is needed to help with personal care. A disabling or long-term (chronic) medical condition is what usually triggers the need for this type of assistance. ADL (Activities of daily living) is a term used to mean various basic day-to-day activities, which tend to be taken for granted, but which may pose problems for older Americans.

Section 10232.8 of the CIC is very specific in the area of conditions for eligibility for long-term care insurance benefits.

## **Tax Qualified**

Qualified long-term care insurance has the following threshold for establishing eligibility for home care benefits;

Benefits under the contract must be made available to a chronically ill insured if either one of these two tests is met;

- 1.) There is impairment in two out of six activities of daily living.
- 2.) There is an impairment of cognitive ability.

Qualified long-term care insurance- The definitions of ADLs are as follows;

- 1.) Eating, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- 2.) Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.
- 3.) Continence, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- 4.) Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- 5.) Toileting, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- 6.) Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.

Health assessments are to be performed promptly with the certification completed as quickly as possible by a licensed health care practitioner to ensure that an insured's benefits (if entitled to benefits) are not delayed. Certification is to be renewed every 12 months and a written plan of care must be provided by the medical professional. Examination or certification costs do not count against the policy lifetime benefits. The term "independent of the insurer," means the medical professional is not employed or compensated by the insured. (Sec. 10232.8(c), 10233 of the CIC)

The Internal Revenue Service defines licensed health care practitioner (LHP) in very general terms. It may include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. California Insurance Code section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and "shall not be compensated in any manner that is linked to the outcome of the certification".

### **Non-Tax Qualified**

Long-term care policies not intended to be federally qualified long-term care insurance contracts, but providing home care benefits, must have at least the following qualifications;

Benefits under the contract must be made available if either one of these two standards are met;

- 1.) There is impairment in two out of seven activities of daily living (ADL's).
- 2.) There is an impairment of cognitive ability.

Non-qualified long-term care insurance- Here are the definitions of ADLs to be used verbatim in policies and certificates that are not intended to qualify under Public Law 104-191;

- 1.) Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.
- 2.) Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
- 3.) Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.
- 4.) Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.
- 5.) Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.
- 6.) Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.
- 7.) Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

The insurance contract can provide a lesser but not greater eligibility threshold and other combinations of criteria can be used or determined by the commissioner if conditions warrant (Sections 10232.8(a) and (g) of the CIC).

From time to time, federal law may call for changes in the way in which eligibility for benefits is established. If other kinds of incapacity are used by the federal government to determine disability, the commissioner can issue emergency regulations in order to bring state regulations in line with the federal.

## **Reference to the Internal Revenue Code**

As a way of understanding the precise meanings of the definition of contract provisions, the California Insurance Code refers to the Internal Revenue Code. This is done to avoid any conflicting interpretations and to preserve the tax benefits sought under these policies. Things considered to be "activities of daily living" are spelled-out in Section 7702B of the Internal Revenue Code. Definitions of other terms used in connection with long-term care contracts are provided in IRS Notice 97-31 of May 6, 1997. This notice can be accessed on the Internet from the IRS home page;

<http://www.irs.ustreas.gov>

A discussion of IRS Notice 97-31 can be found in another section of this text under the subheading "Definitions Under IRS Notice 97-31."

## **Other Criteria at Commissioner's Discretion**

In addition to the verbatim definitions, the commissioner may approve additional descriptive language to be added to the definitions, if the additional language is warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and strictly limited to that language which is necessary to ensure that definitions are not misleading to the insured. (Sec. 10232.8 of the CIC)

## **Flexible Benefits Mandated**

Long-term care policies must define the maximum lifetime benefit as a single dollar amount that can be used equivalently for any home/community based services or assisted living benefit (as previously defined). There can be no such limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home/community-based care and for assisted living care. (Sec. 10232.93 of the CIC)

## **Prohibited Practices**

**Proscriptions-** Section 10233.2(d) of the CIC provides that contracts for long-term care insurance may not do any of the following things;

- a.) Be cancelled or terminated because of the age or deterioration of the mental or physical health of the insured individual.
- b.) Contain a provision establishing a new waiting period for conversion or replacement of existing coverage by the same insurer. An exception is an increase in benefits voluntarily selected by the insured.
- c.) Provide coverage mostly or exclusively for skilled nursing care rather than lower levels of care
- d.) Provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar import.
- e.) Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.
- f.) Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits in Section 10232.9, of the CIC the assisted living benefit in Section 10232.92 of the CIC, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

## **Medical Necessity**

Home care benefits cannot be limited or excluded by requiring "medical necessity" or similar standard as a criteria for benefits. (Sec. 10232.9(c)(7) of the CIC)



## **Prior Hospitalization**

Long-term care insurance contracts are prohibited from requiring prior hospitalization before making benefits available. Nor can eligibility for benefits for institutional care or home health care benefits be predicated on previous receipt of some other, previous form of institutional care (Sec. 10232.5 of the CIC).

## **Verify Necessity**

Insurers may verify necessity with any source of independent judgment. In order that a fair and impartial determination of eligibility for services under the policy can be made, the medical practitioner must be independent of the insurance company. Use of an independent third party serves to protect the interests of all parties. If a health care practitioner makes a determination that an insured does not meet the definition of "chronically ill individual," the insured is entitled to a second assessment by a licensed health care practitioner (Sec. 10233 of the CIC).

## **Contractual Methods of Payment**

### **Reimbursement**

Long-term care policies must define the maximum lifetime benefit as a single dollar amount that can be used equivalently for any home/community based services or assisted living benefit (as previously defined). There can be no such limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home/community-based care and for assisted living care. If a long-term care policy provides reimbursement for care in a nursing facility, it shall cover and reimburse for per diem expenses, as well as ancillary expenses, up to the policy's maximum lifetime daily facility benefit. Most policies limit the number of years for which benefits will be paid. This maximum is called a Benefit Period, Maximum Benefit Period or Lifetime Maximum. Some insurers offer Lifetime or Unlimited benefits with no limitation; some short-term policies over 3-month or 6-month Benefit Periods. But most policies will pay benefits between 1 year and 10 years. Usually, the Benefit Period will be chosen when the policy is purchased. The premium cost will be higher with the choice of longer Benefit Periods.

### **Indemnity contracts**

With an indemnity contract a daily maximum benefit is provided to the insured. The indemnity contract has two options;

**Cash Benefit-** The insured receives the benefit as cash, independent of actual expenses. For instance, a cash benefit option may provide for up to \$50 per day in cash. As long as the insured qualifies for coverage, he or she would receive \$1,500 a month (30 days times \$50), regardless of actual expenses. This adds flexibility in providing the insured with cash to use at his or her discretion. Under the cash benefit charges for qualified long-term care services do not need to be incurred. However, in order to receive the cash benefit, the chronic illness or disability must be certified as set forth in the policy.

**Per Diem-** This type policy pays on a per day basis. The per diem limit for tax year 2018 was \$360 – the daily amount of benefits under a tax-qualified indemnity plan that can be received tax-free without regard to expenses incurred. Benefits in excess of the per diem limit may also be received tax-free, if they do not exceed expenses actually incurred and proof is given.

In a cash benefit example, a maximum of \$120/day might be paid for each day spent in a long-term care facility. Keep in mind that this is not an absolute amount to be paid. Rather, this is the highest dollar value that will be paid. If per diem expenditures are less than this, expenses are not paid and the patient pockets the rest. Only those expenses incurred by the caregiver(s) are paid. The most common long-term care policies are the "indemnity" policies that pay a fixed dollar amount each day that the insured receives covered care. Much less common are policies that cover a certain percentage of the costs associated with various services. Another type of policy pays a specific dollar amount to cover the actual charges for services received.

**Benefit Period-** The period of time during which the insurance policy pays costs on the insured's behalf. This period can be from one year to the remaining lifetime of the insured. The benefits under a long-term care contract can be expressed in a time-dollar value combination. That is, a number of years (it can be shown as a number of days) of benefit payouts as well as an actual maximum dollar value to be paid. Purchasers are given a choice of benefits, such as a \$50 daily and \$100,000 lifetime maximum; \$80 daily and \$150,000 lifetime maximum; or \$120 daily and \$250,000 lifetime maximum.

**Important-** Agents must make it very clear to current and prospective policyholders the significance of how the word "lifetime" is used in the context of a benefit period. A policyholder could easily assume that the "lifetime" refers to his or her lifetime and not that of the policy. Once the policy limits have been reached, the life of the policy is complete. No further payments will be made.

**Dollar Amounts-** The daily maximum benefit is a dollar amount chosen by the insured that can be affected by at least three things; daily cost of a nursing home stay, projected future ability of the insured to defray a portion of the expense, the amount of premium the insured is currently willing or able to pay.

## Definitions of Providers

Providers are defined in policies as any individual or group of individuals that provide a health care or long-term care service. Providers who are licensed in a particular area of expertise may be the only ones allowed to provide skilled or professional services.

Policies must provide benefits for care rendered by unlicensed providers if the state has no licensing requirements for that particular service. Personal care and homemaker services generally comprise these types of help. This assistance is given to and performed for the elder in their home by a family member or unskilled worker. Often a company is paid by the patient. Non-medical aid is provided and may include housekeeping, companionship, shopping, or cooking; in addition to daily living assistance (Sections 10232.9 and 10232.92 of the CIC).

## Inflation Protection

Insurers must offer to policyholders the option to purchase a long-term care policy that provides for benefit levels to increase because of increases in the costs of long-term care. Such an inflation protection policy must include at least one of these

- 1.) It increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5%.
- 2.) Guarantee that the policyholder has the right to increase benefit levels at least on each anniversary date of the policy. The additional coverage may cost more, and may be based on the attained age of the insured. An extra premium can be paid for riders that increase coverage in any of the following ways;

- a.) Increase the amount of the per diem benefits.
- b.) Increase the lifetime maximum benefit.
- c.) Increase the amount of both the nursing facility per diem benefit and the home- and community-based care benefits of a comprehensive long-term care insurance policy or certificate. (Section 10235.51(a) of the CIC)

### **Requirement to Offer**

Prospective insureds must be given the option to purchase benefit levels that account for reasonably anticipated increases in the costs of long-term care services covered by the policy. At the time of purchase insurers must offer the option to purchase an inflation protection feature which offers at least one or more of the following options:

- Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5%.
- Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status and without regard to claim status or history so long as the option for the previous period has not been declined.
- Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.

Partnership Policies use an age-based system for provision of inflation protection: Those under age 61 at date of purchase must have compound annual inflation protection. Those at least 61 years of age but under the age of 76 must have some level of inflation protection. Those over the age of 76 may have but are not required to have inflation protection. Another way to approach inflation protection is to allow the insured the choice of increasing benefits periodically, such as every two or three years. With a periodic increase option, insureds usually do not have to show proof of good health. The premium will increase if benefits are increased.

Similar requirements apply to issuers of group long-term care policies (Sec. 10237.1 of the CIC).

An inflation protection provision that increases benefit levels annually so that the increases are compounded at not less than 5% is to be included with the policy unless an insurer obtains a the following rejection of inflation protection signed by the policyholder;

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.

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Signature of Applicant

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Date (Sec. 10237.5 of the CIC)

### **Other Methods of Providing Inflation Protection**

Insurers cannot issue long-term care policies that do not offer inflation protection. Various methods of providing inflation protection include;

- Compounded inflation

- Simple inflation
- Consumer Price Index (CPI)
- Periodic increases
- Defined number of years
- Defined age

### **Waiver of Premium, Elimination/Waiting Period**

This provision allows the insured to stop paying premiums once in a nursing home and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait 60 to 90 days. Waiver of premium may not apply if a person is receiving care at home.

### **Benefit Period**

This is the length of time during which the insurer will provide benefits. It is normally expressed in a number of days or years. There can also be a maximum lifetime dollar value.

### **Restoration of Benefits**

This rider to a contract allows the insured to have a portion of the maximum benefit available under a contract to be restored during subsequent calendar years in which the insured did not require services under the contract. This applies when the benefit period is less than lifetime. There are an ever-increasing number of people who recover from illnesses that used to quickly result in death. People who have heart attacks or strokes may need long-term care for a few months, and then fully recover. Those policies containing a restoration of benefits clause eliminate the fear of all policy benefits being extinguished. The policyholder's benefits will be fully restored as long as he or she does not need care for certain periods of time (often six months) after benefits are accessed.

### **Home Modification and Other Ancillary Benefits**

Home modifications are adaptations to the living environment intended to increase ease of use, safety, security, and independence. Modifications can include:

- Changes or additions to the structure (e.g., widening doorways, adding a first floor bathroom or a ramp)
- Installing special equipment (e.g., grab bars and handrails)
- Adjusting the location of items (e.g., moving furniture)

Home modifications overlap considerably with assistive devices (e.g., bath benches, walkers), ancillary supplies and services. In addition, home modifications are often accompanied by repairs (e.g., fixing worn-out stairs) to ensure their usefulness. There is general agreement that an accessible and supportive environment is vital to the quality of life of older adults and younger persons with disabilities.

The cash benefit model of long-term care policy offers an obvious advantage for the insured in its flexibility as to how funds can be used. This allows the insured to use the cash payment for nontraditional providers of care, informal caregivers, non-licensed providers, home modifications, and other ancillary benefits that are either not covered or are covered on a more limited basis under a traditional reimbursement product.

## **Survivor Benefits**

A benefit which is paid by a policy to the designated beneficiary of the insured upon the death of the insured is a survivor benefit.

## **Return of Premium**

This is a type of nonforfeiture benefit for an LTC policy. The policyholder's estate or a designated beneficiary will be entitled to the return of some or all of your premiums if the policy isn't used during the lifetime of the beneficiary. The two types of return of premium upon death are one that can be built into a policy at a minimal cost and another is added as a rider.

## **Nonforfeiture**

Long-term care policies must offer at the time of application an option to purchase a shortened benefit period nonforfeiture benefit. Nonforfeiture refers to the non-surrender of the policy even though some act or omission has occurred on the part of the insured that, under normal circumstances, would cause the policy to terminate. The purpose of nonforfeiture provisions is to provide the insured with a mechanism where all policy values or benefits will not be forfeited, should premium payments on the long-term care policy be stopped. These provisions do not apply to life insurance policies that accelerate benefits for long-term care. The shortened benefit period nonforfeiture benefit must contain the following features:

- Eligibility begins no later than after 10 years of premium payments.
- The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.
- The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.
- The lifetime maximum benefit may be reduced by the amount of any claims already paid.
- Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.
- The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

These conditions do not apply to life insurance policies that accelerate benefits for long-term care. (Sec. 10235.30 of the CIC)

## **V. California Statutory Policy Provisions, Requirements and Terminology**

### **Company Responsibilities and Prohibitions**

It is the insurance company's responsibility that their agents have the proper tools and training to provide policies and information to consumers. Benefits and premiums vary, so does the cost of care. Consumers make the ultimate decision regarding product purchase.

## **Application and Underwriting**

### **Applications Must Ask "Yes" or "No" Health Questions**

Long-term care insurance applications should feature clear, unambiguous, simple questions- those to which only "yes" or "no" are the anticipated answers. The questions must be designed to ascertain the health condition of the applicant and can contain only one health status inquiry per question. The application may also include a request for the name of any prescribed medication and the name of a prescribing physician. A mistake in the provision of that information cannot be used as a basis for the denial of a claim or the rescission of a policy (Section 10232.3(a) of the CIC).

### **Warning on Application That Misstatements May Result in Rescission**

The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block:

"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."  
(Section 10232.3(b) of the CIC)

### **Insurer Must Have, Use and Apply Suitability Standards**

The issuer of an insurance contract is required to use the suitability standards it has developed in determining the propriety of issuing long-term care insurance coverage to an applicant. All insurers must maintain a record of rescissions, statewide and nationally, except for those initiated by the insured. This information must be reported on an annual basis to the commissioner. (Section 10232.3(f) and (h) of the CIC)..

### **No Post Claim Underwriting**

The company must resolve all underwriting issues submitted on the application. No post claim underwriting is allowed. When an insurer does not complete medical underwriting on a person, then only fraud or material misrepresentation are grounds for the denial of a claim or rescission of a policy. The fraud in question must;

Pertain to the condition for which benefits are sought

Involve a chronic condition or dates of treatment before the date of application

Be material

(Section 10232.3(d) of the CIC)

### **Every Application Shall Include a Checklist**

Applications for long-term care insurance must include a checklist for the forms and documents required to be given to the applicant at the time of policy solicitation, including the following;

- 1.) The Important Notice Regarding Policies Available
- 2.) The Outline of Coverage
- 3.) The HICAP Notice. At the time of solicitation, the consumer must be given written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides taxpayer-funded health insurance counseling to senior citizens in California.
- 4.) The long-term care insurance shoppers guide. Insurers must provide a copy of the California Department of Aging's publication, "*Taking Care of Tomorrow*, A

*Consumer's Guide to Long-Term Care*" to prospective applicants before the presentation of an application or enrollment form.

5.) The "Long-Term Care Insurance Personal Worksheet." This worksheet can be readily found in the back of the pamphlet entitled "*A Shoppers Guide to Long-Term Care Insurance*" published by the NAIC.

6.) The "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance," as found in another section of this book.

(Section 10232.3(c) of the CIC)

### **Definition of Preexisting Condition**

Pre-existing conditions are exclusions to health insurance policies. They are conditions that existed for a stated time period before the policy was purchased which the insured knew or had reason to know existed. A definition of preexisting condition cannot be used by long-term care insurance policies that is more restrictive than for medical advice or treatment recommended by, or received within six months preceding the effective date of the policy. Benefits may be excluded from long-term care insurance policies for a waiting period of six months following the effective date of the policy for pre-existing conditions. This does not apply to an employer's group policy. (Sec. 10232.4(a) of the CIC)

The way preexisting conditions are defined does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant. Based on the application answers, the insurer can underwrite in accordance with that insurers established underwriting standards. Regardless of whether it is disclosed in the application, a preexisting condition does not have to be covered until the policy prescribed waiting period expires. Only if the policy specifically states otherwise does a preexisting condition have to be covered.

### **No New Preexisting Conditions on Replacement Policies**

No long-term care policy can exclude any specifically named or described preexisting diseases or physical conditions beyond the six-month waiting period previously described. It must be pointed out to a consumer in a notice that health conditions which he or she may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under existing coverage (Sec. 10235.18(a)(1) of the CIC).

### **Contestability Period is Two Years**

The contestability period for long-term care insurance is two years (Sec. 10232.3(f) of the CIC).

### **Completed Application Must be Delivered with Policy**

At the time the policy or insurance certificate is delivered, a copy of the completed application must also be rendered to the insured (Sec. 10232.3(f) of the CIC).

### **Protection against Unintentional Lapse**

Applicants for long-term care coverage must be given the right to designate at least one person other than the applicant, to receive notice of policy lapse due to nonpayment. Applicants need to supply the insurer;

- A written designation listing the name, address, and telephone number of at least one individual other than the applicant who is to receive notice of lapse of policy
- A waiver is required from the applicant, electing not to designate additional persons to receive notice. Here is the notice form;

#### Protection Against Unintended Lapse.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



The insured has the right to change the designee at least every two years. If premiums are paid via a payroll or pension deduction plan, the written designee is not required. The application for long-term care must clearly indicate that some type of deduction/drafting plan is in effect. Within 60 days after the policyholder leaves any such arrangement, the requirements concerning written designee or waiver as outlined above must be met. At least 30 days before the lapse of a policy, the insurer must mail notice to the insured and the other parties designated to receive the information. As a further means of protecting the insured, long-term care policies must provide at least a five month reinstatement period if evidence is presented that the insured suffers loss of functional capacity or cognitive impairment. (Sec. 10235.40 of the CIC)

#### Inflation Protection

In or with the Outline of Coverage, insurers are to include the following information.

A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

It is acceptable for the insurer to use a reasonable hypothetical or graphic demonstration for purposes of the particulars for the above-mentioned disclosure (Sec. 10237.6 of the CIC).

An inflation protection provision that increases benefit levels annually so that the increases are compounded at not less than 5% is to be included with the policy unless an insurer obtains the following rejection of inflation protection signed by the policyholder;

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date (Sec. 10237.5 of the CIC)



## Reporting Requirements

### Insurers Must File Rescission Annually

All insurers must maintain a record of rescissions, statewide and nationally, except for those initiated by the insured. This information must be reported on an annual basis to the commissioner. (Sec. 10232.3(h) of the CIC)

### Insurers Must Report the Number of Replacement Sales and Lapses

Insurance companies must keep records for each agent's replacement sales. The data is to be expressed as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

$$\% \text{ Replacement} = \frac{\$ \text{ amount of replacement sales}}{\$ \text{ value of total annual sales}}$$

$$\% \text{ lapses} = \frac{\$ \text{ value of LTC lapses}}{\$ \text{ value of total annual sales}}$$

By June 30<sup>th</sup> of each year, insurers must report the following data to the state. The period covered by the information is the preceding calendar year. The purpose of such reporting is to monitor agent activity with respect to sale of long-term care policies. Lapse and replacement rates do not connote wrongdoing.

- ▶ They must report the 10% of agents with the greatest percentage of lapses and replacements according to these formulas. By the same deadline the following facts must also be forwarded to the state.

- ▶ The number of lapsed policies as a percent of the insurers total annual sales, shown as a percentage of the total number of policies in force in the state and as a total number of each policy form in the state.

- ▶ Report the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force in the state. (Sec. 10234.86 of the CIC)

### Insurers Must File Personal Worksheet Upon Each Rate Increase

Before an insurer can consider an applicant for coverage, the applicant must complete and return a personal worksheet. Worksheet information must be kept confidential by the insurer. The worksheet requirement does not apply to group insurance certificates. In the event that an applicant does not meet the insurer's financial suitability standards or if the applicant declines to provide the information, the application may be rejected. A different approach is to send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the NAIC. A sample can be seen at Figure V - 3. In the event the applicant declines to provide the requested financial information, some other means can be used to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification can be included in the applicant's file.

A new personal worksheet shall be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner (Section 10234.95(c)(4) of the CIC).

Insurers are to annually report the total number of applications received to the commissioner. Additional information to be reported is the number of people who did not want to provide information on the personal worksheet, the number of applicants who did not meet suitability standards, and the number who chose to conform after receiving the suitability letter. The requirements listed here do not apply to accelerated benefits for long-term care under life insurance policies. (Sec. 10234.95(i) of the CIC)

## Personal Worksheet

### Figure V – 1 Personal Worksheet

#### Long-term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

#### Premium Information

Policy Form Numbers \_\_\_\_\_

The premium for the coverage you are considering will be [\$\_\_\_\_\_ per month, or \$\_\_\_\_\_ per year,]  
[a one-time single premium of \$\_\_\_\_\_.]

**Type of Policy** (noncancellable/guaranteed renewable): \_\_\_\_\_

**The Company's Right to Increase Premiums:** \_\_\_\_\_

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.]  
[Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

**Rate Guide-** A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site ([www.insurance.ca.gov](http://www.insurance.ca.gov))."

#### Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

**Drafting Note:** A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

### Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income

☐ From my Savings/Investments

☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

**Drafting Note:** The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) ☐ Under \$10,000    ☐ \$[10-20,000]    ☐ \$[20-30,000]    ☐ \$[30-50,000]    ☐ Over \$50,000

**Drafting Note:** The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change

☐ Increase

☐ Decrease

*If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

**Will you buy inflation protection?** (check one) ☐ Yes    ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income

☐ From my Savings/Investments

☐ My Family will Pay

*The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.*

**Drafting Note:** The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

**What elimination period are you considering?** Number of days \_\_\_\_\_ Approximate cost \$ \_\_\_\_\_ for that period of care.

**How are you planning to pay for your care during the elimination period?** (check one)

☐ From my Income

☐ From my Savings/Investments

☐ My Family will Pay

### Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under \$20,000

☐ \$20,000-\$30,000

☐ \$30,000-\$50,000

☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same

☐ Increase

☐ Decrease

*If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.*

## Disclosure Statement

☐ The answers to the questions above describe my financial situation.

**Or**

☐ I choose not to complete this information.  
(Check one.)

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: \_\_\_\_\_  
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed: \_\_\_\_\_  
(Agent) (Date)

Agent's Printed Name: \_\_\_\_\_]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: \_\_\_\_\_ ]  
(Applicant) (Date)

**Drafting Note:** Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

*The company may contact you to verify your answers.*

**Drafting Note:** When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.



## Insurers Must File Commission Structure for Replacement Coverage

Any time long-term care coverage is replaced, the sales commission paid by the insurer shall be calculated based on the difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission is limited to the percentage of sale normally paid for policy renewal. Replacement shall be contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured. In this context "commission or other compensation" means remuneration of any kind relating to the sale such as bonuses,

gifts, prizes, awards, and finder's fees. Insurers selling LTC policies must file the commission structure or an explanation of the insurer's compensation plan with the commissioner. Any amendments to the commission structure shall be filed with the commissioner before implementation. (Sec. 10234.97(c) of the CIC)

### **Insurers Must Semiannually File All Agents Authorized to Sell Long-Term Care Insurance**

Every six months insurers are to submit or update to the commissioner a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance (Sec. 10234.97(a)(3) of the CIC).

### **Insurers Must File Initial Premium Rates**

Section 10236.11 of the CIC informs that rate schedules for individual and group policies must be filed and receive prior approval before being marketed. All initial rate filing are subject to the following conditions:

- The actuary performing the review of the initial premium schedule must certify that the rate is sufficient to cover anticipated costs. This guarantee can rely on supporting data in the filing. An actuarial demonstration can be used to demonstrate the assumptions are reasonable. The actuarial demonstration can include either premium and claim experience (adjusted for differences) on similar policy forms relevant and creditable data from other studies, or both.
- The following information is required for approval of a rate filing:
  - An actuarial memorandum describing assumptions used by the insurer to develop rates
  - An actuarial certification stating the following:
    - Initial premium rate is sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule is reasonably expected to be sustainable
    - Policy design and coverage have been reviewed and taken into consideration.
    - The underwriting and claims adjudication processes have been reviewed and taken into consideration
  - Description of the basis for contract reserves that are anticipated
    - Sufficient detail or sample calculations provided
    - Assumptions used for reserves contain reasonable margins for adverse experience
    - Net valuation premium for renewal years does not increase (except for attained-age rating where permitted).
  - The difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses. If this is not the case, what is needed is a complete description of the situations in which this does not occur and the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.
  - A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms

### **Insurers Must File All Rate Increase Requests for Approval**

Premium rate schedule increases that have been approved are subject to the following:

- For each rate increase that is implemented, the insurer files for approval by the commissioner updated projections (defined in first paragraph of Sec. 10236.13(b) of the CIC) annually for the next three years and includes a comparison of actual results to projected values. The commissioner may extend the period to greater than three years.
- If the commissioner determines actual experience following a rate increase does not adequately match projected experience and that current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of

premiums specified above, the commissioner may require the insurer to implement any of the following:

- Premium rate schedule adjustments
- Other measures to reduce the difference between the projected and actual experience

In determining whether the actual experience adequately matches the projected experience, consideration should be given to Sec. 10236.13(b) fifth paragraph of the CIC, if applicable. If the commissioner demonstrates, based upon credible evidence that an insurer has engaged in a persistent practice of filing inadequate premium schedules the commissioner may, after proper notice, prohibit the insurer from filing and marketing comparable coverage for up to five years. This section shall not apply to life insurance policies and certificates that accelerate benefits for long-term care. (Sec.10236.15 of the CIC)

## **Required Policy Definitions**

Here are some terms that must be defined in an insurance policy so as to meet and satisfy the following requirements;

Medicare- It is to be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended," or "Title I, Part I of Public Law 89-97, as enacted by the 89<sup>th</sup> Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import. (Sec. 10235.2(a) of the CIC)

Other services defined- Those such as "Skilled nursing care," "intermediate care," "home health care," shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is required to be delivered. All definitions that relate to the providers of these and other services must follow these guidelines: The providers of services shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified. (Sec. 10235.2(b) of the CIC)

## **Home Care**

Home care or community-based services- The services and a brief description of each are provided. Naturally, services above this level can be included in the contract. Long-term care policies that offer this type coverage must provide at least the following:

- Home health care- skilled nursing care or similar professional services in the residence
- Adult day care- involves care on a less than round-the-clock basis. It is accomplished in a licensed facility, not the home, and can be medical or non-medical in nature, such as help with ADLs
- Personal care- Either a skilled or nonskilled person who helps with the activities of daily living. Examples of this include fixing meals, housekeeping, laundry, and taking medicines. It shall be provided under a plan of care developed under medical supervision.
- Homemaker services- this includes skills necessary for a person to remain in their home, involving a plan of care developed under medical supervision
- Hospice services- Services intended to ease the physical and mental distress of terminally ill patients. These services are not paid for by Medicare. They are administered by skilled or unskilled personnel under an approved medical plan
- Respite services- This type care is designed to relieve a principal caregiver for a short period of time. It can be provided at home, in a community-based program or an

institution. "Short term" has to be defined so as not to be misconstrued. This type coverage is a separate benefit with unique benefits and conditions. (Sec. 10232.9(b)(1-6) of the CIC)

### **Residential Care Facility for the Elderly (RCFE)**

A "Residential care facility" means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code (Sec. 10232.92(a) of the CIC). Portions of large residential facilities, CCRC's, often have an RCFE license. This assisted living option is designed for the more mentally alert resident who needs occasional assistance. The residents live in their own unit and have scheduled appointments for assistance with bathing, dressing or other ADL's. There are other RCFE facilities that are licensed to provide custodial care. All RCFE's are considered board-and-care facilities but when thinking of board-and-care homes, people commonly associate the term with smaller, custodial care facilities. See IV H for California Department of Social Services (CDSS) Community Care Licensing Division (CCLD) info on RCFEs.

The reader will note that the terms 'Board and Care' and 'Assisted Living' have no legal standing in California law. References to the terms are always directed back to RCFE.

### **Consumer Protection**

All insurers and insurance professionals owe the policyholder, or a prospective policyholder, a duty of honesty, good faith and fair dealing. This applies to long-term care insurance as well as other forms of insurance transactions. The legal issues involving long-term care are challenging, the ethical issues can be seen as even more complex. Dealing with fiduciary matters involving the elderly is a formidable task. When it is someone the public perceives as frail, grandmotherly, and perhaps lacking cognitive skills, the agent's conduct must always be above board. The best advice is the same as applies in other situations: document everything and don't make decisions for people. (Sec. 10234.8 of the CIC)

### **Shortened Benefit Period**

Long-term care policies must offer at the time of application an option to purchase a shortened benefit period nonforfeiture benefit. Nonforfeiture refers to the non-surrender of the policy even though some act or omission has occurred on the part of the insured that, under normal circumstances, would cause the policy to terminate. These provisions do not apply to life insurance policies that accelerate benefits for long-term care. The shortened benefit period nonforfeiture benefit must contain the following features:

- Eligibility begins no later than after 10 years of premium payments.
- The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.
- The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.
- The lifetime maximum benefit may be reduced by the amount of any claims already paid.
- Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.
- The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

These conditions do not apply to life insurance policies that accelerate benefits for long-term care. (Sec. 10235.30 of the CIC)

### **Distinguish Between Groups and Individual Disclosure in Certificates**

Group Insurance- Any long-term care group policy issued in California must meet these requirements;

- \*The master policy and certificate, outline of coverage, and advertising must be filed with the commissioner 30 days in advance of issue.
- \*Must be an association organized for a purpose other than that of obtaining insurance. (Automobile dealers, unions, social, etc.)
- \*The group is ongoing and holds periodic meetings involving representatives of its constituency, and files details concerning same with the commissioner of insurance (Sec. 10232 of the CIC)

The group policyholder is issued the master policy and each individual insured receives a certificate of insurance specifying the following:

- ♦A statement of the exclusions and limitations contained in the policy
- ♦A description of the terms by which the policy or certificate can be continued or discontinued, along with a notification of the insurer's right to change premiums
- ♦A recital of the principal benefits and coverage provided by the policy
- ♦Explanation of continuation, conversion and replacement rights of the insured
- ♦Recognition that the group master policy determines contract provisions, not the certificate. (Sec.10233.6 of the CIC)

### **30-day Free Look**

Individual policy applicants (not group) have the option to return a policy by mail if not satisfied with the product. The policy can be mailed back within 30 days for a full refund of the premium. Such an action by the applicant voids the policy and puts both parties back in the position they were in before the policy was issued. Policies must have information regarding this return feature printed prominently on the first page of the policy. (Sec. 10232.7 of the CIC)

### **Right to Reduce Coverage and Lower Premiums**

Every policy must grant the following rights to reduce coverage and lower premiums. After the first year, the policyholder has the right to lower the premium in one of the following three ways;

- Reduction of the lifetime benefit
- Lowering the nursing facility per diem and reducing home and community-based service benefits of a home care only policy and of a comprehensive long-term care policy.
- Changing a "comprehensive long-term care" contract to a "Nursing Facility Only" or a "Home Care Only" policy or certificate. Of course, this can only be accomplished if the insurer issues those type policies in the state.

The new or converted policy will have a premium based on the age of the insured as of the original issue date. If the original contract had provisions for cost-of-living/cost-of-care increases, then the new policy will reflect the same. If a policy is on the verge of lapsing, the insurer must provide written notice to the insured of the options as outlined in the preceding paragraphs. Additional options may be included. The notice will give the insured at least 30 days in which to elect to reduce coverage and the policy shall be reinstated without underwriting if the insured elects the reduced coverage. In the event of



premium increases, the insured must be offered the option of lower premiums and reduced coverage. (Sec. 10235.50 of the CIC)

### **Right to Increase Coverage**

Similar to the idea of downgrading coverage, by each anniversary date each insured must be given the option to pay extra premium for riders that will increase coverage in the following ways;

- Increase the amount of the per diem benefits
- Increase the lifetime maximum benefit
- Increase the per diem amounts for nursing facility, home-based and community-based benefits

Premiums for such riders can be based on the attained age of the insured, without impacting the premium for the original policy or certificate (Sec. 10235.51 of the CIC).

### **Insurer May Require Insured to Undergo New Underwriting**

The carrier may require new underwriting for the riders and the insurer may restrict the age and amount of the additional coverage to the same as that for similar new policies. (Sec. 10235.51 of the CIC)

### **Policy Replacement**

Replacement & reduction- An insurer replacing an existing long-term care policy must waive any preexisting condition or probationary period requirements applicable to comparable probationary periods that were fulfilled under the previous policy. Benefits for long-term care insurance cannot be reduced because of out-of pocket expenditures by the insured or by others on the insured's behalf. (Sections 10233.3, 10233.4 of the CIC)

### **Premium Credits for Replacement Policies**

In the event of replacement of a previously issued policy or certificate, the insurer must grant premium credits. This is applied to all future premium payments.

### **Five Percent of Prior Annual Premium**

The credits go towards the premiums on the new policy and are equal to 5% of the former policy's annual premium value. The premium credit is cumulative for every year the policy was in force but does not have to exceed 50% of the old annual premium value.

### **Example 1**

Mr. Jones held a long-term care policy issued by Company A for eight years. The policy's annual premium was \$1,000 per year. An agent offers a new policy to Mr. Jones with more benefits. That is, it materially improves the position of the insured. The new policy has an annual premium of \$1,600 yearly. Thus,

$$\begin{array}{l} 8 \text{ yrs} \times 5\% = 40\% \text{ premium credit} \\ 40\% \times \$1,000 = \$400 \text{ premium credit for new policy} \\ \begin{array}{rcl} \text{new policy} & & \$1,600 \\ \text{less credit} & & \underline{\leq 400} \\ \text{annual premium} & & \$1,200 \end{array} \end{array}$$

### Example 2

A second example premium credits; Ms. Smith held a long-term care policy issued by Company B for eleven years. The policy's annual premium was \$1,000 per year. An agent offers a new policy to Ms. Smith that materially improves her position as an insured. The new policy has an annual premium of \$1,400 yearly. Thus;

11 yrs x 5% = 50% premium credit (it does not have to exceed 50%)

50% x \$1,000 = \$500 premium credit for new policy

new policy	\$1,400	
less credit	<u>&lt; 500&gt;</u>	
annual premium	\$ 900	>> <u>\$1,000</u>

In this example the resulting premium for the new policy comes out less than that for the old policy. However, the cumulative credits allowed need not reduce the premium for the replacement policy or certificate to a figure less than the premium of the original policy. In this example, the annual premium would not be lower than \$1,000.

The premium credit system does not apply to life insurance policies that accelerate benefits for long-term care. The premium credit only applies when a replacement policy comes from the same company and no premium credit is due if a claim has been filed on the policy. (Sec. 10234.87 of the CIC)

### Replacement Policy Conversions

Group insurance LTC in California must provide for continuation or conversion coverage for the certificate holder if the group coverage terminates for any reason except the following:

- The termination of group coverage resulted from the insured's failure to make any required payment of premium or contribution when due.
- The terminating coverage is replaced within 31 days by new group coverage effective on the day following the termination and the replacement coverage meets both of the following criteria:
  - ♦ The replacement coverage provides benefits identical, substantially equivalent to, or in excess of, those provided by the terminating coverage.
  - ♦ The premium for the replacement coverage is calculated on the insured's age at the time of issue of the group certificate for the coverage which is being replaced. If the coverage being replaced has itself replaced previous group coverage, the premium for the newest replacement coverage is calculated on the insured's age at the time the previous group certificate was issued.

Conversion coverage- This means an individual policy of long-term care insurance must be made available to each certificate holder, without regard to insurability, and containing identical or substantially equivalent benefits to the group policy. The term 'substantially equivalent' must take into consideration the relative advantages of managed care plans that use restricted provider networks, considering items such as service availability, benefit levels, and administrative complexity.

The premium for the converted policy shall be calculated on the insured's age at the time the group certificate was issued. If adequate notice is given to certificate holders, the insurer may require the following before issuing conversion coverage;

- 1.) The individual must have been continuously insured for at least six months immediately prior to termination

- 2.) Written application and payment for conversion must be submitted by the insured within a reasonable period after termination of the group coverage.
- 3.) A provision for a reduction of benefits can be contained in the conversion policy if the insured has existing long-term care insurance, payable on an expense-incurred basis, which, together with the conversion policy, would result in payment of more than 100 percent of incurred expenses. Such a provision shall not be included in the conversion policy unless the reduction in benefits is reflected in a premium decrease or refund.
- 4.) The conversion policy contains a provision limiting the payment for a single claim, spell of illness, or benefit period occurring at the time of conversion, to the amount that would have been payable had the group coverage remained in effect. (Sec. 10236.5 of the CIC)

Continuation and conversion- Section 10236.5 of the CIC addresses this area.

"Continuation coverage" applies to an individual who is eligible for group insurance because of relationship, not membership, and who may need to continue coverage after death or divorce of the group member. Coverage is maintained under the group policy for this individual for a time period prescribed by law.

"Conversion coverage" applies when the insurer terminates the group coverage. It means an individual policy of long-term care insurance must be made available to each individual, without regard to insurability, and containing identical or substantially equivalent benefits to the group policy. The former group member must pay the entire premium. The individual certificate holder must make timely application for the individual policy. The person must also have been in the group insurance program for at least six months prior to the termination of the group insurance policy.

### **Exchange from Group Non-Tax Qualified to Tax Qualified**

Insurers that offer policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders to life insurance policies providing long-term care coverage, to fairly and affirmatively concurrently offer and market policies and certificates that are not intended to be federally qualified long-term care.

Group policies issued prior to January 1, 1997, can remain in force. If a particular policy is non tax-qualified, the insurer is required to offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.

### **Long-Term Care Personal Worksheet with Company-Specific Premium Increase Information**

Insurance companies must file a copy of the proposed personal worksheet for approval by the commissioner. Each time a rate is increased in California, a new personal worksheet is to be filed for approval by the commissioner. The same holds true each time a new policy is filed for approval by the commissioner. The new personal worksheet is to disclose the following;

- The amount of the rate increase in California
- All prior rate increases in California
- All prior rate increases and rate increase requests or filings in any other state

Insurers will start using the new personal worksheet within 60 days of approval by the commissioner in place of the previously approved personal worksheet.

The new personal worksheet will disclose the rate increases past and proposed in California as well as rate increase requests or filings in any other state. The new personal worksheet can be deployed by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet (Sec. 10234.95(c)(4) of the CIC).

### **Option to Increase Coverage**

Article 5, Section 10237-10237.6 of the California Insurance Code, titled "Inflation Escalator and Benefit Increases," applies to all long-term care insurance contracts made after January 1, 1991.

### **Insurer Must Offer Inflation Protection**

Insurers must offer to policyholders the option to purchase a long-term care policy that provides for benefit levels to increase because of increases in the costs of long-term care. In addition to any other inflation protection, the option to purchase a policy or certificate that provides for benefit levels and benefit maximums to increase to account for reasonably anticipated increases in the costs of services covered by the policy. Such an inflation protection policy must include at least one of these;

- It increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5%.
- Guarantees the insured the right to periodically increase benefit levels without providing evidence of insurability and without regard to claim status or history so long as the option for the previous period has not been declined.
- The amount of the additional benefit will not be less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.
- Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.

### **Five Percent Compounded Annually Unless Applicant Signs Rejection Rejection Statement Must Be Verbatim**

It is mandatory that the 5% benefit increase feature be included in long-term care policies unless the insured specifically rejects it. The rejection of the inflation protection provision must be signed by the policyholder and must be worded in the form prescribed in Sec. 10237.5(b) of the CIC;

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject inflation protection."

---

Signature of Applicant

---

Date

### **Statutory Requirements**

As noted several places in this book, policyholders and applicants for long-term care insurance must be offered at least 5% annual compounded inflation protection. If the applicant does not desire such protection, a statement must be signed refusing such protection before a policy can be issued. The next section looks at increases in California

long-term care costs based on data from the Office of Statewide Health Planning and Development (OSHPD).<sup>8</sup>

### Past Increases in California Long-Term Care Costs

Shown below is a schedule of annual increases in California nursing home rates;

It is for the period 1996 through 2016. The Office of Statewide Health Planning & Development (OSHPD) provides the data. The figures through 1997 are from the "Aggregate Long-Term Care Facility Financial Data Summary" and reflect net revenue by payer for "self-pay" and "other" (presumably insurance pay) categories. The 1998 and 1999 data are from OSHPD's "Long-Term Care Facility Annual Financial Data Report." The 2000 – 2002 data are from the OSHPD's "Long-Term Care Facility Annual Financial Disclosure Report." The 2003-2016 data are from the OSHPD's "Long-Term Care Facilities Annual Financial Data Reports."

The increase from 1996-2016 was \$154.98 – an increase of 140%. In the 20 years reported since 1996. That comes out to a compounded increase around 4.5% yearly.

**Table V – 1 Nursing Home Historical Cost of Care**

Year	Average Daily Nursing Home Rate	Increase From Previous Year	CPI	% Change
1996	110.78	4.0%	156.9	3.0% <sup>9</sup>
1997	112.98	1.9%	160.5	2.3%
1998	123.81	9.6%	163.0	1.6%
1999	129.43	4.5%	166.6	2.2%
2000	137.23	6.0%	172.2	3.4%
2001	143.63	4.7%	177.1	2.5%
2002	153.37	6.8%	179.9	1.3%
2003	158.11	3.1%	184.0	2.3%
2004	168.71	6.7%	188.9	2.7%
2005	178.77	6.0%	195.3	3.4%
2006	189.39	5.9%	201.6	3.2%
2007	198.17	4.6%	207.3	2.8%
2008	205.34	3.6%	215.3	3.8%
2009	213.49	4.0%	214.5	(0.4)%
2010	221.14	3.5%	218.1	1.6%
2011	229.66	3.8%	224.9	3.1%
2012	233.53	1.7%	229.6	2.0%
2013	241.45	3.4%	232.9	1.4%
2014	244.75	1.4%	236.7	1.6%
2015	253.04	3.4%	237.0	0.1%
2016	265.76	5.0%	240.0	1.3%

<sup>8</sup> The OSHPD website enjoins its information users; *Attention Data Users: Please exercise caution when interpreting OSHPD data. The use of improper assumptions and analytical methods may result in erroneous or misleading conclusions. Conclusions drawn from OSHPD data are the sole responsibility of the user. Users should be aware that financial and utilization data products are based on a dynamic database that is constantly being updated. As a result, the same data item for a facility may change over time or be different between products.*  
<http://www.oshpd.ca.gov/HID/Products/LTC/AnnFinanclData/FinancialTrends/default.asp>

<sup>9</sup> Data from the previous year are available but not shown

To determine the nominal rate when present value and future amount are known (using logarithms):

$$R = \left( \frac{S}{P} \right)^{\frac{1}{n}} - 1 \text{ -or- } (1 + R)^n = \frac{S}{P}$$

where

R = Rate of Interest per Period

S = Future Amount

P = Present Value

N = Number of Conversion Periods

These things used to be ciphered with pencil, paper, and a log table. The hand-held financial calculator rendered the use of formulas obsolete. The Internet now provides time value of money calculators for such purposes.

Compare the annual percentage increases in nursing home costs with the changes in the consumer price index (CPI) for the year in the rightmost column. There are several big jumps on the table. The annual increases in recent years have trended downwards and are below 5% but they still exceed the CPI. The **Change in CPI** information is from the Bureau of Labor Statistics, CPI-All Urban Consumers, base period: 1982-84=100.

### Cost of Nursing Home Care Today

The most current data for nursing home rates runs through 2016. The statewide daily average for nursing home care is \$265.76. The data are provided by the OSHPD. Much interesting data can be obtained from the OSHPD pages on the Internet and it behooves the professionals involved in the provision of long-term care insurance to remain up-to-date. Here are examples of nursing home costs from the OSHPD website;

**Table V - 2 Regional Cost of Care**

<u>Region</u>	<u>Net Operating Revenue Per Patient Day</u>
San Francisco County	\$369.24
Los Angeles County	289.82
San Diego County	315.74
Statewide	265.76

### Life Expectancy for Applicants at Different Ages

Here is a table that shows the life expectancy for individuals at different ages. The California Department of Public Health, Center for Health Statistics, Office of Health Information and Research provide the chart and data. Half will live longer and half less than average, but persons healthy enough to qualify for LTC insurance are expected to live longer than average.

**Table V - 3 Life Expectancy Table**

STATE OF CALIFORNIA, CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY,  
DEPARTMENT OF PUBLIC HEALTH

ABRIDGED LIFE TABLE CALIFORNIA, 2004 FOR TOTAL POPULATION								
Age Interval	Proportion Dying			Of 100,000 Born Alive		Stationary Population		Average Remainin g Lifetime
	Uncorrected	Correction Term	Corrected					
Period of Life Between Two Exact Ages	Average Annual Death Rate	Fraction of Last Age Interval Lived	Proportion Dying During Age Interval	Number Living at Beginning of Age Interval	Number Dying During Age Interval	In the Age Interval	In this and All Subsequent Age Intervals	Average Remaining Years of Life
0-1	—	0.177347	0.00516	100,000	516	99,573	8,020,023	80.20
1-5	0.00025	0.40036	0.00099	99,484	99	397,699	7,920,450	79.62
5-10	0.00013	0.50429	0.00064	99,385	63	496,769	7,522,751	75.69
10-15	0.00015	0.58096	0.00075	99,322	75	496,453	7,025,982	70.74
15-20	0.00058	0.59917	0.00287	99,247	285	495,664	6,529,530	65.79
20-25	0.00083	0.49584	0.00416	98,962	412	493,772	6,033,865	60.97
25-30	0.00078	0.49343	0.00388	98,550	382	491,782	5,540,093	56.22
30-35	0.00087	0.52497	0.00436	98,168	428	489,823	5,048,311	51.43
35-40	0.00120	0.52475	0.00600	97,740	586	487,307	4,558,489	46.64
40-45	0.00191	0.53592	0.00951	97,154	924	483,625	4,071,182	41.90
45-50	0.00304	0.52885	0.01510	96,230	1,453	477,725	3,587,557	37.28
50-55	0.00450	0.52113	0.02227	94,777	2,111	468,829	3,109,832	32.81
55-60	0.00636	0.52590	0.03135	92,666	2,905	456,443	2,641,003	28.50
60-65	0.00947	0.52373	0.04631	89,761	4,157	438,906	2,184,560	24.34
65-70	0.01430	0.52682	0.06915	85,604	5,919	414,016	1,745,654	20.39
70-75	0.02274	0.52421	0.10787	79,685	8,596	377,974	1,331,638	16.71
75-80	0.03610	0.52024	0.16611	71,089	11,809	327,118	953,664	13.42
80-85	0.05928	0.51837	0.25939	59,280	15,377	259,372	626,546	10.57
85 +	0.11957	fin	1.00000	43,903	43,903	367,174	367,174	8.36

### Future Nursing Home Costs

Here are some figures that illustrate the future costs of nursing home care;  
Assumptions- We will assume that the individual going in for a nursing home stay is destined to reside there for 2¼ years. Assume for this example nursing home cost increases of 5% per year. The statewide average cost for a nursing home stay as indicated in Table V - 1 is \$265.76 per day. With this information we can determine the following.

Cost for the stay in today's dollars = \$218,255.40  
(2.25 x 365 x 265.76)

Cost for the nursing home stay in the future;  
In 14 years..... \$432,130.76  
' 20 years..... 579,096.55  
' 30 years..... 943,287.26

These figures are determined using the compound interest formula:

$$S = P(1+R)^n$$

where

S = Compound Amount or Future Value

P = Principal

R = Interest Rate per Period

n = Number of Conversion Periods

It can be seen from the price increases that inflation has a noticeable effect on the cost of a nursing home stay.

Policies without inflation protection- Policies can be purchased that offer benefits equal to the average nursing home cost in today's dollars. It is worth noting the out-of-pocket expenses that will be incurred by the insured with such a policy, using the same assumptions and time frames as above.

Cost of 2¼ yr. stay in 14 years	\$432,130.76
Benefits paid in today's dollars	<u>218,255.40</u>
Out-of-pocket (OOP) expense	\$213,875.36

Daily OOP (213,875.36 ÷ 821.25 days)     \$260.43

Cost of 2¼ yr. stay in 20 years	\$579,096.55
Benefits paid in today's dollars	<u>218,255.40</u>
Out-of-pocket (OOP) expense	\$360,841.15

Daily OOP (360,841.15 ÷ 821.25 days)     \$439.38

Cost of 2¼ yr. stay in 30 years	\$943,287.26
Benefits paid in today's dollars	<u>218,255.40</u>
Out-of-pocket (OOP) expense	\$725,031.86

Daily OOP (725,031.86 ÷ 821.25 days)     \$882.84

Policies with partial protection- Policies may also be purchased whose benefits increase in value using simple rather than compound interest. The value of benefits paid in the future would be calculated using a simple interest formula;

$$M_v = P(1+RT)$$

Where

$M_v$  = Maturity value (future value)

P = Principal amount

R = Rate of interest

T = Time frame

Here is a breakdown of the out-of-pocket expenses that will be incurred using just such a policy, again with the same set of assumptions. We refer to the benefits derived with simple interest as benefits derived from "simple increases."



Cost of 2¼ yr. stay in 14 years	\$432,130.76
Benefits paid with simple interest	<u>371,034.18</u>
Out-of-pocket (OOP) expense	\$61,096.58
Daily OOP (61,096.58 ÷ 821.25 days)	<u>\$74.40</u>
Cost of 2¼ yr. stay in 20 years	\$579,096.55
Benefits paid with simple interest	<u>436,510.80</u>
Out-of-pocket (OOP) expense	\$142,585.75
Daily OOP (142,585.75 ÷ 821.25 days)	<u>\$173.62</u>
Cost of 2¼ yr. stay in 30 years	\$943,287.26
Benefits paid with simple interest	<u>545,638.50</u>
Out-of-pocket (OOP) expense	\$397,648.76
Daily OOP (397,648.76 ÷ 821.25 days)	<u>\$484.20</u>

As the benefits increase, the premiums will also increase. It is a trade-off as to what the insured prefers (or can afford, for that matter). Spend more for premiums today or more on out-of-pocket expenses in the future.

### **Direct Impact**

Inflation has a direct impact on the amount of coverage sought by insureds. When the contract is purchased, consumers choose a daily benefit, usually from \$40-\$250. With time, inflation pushes up the cost of care while the policy benefit levels remain constant. The inflation rider is offered by many companies as the solution to the problem. The consumer must decide at the time of purchase whether to take the inflation rider. It can double the annual premium when the policy is purchased from the 40-mid 50's age range. This may be a hard decision when weighing value and price, especially with other family demands pulling at the pocketbook. Still, many experts recommend that younger purchasers take the inflation rider. Some insurers address the problem with a guaranteed increase option. This allows the policyholder to periodically increase the daily benefit a certain amount with no new underwriting. Without such an option or the inflation rider, the only way a policyholder can increase long-term care coverage is to switch to a new policy with higher benefits. That can get expensive since it requires new underwriting and pricing.

As the examples in this section illustrate, inflation is a four-letter word to economists. It is the phenomenon of too much money chasing too few goods and services, manifested as a persistent increase in the general level of prices. It is normally associated with a devaluing of the worth of money. Inflation is a recurring but only intermittent historical occurrence. Its most serious recent appearance occurred in the 1970's in the wake of the quadrupling of oil prices in 1973, when annual inflation rates in the developed world rose as high as 25%. For the rest of the post-war period it has not been unusual for the inflation rate to be exceeded by the real growth rate. A crucial feature of inflation is that price rises are sustained.

Accounts of the causes of inflation are numerous. Among the most popular arguments are these;

- 1.) Demand-Pull Inflation- It is caused by excess demand in the economy.
- 2.) Cost-Push Inflation- It is caused by high costs.
- 3.) Monetarism- It results from excessive increases in the money supply.

These causes often amount to the same thing. All are beyond the scope of this book. All three of the causes amount to an attempt by a nation to live beyond its means, or to enjoy a living standard higher than that allowed by its output and borrowing. This implies that inflation can rarely be cured by a measure that does not suppress attempts at maintaining high living standards and explains why the reduction of inflation is associated with austerity measures. Since the inflation phenomenon exists, policyholders and potential purchasers of long-term care insurance must be protected against the erosion in value of their purchasing power. Insurers must offer an inflation protection long-term care policy that provides for benefit levels to increase because of increases in the cost of long-term care.

### **Mandated Offer Goes to Group Policyholder**

Group insurers (as defined in subdivision (a), (b), or (c) of Section 10231.6) are to offer inflation protection to certificate holders, but are relieved of the obligation if the holder of the group policy declines the insurer's offer. (Section 10237.1(d) of the CIC)

Unless the group is a continuing care retirement community, the offer is made to each proposed certificate holder.

### **Life Insurance With Accelerated Benefits are Exempt**

The mandates in Section 10237.1 of the California Insurance Code regarding the offer of inflation protection are not required for life insurance policies or riders containing accelerated long-term care benefits or expense incurred long-term care insurance policies. This does not include 'expense incurred' policies paying a certain percentage of reasonable and customary charges up to a specified, indemnity-type maximum amount (Sec. 10237.3 of the CIC).

### **No Limits on Inflation Protection**

#### **Regardless of Age, Claim Status, Claim History or Policy Term**

These inflation safeguards continue under the policy without regard to an insured's age, claim status or history, or the length of time the person has been insured under the policy. If automatic benefit increases are offered as a feature of the inflation protection plan, the insurer must quote a premium that is expected to remain constant. Unless the premium is guaranteed to remain constant, any offer of this type must disclose that the premium may change in the future (Sec. 10237.4(a) of the CIC).

### **No Reduction of Inflation Benefit Increases Due to Payment of Claims**

The inflation protection benefit increases under a policy or certificate that contains an inflation protection feature shall not be reduced due to the payment of claims. (Sec. 10237.4(c) of the CIC)

### **Insurer Must Offer Level Premiums If Offering Automatic Increases**

The offer of inflation protection by an insurer that provides for automatic benefit increases is to include an offer of a premium which is expected to remain constant. Unless the

premium is guaranteed to remain constant, the offer must conspicuously disclose that the premium may change in the future (Section 10237.4(b) of the CIC).

## **Outline of Coverage Must Include:**

### **20-Year Graph Contrasting Inflation Protection With No Inflation Protection**

In or with the Outline of Coverage, insurers are to include the following information.

A hypothetical or graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period and must contrast inflation protection with no inflation protection (Section 10237.6(a)(1) of the CIC).

### **Expected Premium Increases to Pay for Inflation Protection**

Any expected premium increases or additional premiums to pay for automatic or optional benefit increases must be included in the outline of coverage (Section 10237.6(a)(2).

It is acceptable for the insurer to use a reasonable hypothetical or graphic demonstration for purposes of the particulars for the above-mentioned disclosure.

### **Illustration Must be Reasonable**

The hypothetical or graphic demonstration used by the insurer for purposes of contrasting inflation protection with no inflation protection must be reasonable (Section 10237.6(b) of the CIC).

## **Other Optional Forms of Inflation Protection**

### **Automatic, Simple and Compound (USC)**

**Automatic-** With this option benefits promised in the policy will automatically increase by a pre-determined amount (generally either 4% or 5%) compounded every year. The increases normally occur on policy anniversary of the effective date of the policy. The premium is designed to include all future inflation increases while the policy is in effect. However, premiums are not guaranteed; they will not change because of age or health but may increase if the insured is among a group of enrollees whose premium is determined to be inadequate.

**Simple-** Similar to the idea of interest and principal, simple interest only takes the principal sum into account. Each time an increase in value (in the case of inflation, a rise in cost) is determined, the operation used is multiplication of the original policy value by the pre-determined amount representing inflation.

**Compound-** This is interest on interest. Each time an increase in value (in the case of inflation, a rise in cost) is determined the operation is multiplication of accrued value (the original policy value plus all previous interest increases) by the pre-determined amount representing inflation.

### **Consumer Price Index (CPI)**

Some policies offer inflation increases tied to the Consumer Price Index. With this option, benefits will increase in line with the annual increase of the CPI as maintained by the Bureau of Labor Statistics. It should be pointed out that there is a potential disconnect between the CPI measure of inflation and projected costs of long-term care. The CPI has averaged about a 2.74% annual increase from 1983-2017.

Long-term care costs, and health care costs are not necessarily tied to the CPI index. The increase in nursing home costs (using this as a proxy) from 1996-2016 was \$154.98 an absolute increase of 140%. In the 20 years reported since 1996 that comes up to a compounded increase of about 5.1% yearly.<sup>10</sup>

### **Future Purchase Option (FPO)**

The basic idea of the Future Purchase Option is that it is not built into the premium until it is offered and accepted. This is why premiums are lower at the beginning; they do not reflect any accumulation of reserves to help pay the higher expected costs of care as people age. FPO guarantees a benefit increase without having to reapply for coverage and submit evidence of insurability. If the benefit increase is accepted, the premium is also increased with the increase related to the amount of benefit and the insured's age at the time of the increase. Because the risk of needing care increases as a person ages, over time these increases become more expensive.

### **Outline of Coverage**

Outline of Coverage- In order that the consumer may be better served; the Code requires that an outline of coverage accompany any presentation to a potential insurance purchaser. It must be delivered at the initial solicitation of business. The attention of the buyer must be directed to the instrument in order to understand and recognize its purpose. It can contain no advertising material. If an agent calls, the agent will provide the prospective purchaser with the outline before any application or enrollment form. If by mail or other direct solicitation, the outline of coverage must be presented in conjunction with the application or enrollment form.

This outline must be a stand-alone document in at least 10-point type

The outline must follow the usage and sequence stipulated in the Code. Any exceptions to this mandate will be noted. The text, which is capitalized or underscored in the outline of coverage, may be emphasized by other means that provide prominence equivalent to capitalization or underscoring.

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<sup>10</sup> The Office of Statewide Health Planning & Development (OSHPD) provides the data. The figures through 1997 are from the "Aggregate Long-Term Care Facility Financial Data Summary" and reflect net revenue by payer for "self-pay" and "other" (presumably insurance pay) categories. The 1998 and 1999 data are from OSHPD's "Long-Term Care Facility Annual Financial Data Report." The 2000 – 2002 data are from the OSHPD's "Long-Term Care Facility Annual Financial Disclosure Report." The post-2003 data are from the OSHPD's "Long-Term Care Facilities Annual Financial Data Reports."

## Outline of Coverage

### **Figure V - 2 Outline of Coverage**

(COMPANY NAME)

(ADDRESS--CITY AND STATE)

(TELEPHONE NUMBER)

#### **LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE**

(Policy Number or Group Master Policy and Certificate Number)

1. This policy is (an individual policy of insurance) ((a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)).

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions.

This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you  
**READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

#### **3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**

(a) Provide a brief description of the right to return-' free look" provision of the policy. [Sec. 10232.7 of the CIC outlines the free look. Individual long-term care policies must give the insured the right to return the policy within 30 days of its delivery. During this time period, the insured may elect to have their premium refunded if the policy proves unsatisfactory to the applicant for any reason.]

(b) Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) Neither (insert company name) nor its agents represent Medicare, the federal government or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government or any state government.

5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a

setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

## 6. BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADL's) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

## 7. LIMITATIONS AND EXCLUSIONS.

Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatments provided by a family member, etc.).

(d) Exclusions/exceptions.

(e) Limitations.

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

(As applicable, indicate the following:

(a) That the benefit level will NOT increase over time.

- (b) Any automatic benefit adjustment provisions.
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.)

#### 9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- (a) Describe the policy renewability provisions.
- (b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.
- (c) Describe waiver of premium provisions or state that there are no such provisions.
- (d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which the premium may change.

#### 10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

#### 11. PREMIUM.

- (a) State the total annual premium for the policy.
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium, which corresponds to each benefit option.

#### 12. ADDITIONAL FEATURES.

- (a) Indicate if medical underwriting is used.
- (b) Describe other important features.

#### 13. INFORMATION AND COUNSELING. The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This

number is 1-800-927-HELP [The text of this guide is included at the end of this book]. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office."



(Sec. 10233.5 of the CIC)

### **Requirement to Make Specimen Policy Available on Website and by Request**

Any entity that offers long-term care insurance in California are required to clearly post on its website site and provide written notice at the time of solicitation that a specimen individual policy form or group master policy and certificate form for each policy form offered is available to a prospective applicant upon request. Within 15 calendar days of a request, the specimen policy form or group master policy and certificate must be made available to a requesting party (Section 10234.93(a)(10) of the CIC).

### **Insurer Must Retain Records for Each Agent for Replacement Sales and Lapses**

By June 30<sup>th</sup> of each year, insurers must report the following data to the state. The period covered by the information is the preceding calendar year. The purpose of such reporting is to monitor agent activity with respect to sale of long-term care policies. Lapse and replacement rates do not connote wrongdoing. Insurers must maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales (Section 10234.86(a) of the CIC).

### **Insurer Must Retain Auditable Procedures for Compliance**

Insurers also must establish auditable procedures. That is, create a paper trail that documents the client file. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the insurer and its representatives to properly assess the need for insurance and substantiates the reason for the sale (Section 10234.93(a)(7) of the CIC).

### **Additional Insurer Obligations**

The California Insurance Code (Sec. 10232.65) imposes limitations of one month (two months if interim coverage is provided) on the amount of premium that may be collected by a long-term care policy issuer with the application prior to the time the policy is delivered. It also requires 60-day notification regarding issuance or non-issuance of a policy and an interest payment made to applicant for failure to notify. The interest is set at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from when the insurer or its representative received the funds

### **California Life and Health Insurance Guarantee Association (CLHIGA)**

Through forces of market, mismanagement or vicissitude, there is always a possibility that a particular insurer may be rendered insolvent. Long-term care insurance policy holders in California are covered by the California Life and Health Insurance Guarantee



Association Act established in Section 1067 of the CIC. The health insurance benefits for which the association becomes liable is the lesser of the following:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer.
- With respect to any one individual receiving health care benefits, \$200,000 in health insurance benefits.

The California Life and Health Insurance Guarantee Association provides coverage for the policies and contracts policyholders who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are beneficiaries, assignees, or payees. The health policies and contracts covered by the Association include life, annuity, health and long-term care insurance, including any net cash surrender and net cash withdrawal values (Sections 1067.02(a)(1) and 1067.02(b)(1) of the CIC).

### **Best Interests of the Insureds**

The California Insurance Code gives the commissioner authority to waive specific provisions of the article with respect to a specific long-term care policy if the following holds true;

- a.) the waiver would be in the best interest of the insureds
- b.) the purposes of the article [presumably the regulation of insurance] could not be achieved without the waiver.
- c.) If any of the following applies:
  - 1.) The waiver is necessary to help foster a new approach for insuring long-term care.
  - 2.) The insurance is to be issued to residents of a continuing care retirement community and the waiver is reasonably related to the unique needs of the community.
  - 3.) The waiver is necessary to allow long-term care insurance to be sold with another insurance product.

Alternate guidelines may be set up by the commissioner in conjunction with the waiver as a means of achieving the purposes of the law (Section 10235.20 of the CIC).

## **B. Agent Responsibilities and Prohibitions**

### **Duty of Honesty, Good Faith, Fair Dealing**

All insurers and insurance professionals owe the policyholder, or a prospective policyholder, a duty of honesty, good faith and fair dealing. This applies to long-term care insurance as well as other forms of insurance transactions. The legal issues involving long-term care are challenging, the ethical issues can be seen as even more complex. Dealing with fiduciary matters involving the elderly is a formidable task. When it is someone the public perceives as frail, grandmotherly, and perhaps lacking cognitive skills, the agent's conduct must always be above board. The best advice is the same as applies in other situations: document everything and don't make decisions for people. (Sec. 10234.8 of the CIC)

## **Long-Term Care Training**

### **Licensees Must Meet Eight-Hour Mandatory Long-Term Care Training Requirement**

Section 10234.93(a)(4)(A) of the CIC states that for licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter eight hours of training prior to each license renewal. Found in Section 10234.93(a)(4)(B) of the CIC is the requirement that for licensees issued a license before January 1, 1992, eight hours of LTC education must be completed prior to each license renewal. Agents should keep in mind that California Partnership for Long-Term Care is a separate and optional eight-hour training requirement.

Agents selling LTC are required to complete training specific to long-term care. Agents must complete eight hours of training specific to LTC every two years. This eight-hour requirement is a part of, not in addition to, the existing training requirements for insurance license holders. Section 1749(l) of the California Insurance Code provides that a licensee who is 70 years of age or older and has been a licensee in good standing for 30 continuous years is exempt from the continuing education requirements set out in Section 1749.3. The exemption does not apply to the eight-hour LTC training.

### **Non-Resident Agents Must Meet Eight-Hour Mandatory Long-Term Care Training Requirement**

Section 10234.93(a)(4)(C) of the CIC requires nonresident licensees not otherwise subject to training requirements (reciprocity) to comply with the eight-hour LTC training requirement.

## **Suitability**

### **Agents Must Use Company Suitability Standards**

Insurers are required to develop and maintain suitability standards to determine whether the purchase or replacement of long-term care by the applicant is warranted. Agents must be trained in the use and employment of suitability standards. The suitability standards must be maintained and made available for review by the commissioner. The suitability standards established by the insurer are to be used in determining whether or not to issue coverage and agents are required to employ the standards in marketing efforts. Factors to be taken into consideration when determining whether an applicant meets the standards include the following;

- 1.) The applicant's ability to pay for the coverage. Any other pertinent financial information concerning the applicant should also be taken into account
- 2.) The applicant's objective with respect to the long-term care insurance and the pros and cons of insurance as a means of meeting the objective.
- 3.) A comparison of the value, benefits, and costs of the applicant's existing insurance versus the proposed new insurance.

Reasonable efforts must be made to determine these goals. Among them must be included the presentation of the "Long-Term Care Insurance Personal Worksheet," as contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners (NAIC). The worksheet must appear in at minimum 12-point type. This worksheet can be readily found in the back of the pamphlet

entitled "A Shoppers Guide to Long-Term Care Insurance" published by the NAIC. This is not to be confused with the California Dept of Aging's *Taking Care of Tomorrow* book mentioned previously. These are two different books and both are very informative for the consumer. Copies of both can be found as appendices at the back of this book. The commissioner must approve a copy of the issuer's personal worksheet.

## Suitability Letter

### Figure V - 3 Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a taxpayer-funded counselor who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

**Drafting Note:** Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

*Please check one box and return in the enclosed envelope.*

☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

**Drafting Note:** Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No**. I have decided not to buy a policy at this time.

---

APPLICANT'S SIGNATURE

---

DATE

*Please return to [issuer] at [address] by [date].*



## **Personal Worksheet**

Before an insurer can consider an applicant for coverage, the applicant must complete and return a personal worksheet. A sample of the Personal Worksheet can be seen at Figure V – 1. Worksheet information must be kept confidential by the insurer. The worksheet requirement does not apply to group insurance certificates. In the event that an applicant does not meet the insurer's financial suitability standards or if the applicant declines to provide the information, the application may be rejected. A different approach is to send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the NAIC.

Insurers are to annually report the total number of applications received to the commissioner. Additional information to be reported is the number of people who did not want to provide information on the personal worksheet, the number of applicants who did not meet suitability standards, and the number who chose to conform after receiving the suitability letter. The requirements listed here do not apply to accelerated benefits for long-term care under life insurance policies. (Sec. 10234.95 of the CIC)

A copy of the issuer's personal worksheet must be filed and approved by the commissioner. A new personal worksheet gets filed each time a rate is increased in California and each time a new policy is filed. The new personal worksheet will disclose the amount of the rate increase in California and all prior rate increases as well as all prior rate increases and requests or filings in other states. The new personal worksheet is to be used by the insurer within 60 days of approval (Sec. 10234.95(c)(4) of the CIC)..

## **Consumer May Decline to Provide Information**

In the event the applicant declines to provide the requested financial information, some other means can be used to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification can be included in the applicant's file (Sec. 10234.95(h) of the CIC).

## **Replacement**

Whenever a long-term care policy is replaced the sales commission paid that represents the percentage of the sale normally paid for first year sales is to be based on the difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission is limited to the percentage of sale normally paid for renewal. Replacement is contingent on the insurer's declaration that the replacement policy materially improves the position of the insured. This provision does not apply to group insurance.

Now, the term "commission" in this case refers to pecuniary or nonpecuniary remuneration of any kind relating to sale or renewal including, but not limited to, bonuses, gifts, prizes, awards, and finder's fees.

Insurers offering long-term care policies are to file with the commissioner their commission structure or an explanation of the insurer's compensation plan. Any amendments or other changes to the commission structure must be filed with the commissioner before implementation.

Here is a situation that can arise; the premium on the replacement is less than or equal to the premium for the original insurance. The sales commission here is limited to the

percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement (and consequently the commission) is subject to the insurer's declaration that the replacement policy materially improves the position of the insured. The declaration provision does not apply to group insurance. "Commission" in this context refers to any kind of benefit, cash or in kind (awards, gifts, prizes, etc.), received from the sale or renewal of policies or certificates.

Insurers are to file with the commissioner their commission structure or justification of the insurer's compensation plan. Future changes and amendments to those plans must be filed with the commissioner's office before implementation. (Sec. 10234.97 of the CIC)

Any time long-term care coverage is replaced, the sales commission paid by the insurer shall be calculated based on the difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission is limited to the percentage of sale normally paid for policy renewal. Replacement shall be contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured. In this context "commission or other compensation" means remuneration of any kind relating to the sale such as bonuses, gifts, prizes, awards, and finder's fees. Insurers selling LTC policies must file the commission structure or an explanation of the insurer's compensation plan with the commissioner. Any amendments to the commission structure shall be filed with the commissioner before implementation. (Sec. 10234.97(c) of the CIC)

### **Replacement Coverage**

Older policies should be read and thoroughly understood. The object is to see that the services in such contracts may be more restrictive than those described in the newer policies. Agents should also be able to succinctly explain the change in services to the prospective insured when an older policy is replaced. The agent must point out the reason for replacement and whether it constitutes a material improvement, a fact that must be attested in the agent certification on the application. Other sections of this text discuss consumer protection and application specifics.

### **Replacement of Existing Insurance Notice**

Applications forms must include a question addressing whether the proposed policy is intended to replace any other accident and sickness or long-term care policy already in force. This proviso is not applicable to insurers using direct response solicitation methods. If a sale requires replacement, the applicant must be furnished a notice regarding replacement. A signed copy of the notice will be kept by the insured and one will be given to the applicant. The form of the notice is as follows:

#### **NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with long-term care insurance coverage to be issued by (company name) Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new coverage.

- (1) Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_(Date)

\_\_\_\_\_(Applicant's Signature)



Group Coverage- If not subject to the 30-day return provision the notice above must be modified to reflect an appropriate time frame. Except when the group insurance is for an employer or labor organization,\* the replacement notice must include the following verbiage;

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons: \_\_\_\_Additional or different benefits (please specify) \_\_\_\_\_.  
 \_\_\_\_ No change in benefits, but lower premiums. \_\_\_\_ Fewer benefits and lower premiums. \_\_\_\_ Other (please specify) \_\_\_\_\_.

\_\_\_\_\_  
 (Signature of Agent and Name of Insurer)

\_\_\_\_\_  
 (Signature of Applicant)

\_\_\_\_\_  
 (Date)

(Sec. 10235.16 of the CIC)



\* As defined in Sec. 10231.6 of the Insurance Code: One or more employers or labor organizations, or a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees.

## **Consumer Protection**

All insurers and insurance professionals owe the policyholder, or a prospective policy holder, a duty of honesty, good faith and fair dealing (Sec. 10234.8 of the CIC). This applies to long-term care insurance as well as other forms of insurance transactions. The legal issues involving long-term care are challenging, the ethical issues can be seen as even more complex. Dealing with fiduciary matters involving the elderly is a formidable task. When it is someone the public perceives as frail, grandmotherly, and perhaps lacking cognitive skills, the agent's conduct must always be above board. The best advice is the same as applies in other situations: document everything and don't make decisions for people.

### **Insurers/Agents Must Provide "Taking Care of Tomorrow"**

When an agent markets long-term care insurance, he or she is making the product known to the public at large. Agents must provide a copy of the California Department of Aging shopper's guide, "*Taking Care of Tomorrow, A Consumer's Guide to Long-Term Care*" to prospective applicants before the presentation of an application or enrollment form. It can be accessed on the Department of Aging's website at-

[www.aging.ca.gov](http://www.aging.ca.gov)

(Section 10234.93(a)(9) of the CIC)

### **CDI Toll Free Consumer Services**

The Consumer Services Division (CSD) is a member of the Consumer Services and Market Conduct Branch of the California Department of Insurance (CDI). CSD is responsible for gathering and responding to consumer inquiries regarding insurance company or producer activities. The goal of CSD is primarily to protect California insurance consumers through enforcement of the California Insurance Code and related laws and regulations. The toll-free consumer services telephone number is 800-927-HELP (4357), or dial locally at 213-897-8921.

### **Agents Required to Provide Local HICAP Program Information**

The Health Insurance Counseling and Advocacy Program offers taxpayer-funded individual counseling about health care issues and Medicare. With an office in every California county and a taxpayer funded toll-free number, HICAP makes it easy to find out what you need to know. Administered by the California Department of Aging, HICAP is staffed with trained volunteers who can help you with many subjects, including:

- Medicare rights and benefits
- Medicare Supplemental Insurance (Medigap)
- Medicare Advantage Plans
- How to appeal denials of Medicare coverage
- Medi-Cal, or the low-income help program
- Long-term care insurance
- Employee and retiree coverage
- Legal help and representation at Medicare appeals or administrative hearings

One may contact HICAP at the taxpayers' expense by dialing 1-800-434-0222. Interested parties may also go online to the California Health Advocates website to find the location of the closest HICAP office.

**Agents are required to know the current name, address and telephone number of the local HICAP program in the area in which they are selling. Agents are encouraged to visit the California Department of Aging website to stay current on this information.**

(Section 10234.93(a)(8) of the CIC)

### **HICAP Information**

The Health Information, Counseling, and Advocacy Program (HICAP) helps older Californians and those with disabilities by providing information about health care coverage and public benefits. HICAP is part of a national network of State Health Insurance Assistance Programs (SHIPs).

HICAP staff and volunteer benefits counselors throughout the state provide counseling, objective information, and some legal services. Counselors also help individuals by;

- Providing information about health insurance, Medicare and Medicaid eligibility, program benefits, and appeal rights
- Explaining Medicare managed care, supplement insurance policy benefits, exclusions, and coverages
- Providing information about long-term care planning and payment options
- Community education and referrals to appropriate agencies and services

HICAP services are provided at no charge. Benefits counselors may not recommend any insurance policy or plan. Their role is to provide factual, unbiased information and assistance and to act as advocates when needed. Community education, individual counseling and some legal services are available in all 58 counties and are administered through the Area Agencies on Aging.

A current list of each program can be found at the California Department of Aging (CDA) website, whose Internet address is-  
[www.aging.state.ca.us](http://www.aging.state.ca.us).

### **HICAP Notice on Outline of Coverage**

Applications for long-term care insurance are required to include a checklist of documents to be given to the applicant at the time of solicitation. This includes the Outline of Coverage, an example of which can be found elsewhere in this book. The Outline is to include notice as to the availability of HICAP and its resources (Section 10232.3(c)(3) of the CIC).

### **Rights to Reduce, Add or Purchase New Coverage**

Every policy must grant the following rights to reduce coverage and lower premiums. After the first year, the policyholder has the right to lower the premium in one of the following three ways;

- Reduction of the lifetime benefit
- Lowering the nursing facility per diem and reducing home and community-based service benefits of a home care only policy and of a comprehensive long-term care policy.
- Changing a "comprehensive long-term care" contract to a "Nursing Facility Only" or a "Home Care Only" policy or certificate. Of course, this can only be accomplished if the insurer issues those type policies in the state.



The new or converted policy will have a premium based on the age of the insured as of the original issue date. If the original contract had provisions for cost-of-living/cost-of-care increases, then the new policy will reflect the same. If a policy is on the verge of lapsing, the insurer must provide written notice to the insured of the options as outlined in the preceding paragraphs. Additional options may be included. The notice will give the insured at least 30 days in which to elect to reduce coverage and the policy shall be reinstated without underwriting if the insured elects the reduced coverage. In the event of premium increases, the insured must be offered the option of lower premiums and reduced coverage. (Sec. 10235.50 of the CIC)

### **Right to Increase Coverage**

Similar to the idea of downgrading coverage, by each anniversary date each insured must be given the option to pay extra premium for riders that will increase coverage in the following ways;

- Increase the amount of the per diem benefits
- Increase the lifetime maximum benefit
- Increase the per diem amounts for nursing facility, home-based and community-based benefits

Premiums for such riders can be based on the attained age of the insured, without impacting the premium for the original policy or certificate (Sec. 10235.51 of the CIC).

### **Insurer May Require Insured to Undergo New Underwriting**

The carrier may require new underwriting for the riders and the insurer may restrict the age and amount of the additional coverage to the same as that for similar new policies. (Sec. 10235.51 of the CIC)

### **New Benefits and Benefit Eligibility**

Policies must contain terms that address the development by the insurer of new benefits or benefit eligibility not included in the current policy. Current policyholders have the following rights;

- 1.) They will be notified of new benefits or benefit eligibility within 12 months. The insurer's notice shall be filed with the Department of Insurance at the same time as the new policy or rider.
- 2.) New benefits or benefit eligibility will be offered by one of these methods:
  - a.) Addition of a rider to the existing policy with payment of a separate premium for it based on the insured's attained age. Existing policy premium remains unchanged.
  - b.) Replacement of the existing policy with the granting of premium credits toward the premiums as outlined previously in the section addressing policy replacement and premium credits.
  - c.) With replacement of the existing contract with a new one, consideration for past insured status recognized by setting the replacement premium equal to that of the original issue age.

New underwriting may be required, but it can be no more restrictive than that for someone applying for a new policy. Group insurance insurers must offer the group policyholder the opportunity to have the new benefits and provisions extended to the existing certificate holders. It is not necessary to do so if the holder of the group policy declines the issuer's offer. (Sec. 10235.52 of the CIC)

### **Right to Choose a Paid-Up Benefit**

The commissioner may require the administration by an insurer of the contingent benefit upon lapse, as described in Section 26 (A), (D) (3), (E), (F), (G), and (J) of the Long-Term Care Insurance Model Regulation promulgated by the National Association of Insurance Commissioners, as adopted in October 2000, as a condition of approval or acknowledgment of a rate adjustment for a block of business for which the contingent benefit upon lapse is not otherwise available.

The insurer must notify policyholders of the contingent benefit upon lapse when required by the commissioner in conjunction with the implementation of a rate adjustment. The commissioner may require an insurer who files for such a rate adjustment to allow policyholders and certificate holders to reduce coverage pursuant to Section 10235.50 to avoid an increase in the policy's premium amount. The commissioner can approve alternative mechanisms filed by the insurer in lieu of the contingent benefit upon lapse. (Sec. 10235.35 of the CIC)

Long-term care premium rate increases require prior approval from the commissioner. To get the approval, insurers submit the proposed increase to the commissioner. The increase must be certified by an actuary. The commissioner may accept the premium rate schedule increase or series of increases without submission of actuarial certification if;

- Accepting the lower premium rate schedule increase or increases is in the best interest of California policyholders.
- The actuarial memorandum discloses to the commissioner the rate increase necessary to provide the certification required by subdivision (a).
- The rate increase filing satisfies all other requirements
- The insurer discloses to affected policyholders the approved premium rate schedule increase or increases, and the amount and timing of any subsequent rate schedule increases (Sec. 10236.13 (a) and (b) of the CIC).

The commissioner may approve a lower increase and may approve the initial increase or more than just the initial increase requested. If the amount of increase after all increases disclosed per the preceding paragraph (approved or not), triggers the contingent benefit upon lapse, the commissioner requires the administration by an insurer of the contingent benefit upon lapse as a condition of approval of this lower premium rate schedule increase. The commissioner may waive this condition of approval if an insurer demonstrates that the waiver is necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus (Sec. 10236.13 (e)(3) of the CIC).

### **Right to Request and Receive Sample Policy**

Any entity that offers long-term care insurance in California are required to clearly post on its website site and provide written notice at the time of solicitation that a specimen individual policy form or group master policy and certificate form for each policy form offered is available to a prospective applicant upon request. Within 15 calendar days of a request, the specimen policy form or group master policy and certificate must be made available to a requesting party (Section 10234.93(a)(10) of the CIC).

### **Right to Appeal Contract Language**

Long-term care policies or certificates are to include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments. (Sec. 10235.94 of the CIC)

### **Replacement of Long-Term Care Insurance Unnecessarily**

Unnecessary replacement of long-term care insurance policies is not permissible. The test for unnecessary replacement is as follows;

The third or subsequent policy sold to a consumer in any 12-month period is defined as unnecessary. The assumption does not apply however, to policies used solely for the purpose of consolidating policies with a single insurer. (Sec. 10234.85 of the CIC)

### **Agent Retention of Records for Five Years**

Agents and insurers are to retain all records applicable or related to an insurance transaction for at least five years. The records shall be kept in an orderly manner so that the information is readily available, and can be inspected or examined by the commissioner at all times. (Sec. 10508.5 of the CIC)

### **Long-Term Care Rate & History Guide**

The Legislature requires the Insurance Commissioner to prepare a consumer rate guide for long-term care insurance annually. This guide consists of an overview of long-term care insurance, the types of benefits and policies available to buy, both as an individual and as a member of a group, and a premium history of each company that sells long-term care insurance in California. The consumer rate guide is distributed through HICAP, the Insurance Department's 800 line, and is available at the Department's web site. Agents must also provide in the "long-Term Care Insurance Personal Worksheet" a statement that reads as follows:

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, sample premiums, and the history of rate increases, if any, for those policies. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)). (Sec. 10234.95(c)(3) of the CIC )

The rate guide consists of two parts: a history of policy rates, and sample premiums for all policies currently offered in California. Insurers are to provide the Department of Insurance information for each policy sold by the company. Group and individual policies are to be presented separately. The information includes policy type, benefits and identification; dates sold; premium rate increases requested and approved, along with date of rate increase approvals; sample premiums for different age groups. Insurers must provide this information by July 31 of each year and the data submitted is considered public record. Beginning in 2000, the Rate Guide must be published by December 1 of each year.

If the insurer does not offer a policy that fits the criteria of the sample premium portion of the policy comparison section of the rate guide, then a statement must be included that no policy is offered fitting those criteria and the agent can direct the consumer to the policy most closely fits the consumers needs. (Section 10234.6 of the CIC)

**This is the Introduction to the Rate Guide, available on-line at the DOI website:**

The California legislature requires the Insurance Commissioner to annually prepare a Consumer Rate Guide for long-term care insurance. This Rate Guide consists of an overview of long-term care insurance, the types of benefits and policies you can buy, both as an individual and as a member of a group, information on what to consider before purchasing a policy and the premium rate history of each company that sells long-term care insurance in California.

This Rate Guide will help answer some of your questions about long-term care insurance. It explains why people may need long-term care and how this type of insurance can help cover the cost for care. Long-Term Care policies most often pay for benefits on a reimbursement basis which means that the payment will be made to you in accordance with policy settlement conditions after you have received the covered care and/or incurred the costs and submitted a claim.

However, there are some policies (typically more costly) that will pay a cash benefit. It is important to understand the coverage provided and how benefits will be paid/reimbursed before you purchase a long-term care insurance policy. When you receive your policy, be sure to read it and ask questions if there is anything in the policy that you don't understand. The Rate Guide explains how long-term care insurance is structured and what benefits you can buy. A qualified long-term care insurance agent or the Health Insurance Counseling and Advocacy Program (HICAP) can help you with these questions and many others.

The California Department of Aging publishes a booklet on long-term care called "Taking Care of Tomorrow" that provides more in-depth information on a broad spectrum of long-term care issues. Agents must give you a copy of it when they attempt to sell you a long-term care insurance policy. That booklet is also available from your local HICAP project.



## **C. Statutory Rate Stabilization Requirements**

### **Importance of Rate Stability in Long-Term Care Insurance**

Consumer protection provisions have been adopted and adapted to address concerns over premium rate increases for long-term care insurance. The goal of these provisions is to increase the likelihood that premium rates offered by long-term care insurance companies will be adequate over the life of the policy, that rate increases will be less likely, that only justified increases will occur, and that necessary increases will be smaller and less frequent.

### **Company Responsibilities**

#### **Submission of New Business Premiums**

Section 10236.11 of the CIC informs that rate schedules for individual and group policies must be filed and receive prior approval before being marketed. All initial rate filing are subject to the following conditions:

- The actuary performing the review of the initial premium schedule must certify that the rate is sufficient to cover anticipated costs. This guarantee can rely on supporting data in the filing. An actuarial demonstration can be used to demonstrate the assumptions are reasonable. The actuarial demonstration can include either premium and claim experience (adjusted for differences) on similar policy forms relevant and creditable data from other studies, or both.

- The following information is required for approval of a rate filing:
  - An actuarial memorandum describing assumptions used by the insurer to develop rates
  - An actuarial certification stating the following:
    - Initial premium rate is sufficient to cover anticipated costs under moderately adverse experience and the premium rate schedule is reasonably expected to be sustainable
    - Policy design and coverage have been reviewed and taken into consideration.
    - The underwriting and claims adjudication processes have been reviewed and taken into consideration
    - Description of the basis for contract reserves that are anticipated
      - Sufficient detail or sample calculations provided
      - Assumptions used for reserves contain reasonable margins for adverse experience
      - Net valuation premium for renewal years does not increase (except for attained-age rating where permitted).
    - The difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses. If this is not the case, what is needed is a complete description of the situations in which this does not occur and the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.
  - A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms

### **Rate Revisions Filed on or After January 1, 2010**

For individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11, and for which rate revisions are filed on or after January 1, 2010, benefits shall be deemed reasonable in relation to the premium if the expected loss ratio is at least 60%. The loss ratio is calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio relevant factors, including the following, are to be considered;

- Statistical credibility of incurred claims
- Rate coverage period
- Experienced and projected trends
- The concentration of experience within early policy duration
- Expected claim fluctuation
- Experience refunds, adjustments or dividends
- Renewability features
- All appropriate expense factors
- Interest
- Experimental nature of the coverage
- Policy reserves
- Mix of business by risk classification
- Product features, such as long elimination periods, high deductibles, and high maximum limits. (Sec.10236.1 of the CIC)

### **Rate Increase Subject to CDI Approval**

Long-term care premium rate increases require prior approval from the commissioner. To get the approval, insurers submit the proposed increase to the commissioner. The increase must be certified by an actuary. The commissioner may accept the premium rate schedule increase or series of increases without submission of actuarial certification if;

- Accepting the lower premium rate schedule increase or increases is in the best interest of California policyholders.

- The actuarial memorandum discloses to the commissioner the rate increase necessary to provide the certification required by subdivision (a).
- The rate increase filing satisfies all other requirements
- The insurer discloses to affected policyholders the approved premium rate schedule increase or increases, and the amount and timing of any subsequent rate schedule increases (Sec. 10236.13 (a) and (b) of the CIC).

The commissioner may approve a lower increase and may approve the initial increase or more than just the initial increase requested. If the amount of increase after all increases disclosed per the preceding paragraph (approved or not), triggers the contingent benefit upon lapse, the commissioner requires the administration by an insurer of the contingent benefit upon lapse as a condition of approval of this lower premium rate schedule increase. The commissioner may waive this condition of approval if an insurer demonstrates that the waiver is necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus (Sec. 10236.13 of the CIC).

### **Premium Increases Subject to the Following**

Premium rate schedule increases which have been approved must comply with the following:

**Premium Rate Increases-** Demonstrate that the sum of the accumulated value of incurred claims (without the inclusion of active life reserves), and the present value of future projected incurred claims (without the inclusion of active life reserves), will not be less than the sum of the following:

- i. The accumulated value of the initial earned premium times 58%
- ii. 85% of the accumulated value of prior premium rate schedule increases on an earned basis.
- iii. The present value of future projected initial earned premiums times 58%
- iv. 85% of the present value of future projected premiums not included in iii on an earned basis.

For rate revision filings calculated in this manner producing a lifetime expected loss ratio less than the highest lifetime expected loss ratio for this policy form in initial or subsequent filings made after January 1, 2013, the insurer reduces the premiums in the filing so that the current lifetime expected loss ratio equals or is greater than the highest initially filed loss ratio (for those filed after 01/01/2013). The margin for moderately adverse experience in determining a lifetime expected loss ratio is reflected and not increased unless the manner in which risks are shared between the insurer and block of policies has been changed by legislative fiat. Lifetime expected loss ratio determination is based on the actual distribution of policies issued and not any assumed distribution prior to actual sales.

If it is determined that a rate increase is justified due to retroactive legal/regulatory changes, a premium rate schedule increase may be approved if the increase provides that 70% of the present value of projected additional premiums get returned to policyholders in the form of benefits. Other requirements applicable to other premium rate schedule increases are met as well.

The maximum valuation interest rate for contract reserves is employed for all present and accumulated values used to determine rate increases. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages. No request for a rate

increase on any policy form approved under Section 10236.11 gets approval by the commissioner except as follows:

The experience on all similar long-term care policy forms issued in this state by the insurer and its affiliates and retained by the affiliated group that have been approved under Section 10236.11 are pooled together and the combined experience used as the basis for assumptions that satisfy the requirements in the Premium Rate Increases calculation listed three paragraphs previous. Assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms are to be classified into one of the following benefit classifications:

- Nursing facility and residential care facility only
- Home care only, or
- Comprehensive long-term care benefits

Insurers are not barred from filing rate increase requests on all of their policy forms if the combined experiences after pooling all applicable policy forms satisfy the Premium Rate Increases calculation requirements shown previously. The commissioner may approve rate revisions filed on or after January 1, 2013, if an insurer demonstrates that the rates are necessary to protect the insurer's financial condition including avoidance of further reductions in capital and surplus (Sec. 10236.14 of the CIC).

### **Rate Increases Subject to Conditions**

Premium rate schedule increases that have been approved are subject to the following:

- For each rate increase that is implemented, the insurer files for approval by the commissioner updated projections (defined in first paragraph of Sec. 10236.13(b) of the CIC) annually for the next three years and includes a comparison of actual results to projected values. The commissioner may extend the period to greater than three years.
- If the commissioner determines actual experience following a rate increase does not adequately match projected experience and that current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified above, the commissioner may require the insurer to implement any of the following:
  - Premium rate schedule adjustments
  - Other measures to reduce the difference between the projected and actual experience

In determining whether the actual experience adequately matches the projected experience, consideration should be given to Sec. 10236.13(b) fifth paragraph of the CIC, if applicable. If the commissioner demonstrates, based upon credible evidence that an insurer has engaged in a persistent practice of filing inadequate premium schedules the commissioner may, after proper notice, prohibit the insurer from filing and marketing comparable coverage for up to five years. This section shall not apply to life insurance policies and certificates that accelerate benefits for long-term care. (Sec.10236.15 of the CIC)

### **What Rates Are Stabilized & Contingent Non-Forfeiture**

Rate stability is one of the most important regulatory issues in long-term care insurance. Unlike regular health insurance, long-term care insurance prefunds an event that, for the most part, occurs once and later in life. Policyholders typically pay premiums for 15 years or more before accessing benefits. Since many people are on fixed incomes when they need care, a large rate increase can often compromise their ability to retain coverage, laying waste to years of premium payments. California rules emphasize the following;

- Premiums for new business must be presented to the insurance department
- Rate increases are subject to California Department of Insurance approval
- For all long-term care policies issued after January 1, 2003, stabilized rates apply
- A contingent nonforfeiture provision must be offered

## **VI. Administration and Enforcement**

The Commissioner of Insurance has the responsibility of administering the requirements created by the insurance code. The commissioner also is charged with the authority to levy administrative penalties and impose sanctions for violation of the provisions of this chapter. If a person or entity violates the code, courts have the authority to assess penalties, attorney's fees and other costs against the violator.

### **A. Authority to Bring Actions and Assess Penalties**

In addition, the Commissioner has authority to assess penalties prescribed in the law for violation of any provision in the Insurance Code against insurers, brokers, agents, and other entities which have been determined by the Commissioner to be engaged in the business of insurance. Upon a showing of a violation of the Insurance Code in any civil action (that is, by right of private action), a court may also assess applicable penalties. The court shall award reasonable attorney's fees and costs to a prevailing plaintiff who establishes a violation of this chapter.

Courts also have power to institute other sanctions as prescribed by the code. Legal authorities representing the State (Attorney General, district, county, or city attorneys) can seek remedy for violations. Such action would include injunctive relief, penalties, damages, restitution or other remedies in law or equity (Section 10234.2 of the CIC).

An equitable principle refers to one that brings about justice or fairness. There can be no strategic maneuvering or wrangling in this situation. All parties in an insurance contract must come into the agreement with clean hands. Remedy in law means this is a part of law that is applied by the courts. No statutory act by the legislature created these notions. They are concepts that have developed over time as a part of our legal tradition.

Only actions brought at law are subject to trial by jury. In many cases an equity action seeks relief other than payment of money. Such relief includes obtaining injunctions, accountings, contract cancellation, or specific performance of contracts.

Civil law affecting commercial transactions comes under two major headings. The first heading is tort. These are cases that seek compensation for loss resulting from the conduct of others that is socially unreasonable. The second heading involves equity cases, the enforcement of agreements such as contracts, trusts, mortgages, mechanics liens, agency, license, and bailment.

#### **Commissioner Regulatory Authority**

As required by Section 10234 of the CIC, as it becomes necessary over time the Insurance Commissioner is required to adopt reasonable regulations, changes and amendments as he or she finds necessary to carry out the requirements of this chapter.

### **B. Violations and Penalties**

The reader is directed to Attachment III at the end of the book for more information.



Interest in the legal aspects of health care has been part of the scene for several decades. There are many similarities in long-term care insurance and other types of insurance. As elder care continues to emerge in significance with the graying of the baby boomer generation, the volume and diversity of issues brought both before the bar and in the form of administrative complaints will continue to increase.

**It is imperative that the insurance professional understand the magnitude and importance of the penalties that can be levied for a breach of the law.** That is to say, for violating the law as laid out in the California Insurance Code, serious civil penalties result. A list of penalties follows:

For Agents-

- Any broker, agent, or other entity engaged in the business of insurance (other than an insurer) who violates this chapter (of the California Insurance Code)<sup>11</sup> is liable for an administrative penalty of not less than \$250 dollars for each first violation.
- The penalty for committing a subsequent or a knowing violation of this chapter shall be not less than \$1,000 and not more than \$25,000 for each violation.
- The penalty for inappropriate replacement of long-term care coverage shall be not more than \$5,000 for each violation.

For Insurers-

- Any insurer that violates this chapter is liable for an administrative penalty of not less than \$5,000 for each first violation.
- The penalty for committing a subsequent or knowing violation shall be not less than \$10,000 for each violation.
- The penalty for violating this chapter in a manner indicating a general business practice shall reflect the magnitude of the violation against the public interest and shall be not less than \$10,000 and not more than \$500,000.

All of these agent and insurer fines are payable to the insurance fund. (Section 10234.3 of the CIC)

Non-monetary sanctions- Besides the monetary penalties listed above, here are some other actions that can be taken by the commissioner upon determining a violation of the provisions of this chapter;

- a.) Suspension or revocation of the license of brokers, agents or producers
- b.) Suspension of an insurer's certificate of authority
- c.) Ordering an insurer to cease and desist marketing a particular long-term care policy, to cease marketing all long-term care policies, or to come into compliance with the terms of the law

## **C. Notice and Hearing**

In a civil proceeding, the party responding to the complaint has several options as far as a response. If a broker, agent, insurer, or someone else is accused of violating the law, the authorities must observe due process of law. "Due process of law" began with the 14<sup>th</sup> amendment to the U.S. Constitution, one of the so-called "Civil War Amendments." The 13<sup>th</sup> –15<sup>th</sup> amendments to the Constitution are seen by some as an extension of the Bill of Rights. They are plainly directed against intrusion by the states upon basic

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<sup>11</sup> "This chapter" as used in this instance is referring to Division 2, Part 2, and Chapter 2.6 of the California Insurance Code, 'Long-Term Care Insurance.

procedural and substantive liberties of the individual.<sup>12</sup> Protections afforded those charged with violating the code includes the following;

- 1.) Written notice must be sent by registered mail and must include a summary of cause of action, citation of that part of the code violated, intent to assess penalty and the respondent's (that is, the person accused) options. The respondent's options include accepting the assessments as laid out in the letter, requesting a hearing on the matter, or responding to the complaints in writing. Any written response can cause the commissioner to issue a final order in the matter or set a hearing.
- 2.) If a hearing results, then it must transpire within 30 days after notice of violation is served. The Administrative Law Bureau of the Department of Insurance is the venue for such a hearing. This is not to be confused with a court of law. Administrative law is a new, almost fourth estate-like branch of the government. Be it in any state, the wildlife commission, the city sign enforcement commission, or the county tax appraisal board, everyone involved other than the respondent is an employee of the branch of government opposed to the actions of the respondent. Alternatives to or the equity in such a system are beyond the scope of this book. However, it is the way many such disputes in many areas of government get resolved. Within 20 days after the hearing, the administrative law judge issues a finding of fact concerning the dispute and a proposed order. Unless reconsideration is granted within 30 days, the judge's decision becomes final. When penalties of more than \$100,000 are assessed, alternate and more formal procedures are followed.

Any administrative hearing is to be conducted under the guidelines of the Government code of California. The Department of Insurance retains the rights for an APA (Administrative Procedures Act) hearing. The Administrative Procedures Act of July 1, 1997, addresses the courses of action that can be taken by the agency (in this case the Department of Insurance) and the respondent in order to resolve the matter in question.

- 3.) Any final order, no matter through which channel arrived, can contain more than one remedy. Fines are not limited to any amount originally stated in the notice to the respondent
- 4.) In addition to any penalties called for in the insurance code, the commissioner can also suspend the insurer's certificate of authority if it is determined that the insurer knowingly allowed violations to occur. (Sec. 10234.5 of the CIC)

## **VII. Advertising Guidelines and Marketing Practices**

### **A. Advertising Guidelines**

When the agent advertises he/she is making the product known to the public at large. There are many different ways to advertise. The following are the major methods of advertising.

- Printed and/or published materials.
- Newspaper, radio, television, computers, billboards.
- Ads, circulars, leaflets, descriptive literature.
- Business cards, business brochures, prepared sales talks.
- Telephone solicitations.
- Any material used to sell, modify, update or retain a policy of insurance.

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<sup>12</sup> W. Mendelson, *The Constitution and the Supreme Court 1974* Pp. 276-278

Agents wishing to advertise must obtain approval from their respective insurance company. All advertisements for life, accident, and health insurance must include and identify the insurance company the agent represents.

Advertisement that would not require prior insurance company approval would be one in which the only information given is the agent's name, address, telephone number, and description of the services being offered. Agency history and a simple statement of products offered, such as life, health, and/or annuities would also apply. There must be no reference made to specific policies, benefits or cost. Here is a list of best practices regarding advertising;

**The agent must do the following in all advertising:**

- Make clear that insurance is the subject of the solicitation, clearly identify the type of insurance being sold, and the full name of the insurer.
- Include all limitations and exclusions affecting the payment of benefits or cost of a policy, as well as disclose any charges or penalties, such as administrative fees, and surrender charges contained in a life or annuity policy, or withdrawals made during the duration of the contract years.
- If a policy offers optional benefits or riders, disclose that each optional benefit or rider is available for an additional cost.
- For a life insurance policy with accelerated death benefits, clearly disclose the conditions, care or confinement which will initiate any acceleration of payment of the death benefit and/or other values under the life policy.
- If a policy includes a payment endorsement, disclose that fact.

**The agent MUST NOT do the following in any advertising:**

- Be deceptive or misleading by overall impression or explicit information.
- Refer to considerations paid on an individual policy or annuity, including policy fees.
- Use terms such as "Financial Planner", "Investment Advisor", "Financial Consultant", or "Financial Services" in such a way as to imply the engagement in an advisory business in which compensation is unrelated to insurance sales, unless this is actually the case.
- Use a service mark, trade name or group designation without disclosing the name of the actual insurer, if specific coverages benefits or costs are described.
- Make unfair or incomplete comparisons of policies.
- Disparage competitors, their products, their policies, their services, business or marketing methods.
- Make untrue or misleading statements with respect to another company's insured assets, financial standing or relative position in the insurance business.
- Imply group coverage, certificate or enrollment when the policy offered is actually an individual policy.
- State that the policy is a limited offer and the applicants will receive advantages by accepting the offer, and that such advantages will not be available at a later date, if this is not the fact.
- Advertise a free gift, bonus, or anything of value outside of -the policy contract, which is an inducement to buy and considered rebating.

- Advertise for life, health, accident or annuities, use the existence of the GUARANTEE ASSOCIATION as an inducement to buy.
- Use misleading words or symbols or imply the material is being sent by a government entity.
- Use the phrase "low cost" without providing disclosures and the caveats associated with the particular plan.

Advertising can be a great way to meet the market when utilized effectively, legally and ethically.

### **Agent Designations**

The California Insurance Code establishes in Section 787.1 several conditions for the use of a "senior designation" by an agent or broker. Specifically, an agent or broker may not use a senior designation unless all three conditions below are met:

- (1) The broker or agent has been granted the right to use the designation by the organization that issues the designation and the broker or agent is currently authorized by the organization to use the designation;
- (2) The designation has been approved by the commissioner for use by brokers and agents in the sale of insurance to seniors; and
- (3) The broker or agent has been licensed for at least four years to sell the types of insurance with which the designation is used. (Sec. 787.1(b)(1) of the CIC)

The "New Law Regulating Use of Senior Designations" notice was sent to insurers, agents, brokers and other interested parties in December 2008.

### **Definitions**

- "Senior designation" means any degree, title, credential, certificate, certification, accreditation, or approval, that expresses or implies that a broker or agent possesses expertise, training, competence, honesty, or reliability with regard to advising seniors in particular on finance, insurance, or risk management.
- "Use": The use of a senior designation means utilizing a word, phrase, acronym, or logo, in any oral or written communication from which a sale of insurance to a senior may directly or indirectly result, that states or suggests, alone or in context, that a broker or agent holds a senior designation.

Designation Variations: A word, phrase, acronym, or logo constitutes a senior designation if it contains "senior," "Medicare," "Medi-cal," "retire," "mature," "gerontology," or "elder," or any variation or synonym of one of these words, within several words of the word "certified," "chartered," "registered," "adviser," "specialist," "consultant," "agent," "broker," "insurance," "planner," "professional," "enrolled," "accredited," "analyst," or "fellow," or any variation or synonym of one of these words.

A word, phrase, acronym, or logo may also constitute a senior designation even if it does not contain any of the above words (Sec. 787.1(e)(1) of the CIC).

### **Advertisements Must Be Filed**

Advertising for LTC products must be provided to the commissioner for review at least 30 days before publication. In addition to conformity with all applicable law, the advertising copy must be retained by the insurer for three years. Ads designed to produce leads must contain the following statement prominently displayed;

"An insurance agent will contact you."

If some sort of cold lead device causes an insurance company representative to contact a consumer for the purpose of soliciting business, this fact must be immediately disclosed to the consumer. (Sec. 10234.9 of the CIC)

## **Identify the Rules Regarding Internet Advertisements**

Agents who advertise insurance products on the Internet in California must disclose the following information online;

- His or her name as it appears on the insurance license
- The state of his or her domicile and principal place of business
- License number

Internet advertising regulations apply to agents regardless of whether he or she maintains the Internet presence or if it is maintained on his or her behalf.

A person is deemed to be transacting insurance California if he or she advertises on the Internet, and does any of the following:

- Provides an insurance premium quote to a California resident
- Accepts an application for coverage from a California resident
- Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy  
(Section 1726 of the CIC)

## **B. Marketing Practices**

### **Insurer Responsibilities**

Insurers are required to establish marketing procedures for agents. Companies that offer policies are required to report to the commissioner on a semiannual basis a list of representatives authorized to sell long-term care insurance. The list must be updated every six months. Insurers must require agents selling LTC to complete training specific to long-term care. Agents in the first four years of licensure must complete eight hours per year. After that, agents selling long-term care must complete eight hours of training specific to LTC every two years. This eight-hour requirement is a part of, not in addition to, the existing training requirements for insurance license holders.

Section 1749(l) of the California Insurance Code provides that a licensee who is 70 years of age or older and has been a licensee in good standing for 30 continuous years is exempt from the continuing education requirements set out in CIC Section 1749.3 (25 hours/year first four years and 30 hours/renewal period thereafter). The exemption does not apply to the eight-hour LTC training. Found in §10234.93(a)(4)(B) of the CIC is the requirement that for licensees issued a license before January 1, 1992, eight hours of LTC education must be completed prior to each license renewal.

Insurers must display the following statement prominently on the front page of the policy or certificate and the outline of coverage:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

Insurers are to provide prospective insureds, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provide taxpayer-

funded health insurance counseling to seniors. Agents shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.

Insurers also must establish auditable procedures. That is, create a paper trail that documents the client file. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the insurer and its representatives to properly assess the need for insurance and substantiates the reason for the sale (Section 10234.93 of the CIC).

### **Agents Responsibilities**

When an agent markets long-term care insurance, he or she is making the product known to the public at large. There are several different ways to market LTC. No matter how it is handled, the agent has some basic responsibilities. Consumers must be given fair and accurate comparisons of policies (apples to apples). No excessive insurance or inappropriate replacement policies may be sold. Agents must seek to determine an applicant's existing coverage. Agents must provide a copy of the California Department of Aging shopper's guide, "*Taking Care of Tomorrow, A Consumer's Guide to Long-Term Care*" to prospective applicants before the presentation of an application or enrollment form (Section 10234.93 of the CIC).

## **VIII. California Partnership for Long-Term Care**

### **A. Introduction to the Partnership**

The Long-Term Care Partnership Program is a public-private partnership between states and private insurance companies, designed to reduce Medicaid expenditures by delaying or eliminating the need for some people to rely on Medicaid to pay for long-term care services. Individuals, who buy select private long-term care insurance policies that are designated by a state as partnership policies and eventually need long-term care services, first rely on benefits from their private long-term care insurance policy to cover long-term care costs before they access Medicaid. To qualify for Medicaid, applicants must meet certain eligibility requirements, including income and asset requirements. Traditionally, applicants cannot have assets that exceed certain thresholds and must "spend down" or deplete as much of their assets as is required to meet financial eligibility thresholds.

To encourage the purchase of private partnership policies, long-term care insurance policyholders are allowed to protect some or all of their assets from Medicaid spend-down requirements during the eligibility determination process, but they still must meet income requirements. The definition of assets differs between the Long-Term Care Partnership Program and Medicaid. The Long-Term Care Partnership Program uses the term 'assets' to denote savings and investments, and excludes income. For purposes of Medicaid eligibility, assets include both income, which is anything received during a calendar month that is used or could be used to meet food, clothing, or shelter needs, and resources, which are anything owned, such as savings accounts, stocks, or property.

The asset protection feature of the Partnership Program is its guarantee that the State and Federal Government will provide a financial backstop should the LTC benefits provided by a Partnership policy be insufficient to meet the needs of the purchaser.

Individuals who buy Partnership policies are entitled to keep additional assets equal to the amount their policy pays out, should they ever need to apply for Medi-Cal for health or LTC benefits. In the absence of such protection, single individuals can only retain \$2,000 in non-exempt assets in order to qualify for Medi-Cal benefits. This special asset protection helps assure consumers who can only afford premiums for a one or two-year policy, that should they exhaust their policy benefits they won't have to become impoverished before they can receive Medi-Cal benefits. Individuals who purchase Non-Partnership policies and use up their policy benefits must "spend down" their assets to poverty level in order to receive Medi-Cal assistance.

Partnership product allows dollar-for-dollar offset of benefit with Medi-Cal spend-down recovery. This special asset protection provision, only available in Partnership policies, provides one dollar of asset protection for each dollar paid out in Partnership policy benefits. This dollar-for-dollar protection allows for a variety of product designs ranging from one year to lifetime coverage. The Partnership policies offer everyone high quality benefits and dollar-for-dollar asset protection against the costs of LTC, including consumers who can afford lifetime coverage. Most important, however, Partnership policies provide people with moderate incomes the option of choosing a shorter duration policy with the "high quality protection" they need and can afford, and eliminate the fear they might end up in poverty because their LTC costs used up their policy benefits.

The impoverishment protection offered by Partnership policies provides an especially good option for the elderly, who are often less able to afford longer duration high quality policies of four years or more.

Agents should know that California Partnership for Long-Term Care is a separate and optional eight-hour training requirement. Special Partnership certification is required in order to sell Partnership product.

More Partnership Program information is available online at:  
<http://www.dhcs.ca.gov/services/ltc/pages/cpltc.aspx>

## Attachment I      Medi-Cal Requirements<sup>13</sup>

### When to Apply for Medi-Cal

Medi-Cal eligibility is not automatic. You must apply for Medi-Cal to become eligible for public assistance. To become eligible for Medi-Cal, you must:

- Be aged, blind, or disabled;
- Be a citizen or have satisfactory immigration status; and
- Meet the Medi-Cal property and asset requirements.

Once your eligibility has been determined, you may be required to pay, from your income, a monthly "share of cost" for your care. .

Once accepted by Medi-Cal, you are eligible for all services that Medi-Cal covers. Medi-Cal services may be different than those you received under your private long-term care insurance. For example, Medi-Cal has no limits on the number of days covered, if they are medically necessary. **However, Medi-Cal will not pay for your stay in a Residential Care Facility.** Medi-Cal will pay for some nursing services in the home, including services in a Residential Care Facility, if that is where you live, and if you are temporarily or permanently unable to leave your home. For example, if you are recently discharged from a hospital, Medi-Cal will pay for follow-up care which can be provided in your home.

### Medi-Cal Property and Asset Limitations

There are property/asset limits for the Medi-Cal program. If your property/assets are over the Medi-Cal property limit, you will not get Medi-Cal unless you lower them according to the program rules.

The county looks at how much you and your family have each month. If your property/assets are below the limit at any time during that month, you will get Medi-Cal, if otherwise eligible. If you have more than the limit for a whole month, you will be discontinued until you are once again below the limits.

The home you live in, furnishings, personal items, and one motor vehicle are not counted.

A single person is allowed to keep \$2,000 in property/assets, the limit is higher if you are married or have a family.

For more information, please ask your county welfare office (usually the Department of Social Services) for a form called "Medi-Cal General Property Limitations for all Medi-Cal Applicants" (MC Information Notice 007).

### Medi-Cal Property and Asset Limitations for Married Couples When One Spouse is in a Nursing Home

If one spouse (husband or wife) goes into a nursing home, and the other spouse is still at home, the spouse at home may keep up to \$123,600 (this is the amount allowed in 2018; the amount is adjusted by the annual increase of the Consumer Price Index). The institutionalized spouse may keep \$2,000.

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<sup>13</sup>Data reproduced from the 2013 Before You Buy guide, with the approval of the California Partnership for Long-Term Care.



In 2018, the minimum amount of monthly income to which the non-applicant spouse is entitled (depending on the particular Medi-Cal program) falls between \$2,057.50 / month and \$3,090 / month. This rule allows the Medi-Cal applicant to transfer income to the non-applicant spouse to ensure he or she has sufficient funds with which to live. The spouse at home may keep all of the couple's income he/she receives in his/her own name. If this amount is under the minimum needs allowance, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse's income up to at least the minimum. This is referred to as the at-home spouse's "monthly maintenance needs allowance." (This amount is also adjusted annually by the cost of living increase.)

The at-home spouse may retain additional income or assets through a "fair hearing," or by court order. The spouse in the nursing home is permitted to keep \$35 a month for personal needs.

### **Medi-Cal Share of Cost**

If you are on Medi-Cal, you may need to use some portion of your monthly income from Social Security, a pension, etc. to pay for your health and long-term care expenses. Your income will probably not be enough to pay the entire bill, so Medi-Cal will pay the rest of your nursing home bill or any other medical expenses you may have.

You will be allowed to keep a certain amount of your income each month. In 2018, you may keep the following "Maintenance of Need" amount: If you are in a nursing home, an individual may keep \$35 for personal needs. If he or she has a spouse at home, the at-home spouse may keep all of the couple's income he/she receives in his/her name. If this amount is under \$3,090 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse's income up to at least \$3,090 per month.

\*There may be other adjustments allowed based on individual circumstances

In determining your share of cost, Medi-Cal will calculate the applicant's/institutionalized spouse's total monthly income. This figure is your net income. The county will subtract the allocation to the at-home spouse, if applicable. Then the "Maintenance of Need" amount is subtracted from your net income. The remaining amount is your monthly share of cost – the amount you would have to spend on medical or long-term care before Medi-Cal begins payment.

For more detailed information on how the Medi-Cal share-of-cost is calculated, contact your county Department of Social or Human Services (also known as the county welfare office).

# Attachment II Tax Treatment of Long-Term Care Insurance & Expenses

## Tax Treatment of Long-Term Care Insurance & Expenses

### Introduction

Federal and state tax codes have a purpose beyond raising revenue. Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The 1996 Health Insurance Portability and Accountability Act (HIPAA – Public Law 104-191, 110 Stat. 1936, 2054 and 2063) is one of the most far-reaching laws passed by Congress in the latter part of the 20th century. The effects of HIPAA are so complex that federal and state governments as well as the insurance and health care industry continue to grapple with it.

By including long-term care insurance in HIPAA, Congress attempted to fulfill a number of different public policy objectives including: (1) classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief; (2) categorizing long-term care insurance as accident and health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and (3) providing the general public an incentive to purchase private long-term care insurance.

In addition, as Federal and State governments recognized that long-term care expenses were having a significant financial impact on state Medicaid (Medi-Cal) budgets, Congress was attempting to shift the financial burden of Medicaid to the private sector by providing general tax incentives to purchase long-term care insurance in anticipation of the huge number of baby boomers who may need care in the future.

***Note: The information provided in this treatise gives a broad description of the tax issues related to long-term care and long-term care insurance. Since most agents are not Certified Public Accountants (CPA's) or tax preparers, they should be very cautious and understand their limitations in advising insured's about their specific tax situation and circumstances. Agents should always refer clients to a tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several examples provided in this Attachment that should be included in the course.***

## HIPAA Definitions That Apply to Long-Term Care Expenses and Insurance

**Introduction** The Internal Revenue Code (IRC) allows deductions for medical and dental expenses under certain circumstances (IRC Sec. 213d). Prior to the passage of HIPAA, a broad range of long-term care expenses were generally not deductible. Part of Congress' intent in enacting HIPAA was to provide tax relief to individuals and families that were incurring long-term care costs. However, part of the challenge facing legislators was determining which expenses would qualify.

### **Qualified Long-Term Care Services/Chronically Ill Individual**

The broad and expanding nature of long-term care expenses made it difficult to stipulate a "laundry list" of qualified services. The IRS defines "qualified long-term care services" as:

*Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.*

This is a wide-ranging universe of potential services. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a threshold for initiating benefits by tying services to a state of disability defined as a *chronically ill individual*. A chronically ill individual must be certified by a licensed health care practitioner, within the previous 12 months, as meeting one of the following tests:

- The individual is unable, for at least 90 days, to perform at least two activities of daily living (ADL's) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. (See Internal Revenue Service Notice 97-31, issued May 6, 1997 or California Insurance Code (CIC) section 10232.8(e)(1 – 6) for the definitions of the ADL's.)
- The individual requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Federal and State laws require the certification of the insured's status as a "chronically ill individual" to be renewed annually. It is only when an insured meets this definition that favorable tax treatment for the cost of long-term care services will be granted.

### **Licensed Health Care Practitioner**

The Internal Revenue Service defines licensed health care practitioner (LHP) in very general terms. It may include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. California Insurance Code section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and "shall not be compensated in any manner that is linked to the outcome of the certification".

### **90-Day Certification for Activities of Daily Living**

Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it could have had the unintended consequence of allowing taxpayers to deduct expenses associated with short-term disabilities due to the broad nature of the definition of qualified *long-term care service*.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no

requirement that the person actually receives the full 90 days of care. The insured must be recertified by the LHP (licensed health professional) at least annually.

IRS Publication 502 stipulates that the 90-day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

### **Substantial Assistance**

For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both *hands-on assistance* and *standby assistance*.

- Hands-On Assistance: means the physical assistance of another person without which the individual would be unable to perform the ADL.
- Stand-By Assistance: means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

### **Severe Cognitive Impairment and Substantial Supervision**

Notice 97-31 defines a *severe cognitive impairment* "as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning." Note that the 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be recertified every 12 months to ensure that they still qualify for benefits. Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

## **Tax Qualified Long-Term Care Insurance**

### **Introduction**

Prior to HIPAA, neither long-term care insurance premiums nor benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as accident and health insurance or disability insurance for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free.

HIPAA requires that long-term care insurance policies comply with its guidelines to be considered "qualified" long-term care insurance. As such, qualified long-term care insurance policies are accident and health policies and the tax treatment of their benefits are generally the same as other A & H plans.

Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance. However, HIPAA was silent as to the

tax treatment of benefits received from non-qualified policies issued after January 1, 1997. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

### **Benefits**

Congress created a generalized structure to which qualified LTCi products must adhere. For purposes of HIPAA, a qualified long-term care insurance policy must pay benefits using no less than 5 or no more than 6 of the following activities of daily living: eating; toileting; transferring; bathing; dressing; and/or continence.

Tax qualified long-term care insurance is generally treated the same as an accident and health insurance policy. Some of the rules include:

9. Reimbursement method long-term care insurance benefits pass tax-free
10. Per diem and cash method policy benefits received are subject to an annually adjusted limit amount of \$360/day in 2018 (indexed upwards annually by approximately 5 percent)
11. Premiums are generally deductible
12. Premiums paid by an employer for an employee are 100 percent deductible and do not count as income to the employee
13. Certain tax deductibility limitations apply to individuals, sole proprietors, owners of S-corporations, and LLP's
14. Individuals with Health savings accounts can utilize these funds to pay for qualified long-term care insurance subject to limitations discussed below
15. Qualified long-term care insurance cannot be included in a Section 125 Cafeteria Plan or flexible spending arrangement
16. Qualified long-term care insurance policies may not use "medical necessity" as a benefit trigger and must coordinate benefit payment with Medicare

### **Required Consumer Protection**

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of Senate Bill 1943, Chapter 1132, Statutes of 1992, that included protections related to the following: guaranteed renewal or non-cancellation of the policy; prohibitions on exclusions and limitations; extension of benefits and conversions; replacement; unintentional lapse; post-claim underwriting; requirement to offer inflation protection and rejection by consumer; restrictions on preexisting conditions and probationary periods; disclosure; and, non-forfeiture provisions.

### **IRS Reporting Mechanism**

HIPAA also establishes a reporting mechanism for benefits received under all long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an IRS 1099 LTC Form issued by the carrier. Benefits reported on the 1099 must also be disclosed on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does indicate the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional questions to the taxation of non-qualified

benefits because it provides a vehicle for these benefits to be taxed. Despite continuing confusion, neither the Department of the Treasury nor Congress has clarified this matter.

## **Tax Treatment of Pre-1997 Long-Term Care Insurance Policies**

### **Introduction**

Policies issued prior to January 1, 1997, created a challenge under HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for "grandfathered" policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting "long-term care insurance requirements of the State in which the contract was ... issued" would be grandfathered in for the purposes of tax qualification unless the policyholder made a "material change" to the policy.

### **Definition of "Material Change"**

Although the interim directive did not define "material change", the final regulations issued in December 1998 identified criteria for which a "material change" would result in a policy losing its tax qualified status. The following are treated as "material changes" and considered issuance of a new contract with the resulting loss of tax qualified status:

- A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company;
- A substitution of the insured under an individual contract;
- A change (other than a non-material change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract.

The following, however, are actions that are not considered "material changes" and will not jeopardize the policy's grandfathered status:

- Regarding premiums: a change in the mode of premium payment; an increase or decrease in premiums for all contracts that have been issued on a guaranteed renewable basis; a reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family; a reduction in premium due to a reduction in coverage made at the request of a policyholder; a reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status); the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder.
- Regarding riders: the addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract; the deletion of a rider or provision of a contract (called an HHS – Health and Human Services – rider) that prohibited coordination of benefits with Medicare.
- Other actions include: the effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract; the substitution of one insurer for another in an assumption reinsurance transaction; the expansion of coverage under a group contract caused by corporate merger or acquisition; the extension of coverage to collectively bargained employees; the addition of former employees.

***Note: The critical message for consumers is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised. A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90-day certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for long-term care.***

### **Long-Term Care Insurance Premium Deductibility**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent Department of the Treasury rulings have created four primary deductibility scenarios for tax qualified long-term care insurance. They are: health savings accounts; individual deductibility; deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) and limited liability corporations (LLC); and, deductibility for employee/owners of C-corporations. The tax incentives that allow for premium deductibility may help the self-employed and employees of companies that provide employer-paid long-term care insurance. To a lesser extent, some individual taxpayers, who are not self-employed may benefit from the premium deductibility allowed by HIPAA.

#### **Health Savings Accounts (Medical IRA Account)**

Health Savings Accounts (HSA) and their predecessor MSA's, were established under HIPAA and more recent reforms. Those consumers under age 65, who are willing to take on the responsibility of a larger medical insurance deductible in favor of lower premiums, are provided a tax incentive to do so. Simply stated, the consumer purchases a qualified high deductible medical insurance plan. They are then allowed to make a pre-tax contribution to their HSA account not to exceed (in 2018) \$3,350 (individual) or \$6,900 (family). "Catch-Up" contribution provisions allow HSA holders to add an additional \$1,000 to their account if they are age 55 or older. The money placed in the HSA account grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for unreimbursed medical expense allowed by IRC Sec. 213(d), deductibles and co-insurance. The money in the HSA can also be used to pay the premiums on a tax qualified long-term care insurance policy up to the age banded limits listed below.

HSA's are achieving acceptance in individual and group health insurance markets. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional "low-deductible" plans and the "high-deductible" plans that qualify for the HSA program. HSA's represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

#### **Individual Deductibility**

Taxpayers who itemize their deductions may benefit from the deductibility of qualified long-term care insurance premiums. Based on the taxpayer's age, only a portion of the long-term care insurance premium is deductible. Taxpayers over age 60 with above average income and assets may be interested in long-term care insurance. These individuals may itemize their deductions because they own property and the standard deduction is not in their best interest. Expenses for medical care and insurance premiums

are deductible to the extent that they exceed 10% of adjusted gross income. Prior to HIPAA, most taxpayers in this circumstance would not exceed 10% of their adjusted gross income in unreimbursed medical expenses. However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy. However, unlike other accident and health insurance premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted. In 2018, the age "banded" amounts that may be applied towards the taxpayer's un-reimbursed medical expenses are:

Banded Age Limits	Individuals/Couples
Under Age 40	\$ 420/\$840
Ages 41 - 50	\$ 780/\$1,560
Ages 51 - 60	\$1,560/\$3,120
Ages 61 - 70	\$4,160/\$8,320
Ages 71 +	\$5,200/\$10,400

Individual taxpayers under age 61 who itemize their deductions may not get much of a tax relief by including the allowable long-term care insurance premium amount in their unreimbursed medical expenses. However, someone age 61+ may benefit. Individual taxpayers, who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The deductible premium amount allowed is limited by the age-banded amount in that tax year.

The following is a thumbnail example of how this may work for a hypothetical husband and wife, both ages 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of \$9,000. Assume for the purposes of this example that this couple has an adjusted gross income of \$100,000; therefore they must exceed \$10,000 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

Amount Allowed For TQ-LTCi	\$8,320
Medicare Supplement Premiums	\$5,000
Medicare Part B Premiums	\$3,000
Other Allowable Medical Expenses	\$3,000
• (Rx, eyeglasses, dental)	
<b>Total</b>	<b>\$19,320</b>

In this example, the taxpayers would be allowed to deduct \$9,320 (\$19,320 minus their \$10,000 threshold) of un-reimbursed medical expenses. If they are in a combined federal and state income tax bracket of 35%, their tax savings would equal \$3,262 (\$9,320 x 35%). This would amount to an approximately 36% premiums savings (\$3,262 ÷ \$9,000). The deductible amount allowed for long-term care insurance premiums is not enough to trigger a deduction for these taxpayers; neither are the stand-alone deductions for the other unreimbursed medical expenses. However, the combination of all of them provides this hypothetical couple with a savings. It is important to note that most agents are not qualified tax advisors and as such need to be cautious in their recommendations. Clearly, if the agent inquires as to the unreimbursed expenses illustrated above they may spot a potential tax savings for the consumer and refer them to their tax advisor.



Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses.

### **Deductibility for the Self-Employed**

Premiums for qualified long-term care insurance paid by an employer on behalf of an employee are deductible to the employer as an accident and health insurance premium. That being said, if the employee is an owner of the business entity some limitations apply.

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships ("LLP") and limited liability corporations ("LLC"). An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only. The profit or loss from the business entity is passed through to the owners pursuant to their share of ownership. Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees. Spouses of owners of S-corporations, LLP's and LLC's are considered owners regardless of their direct or indirect participation in the business' activities. With respect to accident and health insurance coverage purchased by one of these entities for a non-owner-employee, premiums are fully deductible. There is no imputed income to the employee of premiums and the benefits pass tax free at the time of the claim.

Beginning in 2003 premiums for accident and health insurance are 100% deductible for owners of these entities. It is not necessary for these taxpayers to exceed 10% of adjusted gross income to benefit from the tax code for these expenses. Tax qualified long-term care insurance (considered accident and health insurance for these purposes), falls into this general rule and the 10% AGI threshold does not come into play. The amount allowable for deduction is limited by the previously discussed age-related schedule.

Consider a self-employed husband and wife, both age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of \$6,000 per year. They would be allowed to deduct \$2,620. If they are in the combined Federal and State tax bracket of 35% their tax savings would be \$917 or approximately 15% of premium. Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 15% of the premium paid. Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses.

*Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several examples provided in this Attachment that should be included in the course.*

### **Deductibility in Closely-Held C-Corporation**

The fine-line difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners. Therefore, premiums paid by

the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees are deductible to the corporation. There is no imputed income to the employee stockholder for premiums paid and the benefits will pass tax-free at time of claim. Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive "like" benefits. Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits. Both are incorrect.

The Internal Revenue Code section 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable class of employees who are eligible for the benefit, is not allowed. The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as "officer employees" can be created for the corporation who are eligible for a specific accident and health insurance benefit.

However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and tax advisors to be judicious in recommending and establishing classes eligible for coverage. It is also important for the corporation to establish the plan in their Minutes and to clearly identify the classes of employees that are eligible for benefits. Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation. There is no income imputed to the employee and the benefits pass tax free at time of claim; however it is important to consult with a tax advisor.

### **New Trends: LTC Insurance, Life Insurance, Annuities and Benefit Riders**

The Pension Protection Act of 2006 (PPA), like HIPAA, is a significant piece of legislation that addresses hundreds of disparate issues. Also like HIPAA, a very small portion (section 844) deals with long-term care insurance and riders that are part of life insurance or annuity contracts. PPA affirms HIPAA as it pertains to life insurance contracts and accelerated benefit riders (ABRs). Over the years, accelerated benefit riders have appeared in various life insurance policies with a promise to pay part of the death benefit (generally 2% to 4% monthly) if a qualifying event other than death occurs; e.g. disability, critical illness, cancer, terminal or chronic illness.

Section 101(g)(1) of the Internal Revenue Code governs the accelerated payment of death proceeds on the life of a terminally or chronically ill insured. HIPAA added section 7702B to the IRC which specified the definition of 'chronic illness'. Essentially, if the qualifying event for benefits matches the chronic illness definition established by HIPAA, the early payout of the death benefit for long-term care expenses will not be taxed as income. However, the payments cannot exceed the per diem limits (\$360 in 2017 and must comply with other provisions of the NAIC Model for long-term care insurance). Per PPA, the premiums (or charges) for this coverage can be deducted from the internal growth of the annuity without a taxable event (income) to the annuitant. In addition, if the annuitant qualifies for care, the long-term care benefits payments from the annuity will be received income tax free. One of the central points is that the long-term care benefits must be consistent with the HIPAA--if it looks like qualified long-term care insurance, it is qualified long-term care insurance.

A typical product design for a single premium deferred annuity (SPDA/LTCI) combo product will provide a long-term care benefit that is generally a multiple of the annuity account value. The payout will be delivered over a certain number of months, 24, 36 or 48. While examples will vary by insurance carrier, age and health conditions, let's say that the insured wants \$6,000 per month of benefit for 48 months ( $\$6,000 \times 48 = \$288,000$ ). To get that \$288,000 benefit, the policy holder may have to place \$100,000 into the SPDA combo product. A risk charge will be taken from the accumulation of the product to provide the additional \$188,000 of coverage.

The first money out of the SPDA to pay the long-term care benefit will be the insured's initial premium to the plan. If the policyholder dies before their contribution is exhausted a beneficiary will receive the difference. Once benefits are paid beyond the initial premium the insurance company will continue to pay benefits until they are exhausted. The risk charge for the benefit beyond the premium will generally be between one-half to 1.25 basis points. In other words, if a typical SPDA was paying a return of 5.5%, the combo plan may only pay 4.5%. Again, since the long-term care benefit under the program qualifies under IRC section 7702B, the cost of the long-term care benefit will not be a taxable event to the insured. Long-term care benefit payments will reduce the basis of the annuity for income tax purposes. This may create a larger tax burden on heirs of the annuity owner after death.

Here are some key points for agents to think about when discussing "combo products" with consumers:

1. How insurance agents and financial advisors who have been working primarily in their narrow specialties will be able to help clients navigate this new world of long-term care planning choices. Benefits available with life and annuity/LTCI combos are likely to be limited as to benefits paid at time of claim.
2. Long-term care benefit qualification must be consistent with HIPAA in order for the combo plan to fall under the PPA guidelines. In order to solicit/sell long-term care insurance in California, Agents need to hold a current license as: Life Agent, Accident and Health Insurance Agent, or Life-Only Agent (only if it is a LTC rider on a full life policy).
3. What sorts of long-term care expenses will the life or annuity combo pay for-- nursing home only, assisted living, home care, or all of the above? Will the plan reimburse for incurred cost or provide some sort of indemnity (per diem) benefit based on a day of service incurred? What sorts of assessments and plans of care will the claims process require?
4. Underwriting criteria will lead to choices of deferral periods based on insured's health issues. This will be a special challenge to life insurance agents selling annuities, marketers and wholesalers not attuned to underwriting issues in the current SPDA environment.
5. 1035 exchange opportunities are likely to occur (moving cash values from life insurance and annuity contracts to those with LTCI benefits).
6. Which type of life insurance product, SPDA, fixed, indexed or variable, will be best suited to specific clients? What if they do not perform as anticipated? Will consumers who purchase a combo plan be faced with a lower level of benefits if the underlying life insurance or annuity contract pays the guaranteed rate as opposed to the current rate? Will there be "true-up" provisions which give the insured an ability to "reinforce" their long-term care pay-out in the event that product investment performance doesn't reach expectations.

**Conclusion**

This complex area of law and especially the advent of "combo products" (life and annuity) raise many new questions regarding how agents discuss long-term care needs and solutions with consumers. Full discussion of suitability of specific long-term care products and disclosure of all terms, conditions and protections will become even more important as will suggesting the correct and suitable solution.

Finally, all insurance agents should be keenly aware that the information provided in this treatise gives a broad description of the tax issues related to long-term care insurance. Since most agents are not Certified Public Accountants (CPA's) or tax preparers they should be very cautious and understand their limitations in advising insured's about their specific tax situation and circumstances. Agents should always refer clients to insured's tax advisor for the final analysis of the tax impact of long-term care insurance and expenses.

## **Sample 1099 LTC and Instructions**

### **LTC 1099-LTC**

#### **Reporting of Long-Term Care Insurance Benefits To Internal Revenue Service**

The federal legislation entitled, *The Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, requires that long-term care insurers report to the Internal Revenue Service any long-term care benefits paid under all insurance contracts beginning with tax year 1997.

The insurers are not required to determine whether any benefits are taxable or non-taxable.

Policyholders who have specific questions pertaining to the federal legislation or the reporting requirements of HIPAA, should be advised to contact their personal tax advisor or the Internal Revenue Service.

#### **1099 Form**

Form 1099 & Taxes- Any benefit paid under a long-term care insurance contract is required to be reported by the insurance carrier. While this adds to the paperwork burden of the insurer, it also places the insured in an uncomfortable position. With a "qualified" LTC contract, the benefits paid are not subject to income tax. Non-tax qualified plans may be different. The benefit recipient must shoulder the responsibility of making that determination. Recipients should consult a tax professional to determine the status of any benefit payments. Here is a copy of Form 1099 and instructions as promulgated by the Internal Revenue Service;

PAYER'S name, street address, city, state, ZIP code, and telephone no.		1 Gross long-term care benefits paid \$	OMB No. 1545-1519  <b>2018</b> Form <b>1099-LTC</b>	<b>Long-Term Care and Accelerated Death Benefits</b>
		2 Accelerated death benefits paid \$		
PAYER'S Federal identification number	POLICYHOLDER'S identification number	3 Check one: Per <input type="checkbox"/> diem Reimbursed <input type="checkbox"/> amount	INSURED'S social security no	<b>Copy A</b> <b>For Internal Revenue Service Center</b>  <b>File with Form 1096.</b> For Privacy Act and Paperwork Reduction Act Notice, see the <b>2018 General Instructions for Certain Information Returns</b>
POLICYHOLDER'S name		INSURED'S name		
Street address (including apt. no.)		Street address (including apt. no.)		
City, state, and ZIP code		City, state and ZIP code		
Account number (see instructions)	4 <input type="checkbox"/> Qualified contract (optional)	5 Check, if applicable: <input type="checkbox"/> Chronically ill (optional) <input type="checkbox"/> Terminally ill	Date certified	

Form **1099-LTC**

Cat. No. 23021Z

Department of the Treasury – Internal Revenue Service

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, ZIP code, and telephone no.		1 Gross long-term care benefits paid \$	OMB No. 1545-1519  <b>2018</b> Form <b>1099-LTC</b>	<b>Long-Term Care and Accelerated Death Benefits</b>
		2 Accelerated death benefits paid \$		
PAYER'S Federal identification number	POLICYHOLDER'S identification number	3 <input type="checkbox"/> Per diem <input type="checkbox"/> Reimbursed amount	INSURED'S social security no	<b>Copy B</b> <b>For Policyholder</b> This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this item is required to be reported and the IRS determines that it has not been reported.
POLICYHOLDER'S name		INSURED'S name		
Street address (including apt. no.)		Street address (including apt. no.)		
City, state, and ZIP code		City, state and ZIP code		
Account number (optional)	4 <input type="checkbox"/> Qualified contract (optional)	5 Check, if applicable: <input type="checkbox"/> Chronically ill (optional) <input type="checkbox"/> Terminally ill	Date certified	

Form **1099-LTC**

(keep for your records.)

Department of the Treasury – Internal Revenue Service

**Instructions for Policyholder**

A payer, such as an insurance company or a viatical settlement provider, must give this form to you for payments made under a long-term care insurance contract or for accelerated death benefits. Payment include those made directly to you (or to the insured) and those made to third parties.

A long-term care insurance contract provides coverage of expenses for long-term care services for an individual who has been certified by a licensed health care practitioner as chronically ill. A life insurance company or viatical settlement provider may pay accelerated death benefits if the insured has been certified by either a physician as terminally ill or by a licensed health care practitioner as chronically ill.

**Policyholder's identification number.** For your protection this form may show only the last four digits of your social security number (SSN), individual taxpayer identification number (ITIN), or adoption taxpayer identification number (ATIN). However, the issuer has reported your complete identification number to the IRS, and, where applicable, to state and local governments.

**Long-term care insurance contract.** Generally, amounts received under a qualified long-term care insurance contract are excluded from your income. However, if payments are made on a per diem basis, the amount you may exclude is limited. The per diem exclusion limit must be allocated among all policyholders who own qualified long-term care insurance contracts for the same insured. See Pub. 525 and Form 8853 for more information.

**Per Diem basis.** This means payments made on a periodic basis without regard to the actual expenses incurred during the period to which the payments relate.

**Accelerated death benefits.** Amounts paid as accelerated death benefits are fully excludable from your income if the insured has been certified by a physician as terminally ill. Accelerated death benefits paid on behalf of individuals who are certified as chronically ill are excludable from income to the same extent they would be if paid under a qualified long-term care insurance contract.

**Account number.** May show an account or other unique number the payer assigned to distinguish your account.

**Box 1.** Shows the gross benefits paid under a long-term care insurance contract during the year.

**Box 2.** Shows the gross accelerated death benefits paid during the year.

**Box 3.** Shows whether the amount in box 1 or 2 was paid on a per diem basis or was reimbursement of actual long-term care expenses. If the insured was terminally ill, this box may not be checked.

**Box 4.** May show if the insured was certified chronically ill or terminally ill, and the latest date certified.

**Box 5.** May show if the insured was certified chronically ill or terminally ill, and the latest date certified.

## Form 8853

This form reports contributions to and distributions from Archer Medical Savings Accounts (MSAs), distributions from Medicare Advantage MSAs, and taxable payments and accelerated death benefits from long-term care (LTC) insurance contracts.

<b>Form 8853</b> Department of the Treasury Internal Revenue Service (99)	<b>Archer MSAs and Long-Term Care Insurance Contracts</b> ▶ Go to <a href="http://www.irs.gov/Form8853">www.irs.gov/Form8853</a> for instructions and the latest information. ▶ Attach to Form 1040 or Form 1040NR.	OMB No. 1545-0074 <b>2017</b> Attachment Sequence No. <b>39</b>
Name(s) shown on return		Social security number of MSA account holder. If both spouses have MSAs, see instructions ▶
<b>Section A. Archer MSAs.</b> If you have only a Medicare Advantage MSA, skip Section A and complete Section B.		
<b>Part I Archer MSA Contributions and Deductions.</b> See instructions before completing this part. If you are filing jointly and both you and your spouse have high deductible health plans with self-only coverage, complete a separate Part I for each spouse.		
<b>1</b>	Total employer contributions to your Archer MSA(s) for 2017 . . . . .	<b>1</b>
<b>2</b>	Archer MSA contributions you made for 2017, including those made from January 1, 2018, through April 17, 2018, that were for 2017. Don't include rollovers (see instructions) . . . . .	<b>2</b>
<b>3</b>	Limitation from the Line 3 Limitation Chart and Worksheet in the instructions . . . . .	<b>3</b>
<b>4</b>	Compensation (see instructions) from the employer maintaining the high deductible health plan. (If self-employed, enter your earned income from the trade or business under which the high deductible health plan was established.) . . . . .	<b>4</b>
<b>5</b>	<b>Archer MSA deduction.</b> Enter the <b>smallest</b> of line 2, 3, or 4 here. Also include this amount on Form 1040, line 36, or Form 1040NR, line 35. On the dotted line next to Form 1040, line 36, or Form 1040NR, line 35, enter "MSA" and the amount . . . . .	<b>5</b>
<b>Caution:</b> If line 2 is more than line 5, you may have to pay an additional tax (see instructions).		
<b>Part II Archer MSA Distributions</b>		
<b>6a</b>	Total distributions you and your spouse received in 2017 from all Archer MSAs (see instructions) . . . . .	<b>6a</b>
<b>b</b>	Distributions included on line 6a that you rolled over to another Archer MSA or a health savings account. Also include any excess contributions (and the earnings on those excess contributions) included on line 6a that were withdrawn by the due date of your return (see instructions) . . . . .	<b>6b</b>
<b>c</b>	Subtract line 6b from line 6a . . . . .	<b>6c</b>
<b>7</b>	Unreimbursed qualified medical expenses (see instructions) . . . . .	<b>7</b>
<b>8</b>	<b>Taxable Archer MSA distributions.</b> Subtract line 7 from line 6c. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to line 21, enter "MSA" and the amount . . . . .	<b>8</b>
<b>9a</b>	If any of the distributions included on line 8 meet any of the <b>Exceptions to the Additional 20% Tax</b> (see instructions), check here . . . . . <input type="checkbox"/>	<b>9a</b>
<b>b</b>	<b>Additional 20% tax</b> (see instructions). Enter 20% (0.20) of the distributions included on line 8 that are subject to the additional 20% tax. Also include this amount in the total on Form 1040, line 62, or Form 1040NR, line 60. Check box c on Form 1040, line 62, or box b on Form 1040NR, line 60. Enter "MSA" and the amount on the line next to the box . . . . .	<b>9b</b>
<b>Section B. Medicare Advantage MSA Distributions.</b> If you are filing jointly and both you and your spouse received distributions in 2017 from a Medicare Advantage MSA, complete a separate Section B for each spouse (see instructions).		
<b>10</b>	Total distributions you received in 2017 from all Medicare Advantage MSAs (see instructions) . . . . .	<b>10</b>
<b>11</b>	Unreimbursed qualified medical expenses (see instructions) . . . . .	<b>11</b>
<b>12</b>	<b>Taxable Medicare Advantage MSA distributions.</b> Subtract line 11 from line 10. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21, or Form 1040NR, line 21. On the dotted line next to line 21, enter "Med MSA" and the amount . . . . .	<b>12</b>
<b>13a</b>	If any of the distributions included on line 12 meet any of the <b>Exceptions to the Additional 50% Tax</b> (see instructions), check here . . . . . <input type="checkbox"/>	<b>13a</b>
<b>b</b>	<b>Additional 50% tax.</b> Enter 50% (0.50) of the distributions included on line 12 that are subject to the additional 50% tax. See instructions for the amount to enter if you had a Medicare Advantage MSA at the end of 2016. Also include this amount in the total on Form 1040, line 62, or Form 1040NR, line 60. Check box c on Form 1040, line 62, or box b on Form 1040NR, line 60. Enter "Med MSA" and the amount on the line next to the box . . . . .	<b>13b</b>
For Paperwork Reduction Act Notice, see your tax return instructions. <span style="float: right;">Cat. No. 24091H Form <b>8853</b> (2017)</span>		

Name of policyholder (as shown on Form 1040)

Social security number of  
policyholder ▶**Section C. Long-Term Care (LTC) Insurance Contracts.** See **Filing Requirements for Section C** in the instructions before completing this section.If more than one Section C is attached, check here . . . . . ▶ ☐**14a** Name of insured ▶ \_\_\_\_\_ **b** Social security number of insured ▶ \_\_\_\_\_**15** In 2017, did anyone other than you receive payments on a per diem or other periodic basis under a qualified LTC insurance contract covering the insured or receive accelerated death benefits under a life insurance policy covering the insured? . . . . . ☐ **Yes** ☐ **No****16** Was the insured a terminally ill individual? . . . . . ☐ **Yes** ☐ **No****Note:** If "Yes" and the **only** payments you received in 2017 were accelerated death benefits that were paid to you because the insured was terminally ill, skip lines 17 through 25 and enter -0- on line 26.**17** Gross LTC payments received on a per diem or other periodic basis. Enter the total of the amounts from box 1 of all Forms 1099-LTC you received with respect to the insured on which the "Per diem" box in box 3 is checked . . . . . **17****Caution:** Don't use lines 18 through 26 to figure the taxable amount of benefits paid under an LTC insurance contract that isn't a **qualified** LTC insurance contract. Instead, if the benefits aren't excludable from your income (for example, if the benefits aren't paid for personal injuries or sickness through accident or health insurance), report the amount not excludable as income on Form 1040, line 21.**18** Enter the part of the amount on line 17 that is from **qualified** LTC insurance contracts . . . . . **18****19** Accelerated death benefits received on a per diem or other periodic basis. Don't include any amounts you received because the insured was terminally ill (see instructions) . . . . . **19****20** Add lines 18 and 19 . . . . . **20**  
**Note:** If you checked "Yes" on line 15 above, see **Multiple Payees** in the instructions before completing lines 21 through 25.**21** Multiply \$360 by the number of days in the LTC period . . . . . **21****22** Costs incurred for qualified LTC services provided for the insured during the LTC period (see instructions) . . . . . **22****23** Enter the **larger** of line 21 or line 22 . . . . . **23****24** Reimbursements for qualified LTC services provided for the insured during the LTC period . . . . . **24****Caution:** If you received any reimbursements from LTC contracts issued before August 1, 1996, see instructions.**25** Per diem limitation. Subtract line 24 from line 23 . . . . . **25****26** **Taxable payments.** Subtract line 25 from line 20. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21. On the dotted line next to line 21, enter "LTC" and the amount . . . . . **26**



## Attachment III

## Applicable Laws & Penalties

Long-Term Care		
Insurance Code	Applicable Law	Penalty
<b>Long-Term Care Insurance</b>  <b>Sections 10230-10237.6</b>	<p><b>§10233.3; §10234.85; §10234.86; §10234.87; §10234.97</b> Various requirements for the replacement of LTC policies.</p> <p><b>§10234.95</b> All sales of LTC insurance shall meet the "suitability" standards.</p>	<p><i>All violations of Chapter 2.6 subject to the following penalties in addition to court penalties, attorney's fees and costs per §10234.2.:</i></p> <ul style="list-style-type: none"> <li>• <b>§10234.3(a):</b> Penalty of not less than \$250 for each 1<sup>st</sup> violation; not less than \$1,000 and not more than \$25,000 for each subsequent or knowing violation; for inappropriate replacement of LTC coverage, penalty not more than \$5,000 for each violation.</li> <li>• <b>§10234.4(a):</b> Suspend or revoke license.</li> <li>• <b>§10234.4(c):</b> Ordered to cease marketing LTC insurance in California.</li> </ul>

General Provisions		
<u><b>Misrepresentation of Policies</b></u>  <b>Section 780</b>  <u><b>Twisting</b></u>  <b>Section 781</b>	<p><b>§780</b> Prohibited statements re: terms, benefits, privileges or future dividends of policy.</p> <p><b>§781(a)</b> Twisting: prohibited statement known to be a misrepresentation to induce person to take out a policy, refuse a policy and take out another, let lapse, forfeit of surrender policy.</p> <p><b>§781(b)</b> Prohibited misleading statement or comparison of insurers or policies to induce person to let insurance lapse, forfeit, change or surrender policy.</p>	<p><b>Section 782:</b> Any person who violates section 780 or 781 is punishable by fine not to exceed \$25,000, or if victim loss exceeds \$10,000, the fine not to exceed 3 times the loss suffered by the victim, by imprisonment not to exceed 1 year or by both a fine and imprisonment. Restitution to victim pursuant to Section 1202.4 of the Penal Code shall be satisfied before any fine imposed by this section is collected.</p> <p><b>Section 783:</b> Any insurance agent, broker or solicitor who knowingly violates section 780 or 781 may have their license suspended for up to three years after a hearing.</p>
<u><b>Unfair Practices</b></u>  <b>Sections 790-790.15</b>	<p><b>§790.01</b> Applies to insurers, agents, etc. and "all other persons engaged in the business of insurance".</p> <p><b>§790.02</b> Prohibits use of unfair trade practices or unfair method of competition or deceptive act or practice in the business of insurance.</p>	<p><i>All violations of Article 6.5 subject to penalties as follows:</i></p> <ul style="list-style-type: none"> <li>• <b>§790.035(a):</b> Civil penalty of NTE \$5,000.00 for each act. If act or practice is willful, civil penalty NTE \$10,000.00 for each act.</li> <li>• <b>§790.05:</b> Cease and Desist Order; subsequent violations license may be suspended/revoked for up to one year.</li> </ul>

	<p><b>§790.03</b> Lists in detail prohibited acts such as: misrepresentations about the terms of any policy issued or the benefits or advantages promised; prohibits making, disseminating, causing to be made or disseminated in any manner any known or reasonably should be known, untrue, deceptive, misleading statement.</p> <p><b>§790.037</b> Unfair practice selling health care products; cold lead advertising; appointments; Medicare products restrictions on sales discussions.</p>	<ul style="list-style-type: none"> <li>• <b>§790.06:</b> Prosecution of acts not defined in §790.03-Cease and Desist Order.</li> <li>• <b>§790.07:</b> Violation of Cease and Desist Order; penalty NTE \$5,000; if willful, penalty NTE \$55,000 plus penalty under §790.05.</li> <li>• <b>§790.08:</b> Provides that the penalties in this Article are in addition to any other powers of the Commissioner to enforce the laws.</li> </ul>
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Other Relevant Insurance Code Sections		
<p><b>Insurance Information &amp; Privacy Protection Act</b></p> <p><b>Sections 791-791.28</b></p>	<p><b>§791.03</b> Prohibits the use of "pretext interviews" to obtain information in connection with an insurance transaction (i.e. "free lunch" seminars).</p>	<p><i>All violations of Article 6.6 subject to penalties as follows:</i></p> <p><b>§791.17:</b> Cease and desist order issued.</p> <p><b>§791.19:</b> Violation of Cease &amp; Desist order: Penalty of not more than \$10,000 for each violation; or not more than \$50,000 if frequent violations constitute general business practice. Suspension &amp; revocation of license for knowing violation.</p>
<p><b>Medicare Supplement Insurance</b></p> <p><b>Sections 10192.1-10192.24</b></p>	<p><b>§10192.18</b> Application forms require certain questions to determine if applicant already has a policy or certificate; must be signed by applicant and agent.</p> <p><b>§10192.21(b)</b> Prohibits sale of a Medicare supplement policy or certificate if individual already has one.</p> <p><b>§10192.23</b> States time periods for replacement of policies.</p>	<p><i>All violations of Article 6 subject to the following penalties:</i></p> <ul style="list-style-type: none"> <li>• <b>§10192.165(a) &amp; (c):</b> Court penalties including damages &amp; restitution.</li> <li>• <b>§10192.165(b)(1):</b> Penalty of no less than \$250 for first violation by agent, broker, other person/entity engaged in business of insurance</li> <li>• <b>§10192.165(b)(2):</b> Penalty of no less than \$1,000 and no more than \$25,000 for each second, subsequent or knowing violation.</li> <li>• <b>§10192.165(d):</b> Order to cease marketing any Medicare supplement policy or certificate.</li> <li>• <b>§10192.165(e):</b> Any person who knowingly or intentionally violates this Article is punishable by imprisonment in county jail NTE one year, or by imprisonment per Penal Code §1170 or a fine NTE \$10,000 or both.</li> </ul>

## **OTHER RELEVANT INSURANCE CODE SECTIONS**

### **Welfare & Institutions Code §15610.27**

"Elder" means any person residing in this state, 65 years of age or older.

### **Welfare & Institutions Code §15610.30**

(a) "Financial abuse" of an elder or dependent adult occurs when a person or entity does any of the following:

- (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
- (2) Assists in doing the above activities.
- (3) Does or assists in the above activities by undue influence, as defined in Section 1575 of the Civil Code.

(b) A person or entity shall be deemed to have committed the above acts for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

(c) For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.

(d) For purposes of this section, "representative" means a person or entity that is either of the following:

- (1) A conservator, trustee, or other representative of the estate of an elder or dependent adult.
- (2) An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

### **California Penal Code §182 – Conspiracy**

(a) If two or more persons conspire:

- (1) To commit any crime.
- (2) Falsely and maliciously to indict another for any crime, or to procure another to be charged or arrested for any crime.
- (3) Falsely to move or maintain any suit, action, or proceeding.
- (4) To cheat and defraud any person of any property, by any means which are in themselves criminal, or to obtain money or property by false pretenses or by false promises with fraudulent intent not to perform those promises.
- (5) To commit any act injurious to the public health, to public morals, or to pervert or obstruct justice, or the due administration of the laws.
- (6) To commit any crime against the person of the President or Vice President of the United States, the Governor of any state or territory, any United States justice or judge, or the secretary of any of the executive departments of the United States.

### **California Penal Code §368(d) – Financial Elder Abuse**

Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult is punishable as follows:

- (1) By a fine not exceeding two thousand five hundred dollars (\$2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars (\$10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars (\$950).
- (2) By a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars (\$950).

### **California Penal Code §459 - Burglary**

Every person who enters any house, room, apartment, tenement, shop, warehouse, store, mill, barn, stable, outhouse or other building, tent, vessel, as defined in Section 21 of the Harbors and Navigation Code, floating home, as defined in subdivision (d) of Section 18075.55 of the Health and Safety Code, railroad car, locked or sealed cargo container, whether or not mounted on a vehicle, trailer coach, as defined in Section 635 of the Vehicle Code, any house car, as defined in Section 362 of the Vehicle Code, inhabited camper, as defined in Section 243 of the Vehicle Code, vehicle as defined by the Vehicle Code, when the doors are locked, aircraft as defined by Section 21012 of the Public Utilities Code, or mine or any underground portion thereof, with intent to commit grand or petit larceny or any felony is guilty of burglary. As used in this chapter, "inhabited" means currently being used for dwelling purposes, whether occupied or not. A house, trailer, vessel designed for habitation, or portion of a building is currently being used for dwelling purposes if, at the time of the burglary, it was not occupied solely because a natural or other disaster caused the occupants to leave the premises.

### **California Penal Code §470 – Forgery**

Every person who, with the intent to defraud, knowing that he or she has no authority to do so, signs the name of another person or of a fictitious person to any of the items listed in subdivision (d) is guilty of forgery.

### **California Penal Code §487 – Grand Theft**

When the money, labor, or real or personal property taken is of a value exceeding nine hundred fifty dollars (\$950)

### **California Penal Code §502(c) – Computer Access Fraud**

(c) any person who commits any of the following acts is guilty of a public offense:

- (1) Knowingly accesses and without permission alters, damages, deletes, destroys, or otherwise uses any data, computer, computer system, or computer network in order to either (A) devise or execute any scheme or artifice to defraud, deceive, or extort, or (B) wrongfully control or obtain money, property, or data.
- (2) Knowingly accesses and without permission takes, copies, or makes use of any data from a computer, computer system, or computer network, or takes or copies any supporting documentation, whether existing or residing internal or external to a computer, computer system, or computer network.
- (3) Knowingly and without permission uses or causes to be used computer services.
- (4) Knowingly accesses and without permission adds, alters, damages, deletes, or destroys any data, computer software, or computer programs which reside or exist internal or external to a computer, computer system, or computer network.

- (5) Knowingly and without permission disrupts or causes the disruption of computer services or denies or causes the denial of computer services to an authorized user of a computer, computer system, or computer network.
- (6) Knowingly and without permission provides or assists in providing a means of accessing a computer, computer system, or computer network in violation of this section.
- (7) Knowingly and without permission accesses or causes to be accessed any computer, computer system, or computer network.
- (8) Knowingly introduces any computer contaminant into any computer, computer system, or computer network.
- (9) Knowingly and without permission uses the Internet domain name of another individual, corporation, or entity in connection with the sending of one or more electronic mail messages, and thereby damages or causes damage to a computer, computer system, or computer network.

**California Penal Code §530 – Identity Theft**

Every person who falsely personates another, in either his private or official capacity, and in such assumed character receives any money or property, knowing that it is intended to be delivered to the individual so personated, with intent to convert the same to his own use, or to that of another person, or to deprive the true owner thereof, is punishable in the same manner and to the same extent as for larceny of the money or property so received.

**California Penal Code §532 – Theft by False Pretenses**

Every person who knowingly and designedly, by any false or fraudulent representation or pretense, defrauds any other person of money, labor, or property, whether real or personal, or who causes or procures others to report falsely of his or her wealth or mercantile character, and by thus imposing upon any person obtains credit, and thereby fraudulently gets possession of money or property, or obtains the labor or service of another, is punishable in the same manner and to the same extent as for larceny of the money or property so obtained.