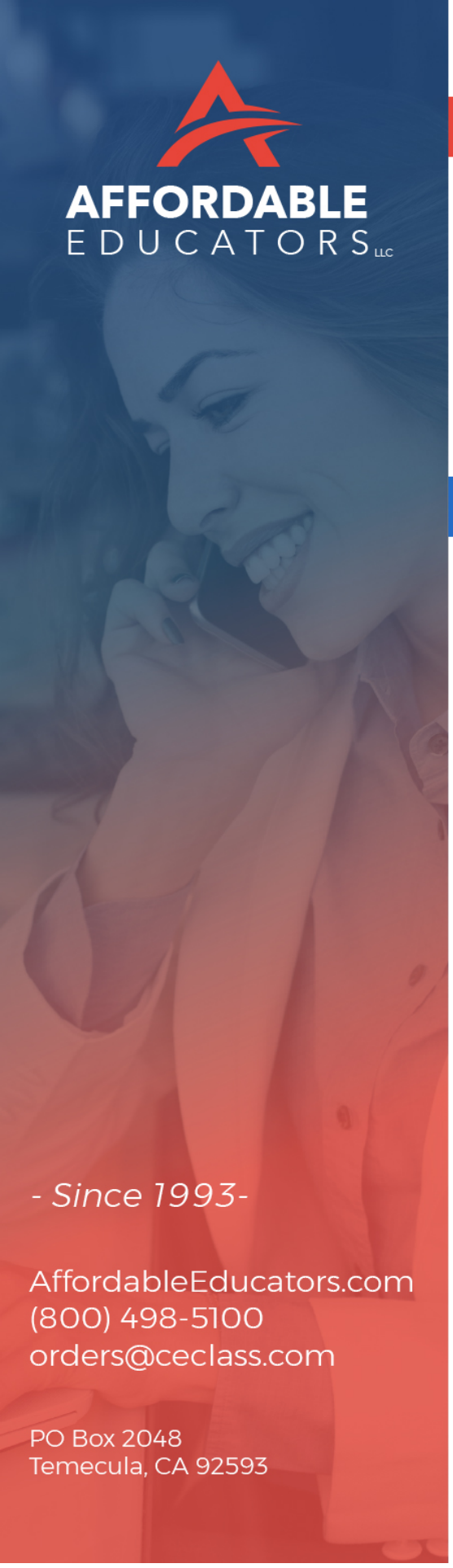

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153

10 HABITS FOR LONG TERM CARE

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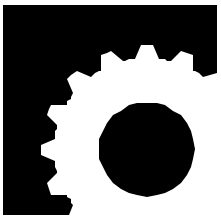


LTCI Agent Responsibility

The long term care insurance boom is under way . . . right now! There are 59 million prospects over age 55 today and every eight seconds, another baby boomer turns 55. Within the next 20 years, they will add another 76 million to the market. LTCI producers will be effective in this market if they act responsibly and develop good habits.

Responsible habits focus on the tools, techniques and ideals you use to bring consistency and fair dealing to your LTC insurance production. In his book The Seven Habits of Highly Effective People", Stephen R. Covey details the things successful people need to do to gain a high level of faith in their work and personal pursuits. He talks about bad habits that we allow to continue simply because it is comfortable to do so. He counsels that we need to understand before being understood and about the need to have a mission statement. He proposes we go about the process of changing old habits and acquiring new ones . . . be proactive, prioritize and develop a win/win attitude. Good advice.

Responsible habits focus on tools, techniques and ideals you use to bring consistency and fair dealing to your LTC practice.

We too are going to talk about habits . . . simple techniques and straight-forward concepts insurance agents can use to responsibly transact long term care insurance. Like anything worthwhile, this task involves some work. It also requires that you believe LTCI to be one of the most revolutionary and beneficial products you will ever ask a client to buy.

Old Habits

Before we share concepts for more responsibility, let's look at some habits to change. It starts with a simple question: How can more long term care insurance be sold responsibly?

LTCI Consumers

Most people are unaware or deny their risk of needing long term care services. Research suggests that persons who live to age 65 face a ***four out of ten chance*** of spending some time in a nursing home before they die and a ***one in six chance*** of spending more than one year. People seem willing to accept the possibility that they will someday get sick and visit a doctor or be admitted to a hospital, but few people are willing to admit they face a significant lifetime risk of becoming disabled and using expensive nursing home or home care services. *This is a habit to change!* Long term care is indeed a priority and risk that consumers need to manage.

Tragically, many consumers have convinced themselves that Medicare, Medigap supplement policies, Medicaid or their HMO will cover long term care. They do not. *Again, people (your clients) need to change their habits or else be forced to rely on welfare or the graces of people willing to take care of them!*

LTCI buyers also need to get over their resistance to the higher cost associated with quality care. People who want quality care need to plan now. The government will simply not provide it. Private insurers can and will. Evidence is the evolution of LTC policies from an era of limited, bare bones coverage, to comprehensive plans complete with alternative care options. This is a higher quality care that comes with a higher price.

I can't afford it? You certainly hear this complaint. And, historically, the elderly were disproportionately poor, unable to afford substantial premium payments. This is less true now as the income of elderly has increased a great deal over the last twenty years, While the elderly still have factions of poverty and near poverty, most current evidence suggests that the elderly as a whole are roughly as well off as the rest of the population. Most estimates of the future income and assets of the elderly project substantial improvements.

LTC Insurers and Agents

On the supply side, the single-most critical obstacle to marketing is the fact that LTCI has not qualified as a ***core product***. Most agents have yet to embrace this product fully (big mistake) and insurers are not yet sure about its profitability (see below). When carriers are willing to tie LTCI sales performance to trips to the Bahamas and gift bonuses, you will know it has reached full product status.

The greatest obstacle to acceptance is the fact the LTCI is still not a core product.

Of course, responsible producers already know the rewards of LTCI. It is a product that virtually everyone needs and wants to hear about. For the less than ethical, this is the cue to abuse and confuse clients, especially the more vulnerable senior. There will always be agents in this category. They seize the opportunity to earn a commission at any price. Others are simply not understanding the depth and breadth of the market. They end up missing entire market groups who are viable and active buyers such as boomers and even younger working adults. LTCI is also NOT and area to simply "dabble". The product is more complex and mistakes are far-reaching. Producers who sell responsibly must shed the notion that it is just another source of commissions. You must believe in and fully understand this product before you can safely transact it. These are agent habits that must change quickly.

Why haven't insurers flocked to LTCI? They're still caught up in the risk. There's the ***moral hazard*** and ***adverse selection***. Moral hazard is the increased use of services that results when people have insurance coverage. Since most LTC is currently provided by family members at no formal costs, the possible increase in use is large. Thus, there is a substantial possibility of increased use of services by a large number of persons who would "medically" qualify. Insurers also worry about adverse selection which is the possibility that people who "know" they will use long term care services will disproportionately buy the insurance, driving up use beyond expectations. This creates a vicious circle where premiums have to be raised, causing low risk people to drop their policies and force additional increases in premiums.

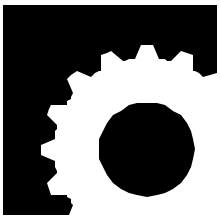
Insurers are also concerned about the timing of premium payments and the ultimate ***use of benefits***. Long term care is needed principally by the elderly, especially those age 85 and over. And, there is likely to be a very long time between initial purchase of the insurance policy and it eventually use. For example, a policy bought at age 65 probably will not be used for 20 years; a policy bought at age 45 probably may not be used for 40 years. Unforseen changes in disability or mortality rates, utilization patterns, inflation in nursing home and home care costs, or the rate of return on financial reserves can dramatically change a profitable policy into a highly unprofitable one.

Despite all the barriers and reasons LTCI has not sold in the past, insurers and agents (the smart ones) are moving forward. Policies are improving rapidly, major marketing efforts are being developed and the marketplace (LTCI buyers) are responding in force.

There is no better time to be involved in responsibly selling long term care insurance. And, it is a perfect time to break old habits that have been keeping production down and/or prohibiting you from transacting this dynamic product at all. Following is our list of 10 new habits you need to develop on your way to becoming a responsible LTCI agent . . .

Ten New Selling Habits For Responsible LTCI Agents

#1— Responsible LTCI Agents Practice Ethical Selling
#2— Responsible LTCI Agents Recognize They Have An Important Job
#3— Responsible LTCI Agents Are Needs Oriented / Solutions Based
#4— Responsible LTCI Agents Know Their Clients
#5— Responsible LTCI Agents Monitor The LTC Continuum
#6— Responsible LTCI Agents Sell What They Know & Believe What They Sell
#7— Responsible LTCI Agents Match Policy Features / Options To Needs
#8— Responsible LTCI Agents Expose The LTC Funding "Minefield"
#9— Responsible LTCI Agents Know All They Can About Underwriting
#10— Responsible LTCI Agents Study Selling Mistakes of Other Agents



#1 -- Responsible LTCI Agents Practice Ethical Selling

Less-than-honest selling is nothing new: ***Caveat Emptor*** *(buyer beware)* is said to have appeared on buildings in ancient Rome. But in the long term care insurance business, it is the magnitude of damage that heightens the dishonesty. An unsuspecting senior client who buys inadequate LTC coverage, for example, is hurt a lot more than someone who buys a fake Rolex for $20 on the street corner. This is why agents need to practice sales ethics.

Ethical selling is something you CHOOSE in order to do a better job for your client.

Most states do not devote large sections of their insurance code to ethics. It's not generally part of license exams or taught at colleges. Therefore, it is something you ***choose*** in order to do a better job for your client. If you need more reasons why you should practice this conduct, here's a short list:

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process, i.e., *you have more control over the sales process and less compliance.*
- Ethical conduct violations drive up the cost of doing business which could effect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation, i.e., *violations can mean less money.*
- Ethical conduct problems erode the public trust and *that can cut into your sales.*
- Ethical conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.

There are many industry groups and agent associations who feel that the movement toward long term care sales ethics is way behind schedule. Too much emphasis and money has been spent on grooming sophisticated "salesmen", they say, when there is a greater need for agent diligence and fair dealing. Especially in the area of long term care where the primary market (seniors) can vulnerable to less-than-honest sales tactics.

The cornerstone of this agent diligence movement is now called ***agent due care*** or ***sales conduct***. Roughly translated, the meaning of sales conduct is an agent's ***professional and ethical handling and choice of company, product and sales presentation to best serve a client's financial planning***. Others have embellished on this definition where the practice of sales diligence might read like this: "Conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would demand for itself. Provide competent and customer-focused sales and service. Engage in active and fair competition. Provide advertising and sales materials that are clear as to purpose and honest and fair as to content. Provide fair and expeditious handling of customer complaints and disputes". In essence, you are placing ethics above selling.

If you believed strongly in sales ethics, you might run your practice by the following credo:

- I will know ***everything*** possible about my client's financial and LTC insurance needs.
- I will have a complete understanding of ***all*** products I sell and present them fairly.
- I will find the ***most*** suitable product for my client and make sure I place him with financially capable companies without "bashing" the competition.

- I will document ***any*** lack of knowledge with a full disclosure agreement.
- I will request each client to sign a binding arbitration agreement for any potential misunderstanding or dispute.

While it would be wonderful if every agent lived by these rules, "real world" situations often get in the way. Taking the time to follow each and every rule would probably add to your work load. On the other hand, a little less free time today might save you considerable time and money by avoiding a major legal confrontation later. Likewise, the loss of a policy sale or two today might make it a whole lot easier to sell one . . . ***or be referred one*** . . . next year.

Ethical Insurance Selling

Do you think you're an honest LTC agent? Could you prove it to a jury? What would your mother say about your sales practices? In the end, how will you judge your sales career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution to "truth in selling".

In a way, the insurance industry is battling a decline of sales ethics; a ***moral combat*** if you will. One battlefield, where it is difficult to win, is the media where in recent times consumers read about state regulators warning 147 New York insurers on deceptive selling practices, or one company being penalized more than $700 million for deception, or an insurer's agreement to pay $25 million to cover the unscrupulous sales techniques of a single agent. ***Ethical selling***, as portrayed by the media, is just another oxymoron.

The troops leading the "offensive" for the industry are sales and motivational speakers and industry associations. Ethics, truth and responsibility are suddenly the core of seminars and newsletters with titles like ***Winning With Integrity, Selling With Integrity, Principled Persuasion*** or ***Selling With Honor.*** Groups and associations are doing their share by promoting proprietary ***codes of ethics*** as the foundation to membership and/or the blueprint for all transactions.

This is not to suggest that simply possessing a moral code is something that sets a professional apart from a mere salesperson. However, maintaining a Code of Ethics does inspire us to do good — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.

Having high ethical standards, or more simply being honest, can be more important than being right because honesty reflects character while being right reflects a level of ability. Unfortunately, the insurance industry, for the most part, still rewards ability. There are, for example, plenty of "million dollar" marketing winners and "sales achievement awards"; but few, if any, "Ethics & Due Care" certificates.

For some, ethical selling, whether by a code of ethics or just plain honesty, is reward by itself. Consider, for example, the satisfaction you would realize when the interest of a client has been served by the proper placement of LTC insurance.

Ethics From The Start

Instilling ethics is a process that must start long before a person chooses LTC insurance as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in a forum like this course of study may not be incentive enough to sway

agents to stay on track. It may be easier to explain that honesty and fair play could mean greater sales and lessen the possibility of lawsuits.

Ethics is a trait that develops long before a person chooses LTC insurance as a career.

Some believe that the ethics problem reflects our current culture which glorifies short-term success at all costs. This includes awards for the most sales in a given period of time as well as "golden boy" stories of the entrepreneur who goes from lonely computer geek to multi-millionaire from a single idea. Neither of these events is meant to say that these individuals accomplished their feats in an unethical manner. It simply "raises the bar" for those who follow them. If those who follow have inadequate skills and work habits, they could employ less than ethical means to reach the same goals.

Ethics For Life

The LTC insurance industry can do a lot more to promote ethics-building habits. At one insurer group, for instance, building a relationship in sales and marketing is emphasized with a program called ***Client for Life***. Its premise is . . . "When you constantly exceed the needs and expectations of your clients, you're doing the right thing". Sales tools such as reports and newsletters are used to educate clients in a non-threatening and highly personalized manner. Long-term success is closely associated with building long-term relationships with clients rather than a quick sale. The results may vary from agent to agent, but a surprising benefit seems to be a ***loyalty factor*** where more than 70 percent of sales comes from existing policyholders or their referrals.

Ethics From Education

The customer can't understand what the salesperson can't explain. Further, a customer who understands a product is much less vulnerable to deceptive selling. Both statements stress the importance and need for more education. A recent study by the Insurance Institute found that four out of every five people don't understand their insurance policies. And, if the agent doesn't understand his product, the company and client are at substantial risk. The same agent ends up concentrating on a "comfort zone" product or "B-level" service even if it is not the most appropriate one because he is uncertain about newer, more complex products.

Constant training is the answer, as well as making a long-term effort to ***demystify products***. One solution is the translating of legalese into easily understandable, everyday English. This includes brochures, advertising, applications and the policies themselves.

The process of educating ethics is also the responsibility of our schools and universities. Currently, there is a glaring lack of attention to the selling disciplines. Besides learning the nuances of every product and the marketing behind them, young people could be taught the importance and responsibilities associated with being a salesperson. Like the athlete who trains long hours to prepare for the moment of action, sales career individuals can be groomed to do the right thing.

Integrity

While many agents believe that "integrity" is a characteristic of choice, many state laws set minimum agent standards to follow, such as:

Qualifications

Insurance Commissioners have been known to suspend or revoke an insurance agent's license if it is determined that he or she is not properly qualified to perform the duties of a person holding the license. Qualification may be interpreted to be the meeting of minimum licensing qualifications (age, exam scores, etc) or beyond.

Lack of Business Skills or Reputation

Licenses have been revoked where the agent is NOT of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In **Goldberg vs Barger (1974)**, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

Activities Circumventing Laws

Agent licenses have been revoked or suspended for activities where the licensee (1) did not actively and in good faith carry on as a business the transactions that are permitted by law; (2) avoids or prevents the operation or enforcement of insurance laws; (3) knowingly misrepresents any terms or the effect of a policy or contract; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In **Hohreiter vs. Garrison (1947)**, the Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants. In **Steadman vs. McConnell (1957)**, a Commissioner found a licensee guilty of making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

Agent Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted. In **McConnell vs. Ehrlich (1963)**, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers who licenses had been suspended or revoked. The Commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than could others because of their "volume plan". If this wasn't bad enough, the letters appeared to be official correspondence of an official state agency. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to repay the agents the amount of the premium plus "charges" amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

Catchall Category

In addition to the specific violations above, most states establish that agent responsibilities MUST NOT violate the “public interest”. This is obviously a catchall category that has been used where agents have perpetrated acts of mail fraud, securities violations, RICO (Criminal) violations, etc.

Ethics In Action

Communication

Transacting insurance is a communication process. Responsible agents know how to simplify, while others tend to complicate their delivery to the point of confusing clients.

The fact is, it's hard for some agents to shut up! Why would a client want to hear about a long list of features he could find on any brochure? Customers today are sophisticated. They don't appreciate someone *telling* them what is best for them to do. Responsible LTC agents, instead, manage to subtly discover and expose the need *without telling*, without arm-twisting or high-pressure manipulative techniques.

There is a scene from a Woody Allen movie where Woody is a crazy prison inmate. When he can't take it anymore he plots an elaborate escape, which of course fails. His punishment is the "locker" . . . solitary confinement. What could be worse? He is locked-up with a big city life insurance agent and forced to hear his pitch for 3 days! The agony. Don't make your clients agonize the same way.

Simplify To Educate

The key to getting through to someone is simplicity. Your long term care presentation could easily last 3 or 4 hours. But who is willing to listen for this length of time? Even retired seniors don't want to spend half their day on things that are too complicated. If this wasn't true, every senior would know how to program his VCR or challenge a computer spreadsheet program. The fact is, they don't want to waste their time.

When it comes to keeping things simple, the content of your message is uppermost. The essence of simplicity is *the absence of unnecessary elements.* Albert Einstein once said . . . "out of clutter, find simplicity".

A concise presentation, however, does not mean shallow. A common mistake is to think that making something easy to understand is a matter of reducing something which is more complete than the "simple" end result. On the contrary, simplicity requires serious thought and effort. It takes more to convey your thoughts and messages in a fewer number of words than to rattle off two hours of statistics and policy features.

A lot of times, making something easier for your client to understand means you have to sacrifice your ego. Face it, you really want to impress clients with your newfound knowledge about long term care facts and features . . . don’t you? It's human nature. But, resist the urge to spout.

Expose Needs

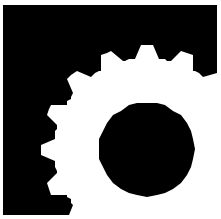
In the simplest way possible make your case about LTC risks and priorities and determine their needs. Then satisfy their needs in a responsible and professional manner. Layout the

possibilities and let them choose. For example, is home care as long as possible with the eventual skilled care of their choice a need? How about assisted living choices or companion care for shopping, cooking, cleaning? Next comes, facility care choices, inflation protection, world-wide coverage. Then discuss tax benefits, ease of claims, the "pool of money" concept, affordability, rate increases, elimination periods and choice of company. Instead of making your policy fit these features, establish their importance and point out that your coverage meets them all!

Be Knowledgable

It's nice to make things easy to understand and interesting for your clients. However, never, ever shirk your responsibility to know your product well. Even though you make it sound easy, you have to be able to answer the tough questions and make professional choices.

KNOW WHAT YOU SELL!



#2 -- Responsible LTCI Agents Recognize They Have An Important Job

Your clients spend a lifetime building their personal wealth. It cannot be wise to allow a single, unexpected or unplanned financial risk, like a chronic long term care illness, wipe it all out. Consider what your clients have done in other areas to preserve their wealth:

What Clients Do To Protect Their Wealth

Wealth At Risk	Odds of Happening	Are They Protected?
Major Medical Illness	1 in 15	√ Protected by medical insurance policy
Automobile Accident	1 in 240	√ Protected by auto insurance policy
Home Fire or Liability	1 in 2400	√ Protected by home and umbrella policy
Long Term Care Illness	**1 in 2**	**Õ Protected ???**

Now let's see the consequences of not covering a long term illness:

The Financial Loss From Various Long Term Care Illnesses

Leading Cause	Length of Care	Cost @ $158 / Day	Cost @ $112 / Day
Alzheimer's	96 months	$455,040	$322,560
Cancer	36 months	$170,640	$120,960
Cardiac	16 months	$75,840	$53,760
Diabetes	48 months	$227,520	$161,280
Pulmonary	36 months	$170,640	$120,960
Stroke	21 months	$99,540	$70,560

If you apply 5% inflation to these figures, the outcome is even more staggering. Ten years from now, after inflation has it's way with LTC costs, the average Alzheimer's private room stay of 96 months could cost a family almost $1 million! Can you see why a long term care agent is really in the ***wealth management business***? And, your job doesn't stop here. Consider the following ways reasons you can be a vital resource for clients:

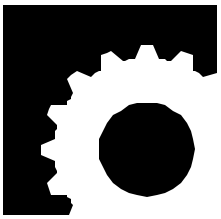
- Long term care protection protects assets but also allows your client choices not possible in the past: Like skilled care at home for as long as possible, companion care for daily activities (shopping, cooking, cleaning, etc), options for advanced care like residential care facilities, assisted living, adult day care, personal independence, the ability to leave something to their kids besides a bunch of debt, the ability to stay off welfare rolls and the choice to have quality care. You have an important job.
- The prospect of shopping for long term care insurance can be intimidating. Despite industry efforts, long-term care insurance is relatively new and complex. Consumers rely on you, the agent, to help compare policies and tailor one to a particular client's needs. You have an important job.
- In marketing long term care insurance, agents need to practice the highest standards in personal ethics and sales conduct because this is a product that may become the most important aspect of a client's life. For some, the need for long term care will not surface for 20 or 40 years. Others may pay premiums for years and never use a dollar of benefit. Such is the way with insurance protection. Still others need your counseling to determine that, for

them, long term care should NOT be purchased at all. Even in this decision, great care must be taken to advise properly. You have an important job.

- A greater measure of care must be practiced in this field because of the clients you will often see -- senior citizens. They are the primary market for long term care insurance and they are vulnerable consumers. Agents must be sensitive to this market's overall suitability for coverage by using higher standards of reasonable care. You have an important job.

If you are not convinced yet, consider that the job of providing long term care coverage is so important that agents who forget to suggest it to clients have been sued. That's right, in a case where you are responsible for a wide range of insurance services for a client or where a client has come to depend on you for his insurance advice, you must advise them that this is important coverage they should consider.

Yes, you have an important job! And, responsible LTC producers are getting paid accordingly.



#3--Responsible LTCI Agents Are Needs Oriented / Solutions Based

As you will learn, LTC is not like other forms of insurance.

Why do we say this? Well, LTC is an emotional issue. The fact that virtually everyone may need it shows a different kind of vulnerability than the need to buy life insurance. It requires buyers to "fast forward" their mind to a time in their life when they will be partially or totally dependent on someone else to help them move across the room or take a shower. This is truly a different mindset than what you may be used to and it takes knowing a client's needs more than other forms of insurance.

Needs Oriented

How do you get down to exposing a client's needs? Start with a client profile and/or suitability survey of your client. Know all you can about him or her, including the various tendencies of people in their age category (see below and the next habit on boomers and seniors) then match their need(s) to benefits offered by your program. For now, let's looks at some basic LTC needs.

An April 1996 article in Best Life and Health targeted the seven most urgent concerns that mature Americans have about their own long term health care. Here they are . . .

- I want to avoid dependence
- I don't want to burden my family
- I want to avoid welfare.
- I don't want to leave a bunch of debt
- I want access to quality care
- I don't want to deplete my savings
- I want to preserve assets for my family

Once you get your client to identify with these concerns (by agreeing that one or more of them are also his concerns), you have established a primary level of need. Now for the some more critical fact-finding:

- How is your client's health today? Past problems? Does his family have a history of problems? Do people live long in his family?
- Where will the money come from to pay premiums? Will his annual income be sufficient to make premium payments today? Down the road?
- Are assets more than sufficient to cover LTC expenses? Are assets so small that Medicaid is a possibility? Is someone going to die and leave him a bunch of money?
- How will inflation affect your client's ability to pay for LTC costs?
- Where is he planning to retire? (LTC expenses cost a lot more in New York than New Mexico).
- Any plans for moving out of the country? (Only a handful of policies offer worldwide coverage).
- Everyone wants home care coverage, but does your client have a support team (family, friends, etc) who can monitor in-home LTC services? Without support, a policy geared more for assisted living and nursing facilities should be considered.

Highly effective agents also educate clients they may never be healthier than they are now. Remember, money pays the premium, but health buys the coverage. And, they will never pay less than they will today. Let's look at what can happen when clients wait:

> *Bill Smith, 56, pays $1,418 a year for his policy, and Joan, 51, pays $1,197 -- rates that reflect their good health and a 20% discount for buying two policies at once. A few months after purchasing the policies, Joan developed health problems that could have jeopardized the preferred rate -- another reason the Smiths are pleased that they bought early. Had they waited until age 65 to buy insurance, a similar policy would have cost Bill about $3,500 a year, and at 70, more than $5,300 a year. However, by then they would likely have wanted a higher daily benefit to keep up with rising costs, boosting the premiums even higher.*

What else does it take? LTC expert Marc Cohen says 50% of recent LTC sales were made not because of cost or value, but because the agent recommended it. This reinforces our belief that LTC is not like other forms of insurance . . . clients rely on you more in this area of insurance than any other . . . you have an important job! Other factors critical to purchasing long term care insurance include the carrier's reputation (40%), cost (30%) and benefits (20%).

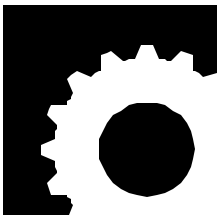
Solutions Based

Clients who have needs, also need solutions. A responsible agent understands that this starts with matching specific needs of a client to dozens of policy features and benefit options – this is not a job for sissies! (See Habit #7 for the many LTCI choices you need to make for your client). When all is said and done, however, a responsible, solutions-based agent must take the final step to assure himself and client that your long term care insurance suggestion is the most effective way to handle his long term care health needs. You must sprinkle your client meetings with the following questions:

- Does this make sense to you?
- Have I given you all the information you need to make a decision?
- Is there something else I can answer to assure you that this is the right solution based on your needs?

These are essential questions because they help "clear the air" circulating around any doubts or concerns your client may have. And, they can also help limit your liability if something goes wrong down the road (see Habit #10 for more ideas on reducing conflicts in your business).

A positive response to these questions is the feedback you need to know that you have "gotten through" to your client and are providing some real solutions to some very important long term care needs.



#4--Responsible LTCI Agents Know Their Clients: Seniors & Boomers

If you are at all "tuned-in" to current trends, you know that LTC insurance is no longer a "senior's only" experience. Today, policies are going to younger and to younger buyers. LifePlans, Inc surveys show that one out of every three buyers (33%) is under the age of 65. This is a significant change from 19% (one out of five) found in 1995. Clearly, long term care insurance is not just for seniors anymore! Your market has expanded to baby boomers and even younger. New prospects are also wealthier and working.

Remember, there are 59 million seniors and matures today and every eight seconds a baby boomer turns 55. In a matter of years, they will add 76 million new people who need LTCI.

To understand the true needs of your clients, you must get to know who they are.

No matter how many people there are in these critical age categories, you still need to ***know*** who they are and what they want you and your products and services to do for them. Some call this process market segmentation, psychographics, or generational marketing.

Insurance consumers today are much more complex than the relatively homogeneous buyer of the immediate post World War II era. Values back then were stable and centered around a shared vision of the American Dream. Now, we see vastly different values, motivations, life experiences and insurance needs. By examining the senior and boomer market groups that make up these modern-day, long term care prospects, you will gain the confidence to understand their core needs and their motivation to insure long term care expenses. The result should net a better client-agent relationship, better coverage and a responsible selling experience.

The Senior and Boomer "Cohort Groups"

A cohort group is simply a band of people who share similar experiences by age, geography, culture, etc. In their book Rocking the Ages, 1998, J. Smith and Ann Clurman suggest that every cohort group passes through the same stages in life, e.g., going to school, graduating getting a driver's license, graduating college, buying a home, the joy and pain of parenting and the uncertainties of retirement. Similarly, each generation or group, must all deal with the same circumstances -- economic downturns, economic booms, wars, droughts, shortages, real estate appreciation, low interest rates, etc. But, each group responds to these life events in different ways depending on generational differences. Therefore, it is likely that the insurance needs of one group are different than another.

To demonstrate this, let's look at the insurance history of today's seniors. In their younger years, virtually everyone bought whole life insurance to cover burial costs and/or to build a small pot of money down the road. You started with a small whole life policy and paid on it forever. LTC coverage never existed. Contrast this with boomers of today, who are closely watching their own LTCI needs through their parents' experiences and typically buy one or more term/universal/variable policies from $250,000 to $1 million and up to cover huge mortgages, expensive college educations for their kids and / or staggering cost of living expectations if the

breadwinner dies young. Both generations bought homes and raised families, but the influences of their individual backgrounds created a need for much different insurance products. The same is true for health and disability coverages. Generations today buy substantially higher liability and lifetime medical limits in response to more lawsuits and escalating hospital bills. Generations past were more likely to self-insure all or a portion of these coverages because the legal and financial consequences were not as grave.

Getting to Know Seniors and Boomers

We have only begun to discuss the primary buyers of LTC insurance: Seniors and Boomers. Each of these generations have unique work ethics, styles and views on issues like quality of product, service and their need for LTC insurance. The agent of the new millennium strives to know as much as he can about these consumer groups because providing and servicing their insurance needs is no longer the boring effort it was years ago. These generations are smarter and more demanding. Your ability to respond to their needs will determine your success in developing long-term business relationships where all parties involved are rewarded.

In addition to knowing these clients, you must develop ways to work with them. If you are a young agent, for example, will you be able to convince a senior that you are capable of understanding his needs and meeting them. Older agents may have similar problems getting younger clients to listen or see value in their experience.

Let's look at the profile of these clients and the issues you face in serving them:

Seniors: *(Born between the turn of the Century and World War II).*

Seniors accomplished their goals through hard work. They are a very "team-oriented" generation having weathered a depression and major world wars. Almost half of the men of this group served in the military which is probably why this generation is so well taken care of by the government. It also didn't hurt that they saw seven of their own in succession in the White House, beginning with John Kennedy and extending through Lyndon Johnson, Richard Nixon, Gerald Ford, Jimmy Carter, Ronald Regan and George Bush, Sr.

Research has shown that different generations tend to catalyze or define themselves in the shadow of a momentous event or members of their generation. Defining moments for seniors include the bombing of Pearl Harbor, "a date that will live in infamy" said President Roosevelt. Hereos of this generation include MacArthur, Patton, Eisenhower, Winston Churchill, Audie Murphy, Babe Ruth, etc.

As Seniors came of age after World War II, they were armed and motivated by the ideology to rebuild society. They shouldered the burden of ensuring foundations of a better life which, indeed, is the reason that the generations behind them experienced stability and growth. Their self-sacrificing was very aptly summed up by John Kennedy in his inaugural speech when he said "ask not what your country can do for you, but what you can do for your country". Things weren't easy, but that was ok. Seniors understood that hard work was its own reward and sacrifice a virtue. Duty before pleasure was their creed and their commitment to accomplish their goal was lifelong, not just a flash in the pan.

In essence, unlike many other generations, Seniors had a clear sense of purpose to what they were doing -- sacrificing for their children. Their individual struggles were shared by an entire nation which led to an unprecedented era of cooperation and mutual support. And, their efforts paid off. Success seemed to follow anyone who worked hard. This only reinforced their core belief that anything worth having is worth working to get.

Because they concentrated on their work and sacrifice, Seniors have always looked to the outside for direction and guidance. Authority figures like Dr. Spock were highly praised as was a general respect for government officials. Government programs flourished under the Seniors starting with the GI Bill of Rights which allowed virtually anyone to buy a house or go to school. The suburbs were filled with starter homes while the government provided all the infrastructure.

The prosperity of the Seniors, the respect they felt for institutions and their desire to conform all resulted into a true loyalty toward brand-name products. Seniors postponed a lot of material rewards, but when they finally let loose, they bought up a storm . . . mostly brand names they saw on TV or in ads. Anything that portrayed a glimpse of the American Dream was an immediate success.

Financial services were not complicated and interest rates were low for most of the Senior generation. Seniors paid of homes, created large retirement savings accounts, secure jobs and retired earlier than the generation before them. They are also richer, have more health benefits, better pension plans and live more comfortable lives. And, even in retirement they still want to conform as they flock to senior-oriented communities with names like Sun City and Leisure World.

Boomers: *(Born between 1946 and 1964).*

There are 76 million Boomers, making them one of the largest consumer groups ever. Boomers are bound together by their early expectations, skills and values shaped unbridled economic growth. For them, the bubble would never burst. They grew up in some of the most optimistic, positive times -- the 50's. With few economic worries to distract them, they felt free to focus instead on themselves, on experimentation and on fulfillment. It didn't help that Boomers grew up spoiled and pampered by permissive parents and authority figures who considered self-expression good for them.

Boomers grew up thinking they were special and the media gave them the spotlight at every turn. They were and still are the "stars of the show". They believe themselves to be more interesting then Seniors or the Xers that follow. They also feel a sense of entitlement and expectation simply because of who they are! After all, they are the best educated and most sophisticated Americans in history. Who else is qualified to run the country. Personal freedom was a right not something to earn. They wanted no penalties for breaking the rules and complete impunity from criticism on the job.

For early Boomers, such was their life . . . simple and orderly. However, this all changed with the Vietnam War, Watergate and the economic hard times of the later 1970's. For Boomers, all of these events represented "cracks" in their world. The system was in doubt and the Boomers saw themselves losing ground for the first time. The post 1979 period was definitely a turning point in Boomer attitudes and expectations. A new desire for affluence emerged -- a "he who dies with the most toys wins" attitude. By the mid-1980's, Regan economic and tax policies made this more pronounced by putting more money into the hands of Boomers who realized that they had to take care of themselves -- RIGHT NOW! It was an era of conspicuous consumption never seen before. BMW's replaced VWs, designer jeans replaced tattered jeans and the Home Shopping Network came into our homes to make it all possible.

Brands for the Boomers no longer dominated the marketplace. They wanted control. Discount and outlet stores thrived. This continued unabated until the shock of the '87 stock market fiasco. Suddenly, Boomers rejected the marketplace. Instead of "shop till you drop" the watchwords were "drop shopping". By the end of the eighties, Boomers were actually losing for

the first big time. Even their kids were suffering because BOTH parents were working. Debt was higher than ever and so was their weight.

Boomers reasoned that they worked hard and played by the rules but still failed. Of course, they also believed that it wasn't their fault. They cast themselves as the victims -- a resentment that lasted well into the 1990's.

Today, to a great extent, Boomers have regained their senses. They are realizing that they have created much of their own stress and they will pick their future battles more carefully. They are also realizing that they are in their peak earning years and they need to start saving for retirement. Are their days of rampant spending at an end? NOT! It is important, say the experts, to remember that Boomers are rule breakers. Their individuality is more important than conformity. They have always done things different than the Seniors before them. If it takes some spending to accomplish this, so be it. Boomers are quite service oriented. They want to be liked, yet they are driven and willing to "go the extra mile" with a tremendous sense to "prove" themselves. Boomers have been described as "the most stressed generation in history", however, they are reaching an age when they want to simplify their lives as much as possible.

Serving Seniors and Boomers

To be an effective and responsible LTC agent you need to know the emotions of your clients and know how to meet their needs. It's called "empathy". Think of it as "walking a mile in their shoes"; imagine how they perceive you as their agent. Are you too young to gain the confidence of a senior? Are you too old to relate to a boomer? Too stuffy? Are you going to fast? Too slow? Do you "speak" their language using words and mannerisms familiar to them. Is your demeanor so casual that a senior might think of you as rude or disrespectful?

This is not about "selling" something you have, it's about how to better communicate transactions so clients can understand them better. For example, if you were approaching a Senior with a long term care policy suggestion you could leverage the brand name of a big insurance company a bit, but you would also know that Seniors have come to be somewhat distrustful of big business. You would need to do more to satisfy their need to know more about your insurer.

It's all about communicating transactions so clients can understand them.

To be effective, you will also have to reach a variety of client groups on different levels. Seniors and Boomers may not respond as well to websites as will boomers. Boomers will want more detail, while seniors will want to know all the risks in plain English.

While all groups want the best price they can get, price alone is not enough. Every generation has demonstrated they will be willing to pay a little more with a guarantee of better service or some perceived value.

As to efficiency, Boomers and Seniors are pre-occupied about what goes on during the sales process. They see the sales experience as unpleasant. It makes the selling experience shorter and easier to understand. So many times, agents get caught up in "benefit limbo" by preaching facts and figures that clients simply "tune out". When you approach these two groups this way, you lose your clients.

Let's look at some more ways you can reach seniors and boomers more responsibly.

Seniors:

Serving seniors responsibly means you must respect their experience. They might like hearing from you how valuable it is to hear the way things worked in the past and that their perseverance is valued. They might also like to see that you are "part of a team" to meet their needs. Messages, literature and brochures should speak to issues of family, home, patriotism and traditional values, e.g., stars and stripes, etc. Use clear enunciation, good grammar and large type. Include "please" and "thank you" and avoid any kind of slang or near-profanity. Also, if it isn't something they feel is needed right away, don't expect seniors to jump on every product you present. They may prefer to get to know you, what to expect from you, your company, your product. They will relate to the true story of your company from where it is to where it is going. Stress the long-haul using "months and years" rather than days and weeks. Seniors will respond to the "personal touch" such as a handwritten note instead of an e-mail or fax. Also, strive to be a respected "mentor" or "coach" to your senior clients. Don't avoid the difficult issues and try to get agreement on potential problems. Agree on a course of action and set a follow-up date.

Financial discipline is still the foundation of this generation. Few of them will betray a lifetime of saving to be big spenders. They might be more willing, however, to spend money on look at something that might benefit their children or grandchildren because they are still the generation that feel they need to make something better for someone else.

When it comes to something new or experimental, you will have a much harder time convincing Seniors. They are less likely to want something new before someone else has tried it.

Responsible agents have also learned that you don't treat today's Seniors as decrepit or broken down. They see themselves as active, health, happy and vivacious. Even those who are not so healthy or energetic dislike advertising or products that remind them of their age or problems.

Seniors like consistency and uniformity in their business dealings, as well as brand name companies. They like to conform and believe in logical matters. Conversations should stay "on the topic" and not get "too personal". Seniors are disciplined but they get frustrated like everybody else with things like poor service or poor directions. The history of your products and companies are very important to this group because to a great extent, they base their decisions on what has happened in the past: What worked? What didn't? Details are also important because seniors are very uncomfortable with conflicts that arise after the sale. Seniors believe very much in law and order so products that might "push the legal limits" may be viewed with suspicion. Technology devices like voice mail, computers or e-mail are not their favorite things. In essence, you are dealing with a very conservative group

One of the best *mediums* to reach seniors are lectures or seminars given by an expert. However, this group does not like to be in learning situations (small or large) in which they might look foolish in front of someone because they don't know the right answer. If you ask a question, make sure they can answer it. Information should be organized, well researched and supported by facts, figures, details and examples. Seniors like their information in condensed form.

Also, few, if any, Seniors would like to be known as old. If you are appealing to them to contacting older clients, there is no need to point out that you are doing something a certain way because they are old. You don't need to point out, for instance, that the letter or policy you sent them uses large type to help them read it better. No one wants to be reminded that their body parts are wearing out!

Boomers:

Serving boomers responsibly will be a challenge. Like seniors, they need to know that their experience is valued. Messages like, "you're important to our success", "we need your business" or "you will really make a difference" are important reinforcements. They need to know they are part of something dynamic and that in the final analysis "they" will be the winners. Instead of historical significance, stress how your company and products are "leading edge". Always focus on the future or near future, rather than the past. It is not specifically huge amounts of data that impress them, but the nature of the data being "inside edge" or "little known" to anyone else. Third party testimonials or articles from "experts" lends more credence to this group. If you need to coach or mentor a boomer, be tactful. Be warm and find opportunities for agreement and harmony. Ask lots of questions to get to their issues. Think of yourself as an equal but always ask permission . . . "Would it be okay if we talked about your long term care?". Respect them, but be advised that they are not fond of being called "sir" or "ma'am". It reminds them of their age and they are determined to approach old age slowly and with style.

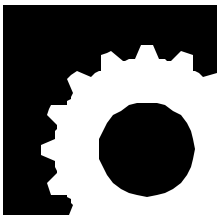
Boomers want to win at most things, however, they are realizing that convenience can also be a good thing. You clearly need to be more detail oriented with Boomers. Technology is important but they are still suspicious. Boomers look for efficient organization of information. Pack it in, but make it easily available. Let them browse.

Brand names are not a "hot button" as long as they have choices. Value, on the other hand, is critical to their thought process -- after all, you can't win if you don't get a good deal!

Because boomers see education as a means of climbing the ladder, they respond well to several learning *mediums*, especially when presented in a somewhat casual environment. To boomers, lots of information is considered a reward not a liability. Start with an overview and give them an option to get greater into the detail later. Seminars and workshops work good although they, like seniors, shy away from involved *role-playing*. They like books, videos, self-help guides and audiotapes.

Money will likely still be a problem for Boomers. After years of spending and lack of retirement planning, they need help. And, they will increasingly delegate these matters to experts. Solid instruments designed to help them save are needed most.

Boomers will continue to reject traditional methods. Asking them to do something because it is what work for the people before them (seniors) is a big mistake.



#5--Responsible LTCI Agents Monitor the LTC Continuum

A continuum is something with a continuous structure. Your life is a continuum of events from going to school, to graduating college, to getting married, to getting your insurance license, etc. It is a structure that is constantly changing, yet continuous until you die. The same is true about long term care. It starts as an illness or injury; its treated; sometimes it gets better, or it progresses to chronic stages needing long term assistance. This is the ***medical continuum***. Top agents recognize that there is also a ***client continuum*** within which clients progress through life and lifestyle changes. Let's discuss both.

The Long Term Care Client Continuum

To responsibly serve your clients you must closely monitor the LTC client continuum. It's all about changes that affect your client's decisions. Consider the following:

- You've been helping Doctor Smith with his disability insurance needs for 10 years. As he nears retirement you suggest the idea of phasing out of his disability program and using the same funds to buy a long term care policy. The continuum changes from income replacement needs to coverage for long term care.
- Recent surveys show that 33% of all LTCI buyers are under age 65. This compares to only 19% five years ago. An increase in married and wealthy purchases is also noted. The LTC client continuum suggests that your emphasis should shift toward younger (boomer), wealthier couples.
- Statistics in the long term care industry support the proposition that women incur more long term care expenses than men. Consider the fact that 80% of nursing home admissions are women aged 82 or over. They're single at this point and their nursing home stay is usually 50% longer than men. Claims in the continuum suggests women need LTC coverage more than men.
- Demographers say that every eight seconds, a baby boomer turns 55. By 2030 there will be 76 million boomers age 65 and older. Another study suggests that by the same year, at their current pace, Medicaid expenditures will EXCEED total federal revenues. The continuum suggests that you learn ways to help boomers.
- You have several wealthy clients who have built substantial estates in excess of $1 million. Traditional thinking suggests that the very wealth don't need long term care. However, does it stand to reason that anyone smart enough to amass a large estate might want to transfer the risk of a long term care illness to someone else? The continuum suggests that the suitability of long term care spans many different market groups and asset ranges.
- In recent years, a lower occupancy trend in nursing homes suggests that people prefer long term care alternatives such as home care, assisted living homes and adult day care centers. Continuum changes suggest that comprehensive LTC coverage is the trend.
- HIPPA (1996) established a whole new class of "tax-qualified" LTC policies. New legislation is moving toward "above the line" tax deductions and even tax credits for caregivers. The LTC continuum suggests that private LTC coverage is on the rise as government wants out of the long term care business.
- Stand alone LTC policies can be expensive. Watch for more "in sickness and in health" type products that blend LTC benefits, annuities and life insurance. How about a fixed immediate annuity with payments that increase upon determination of a chronic disability? The LTC continuum suggests that clients need LTC options.

- The National Association of Insurance Commissioners has launched a huge push for individual states to sanction premium rate stability rules. New disclosures and LTC premium increase histories will be standard procedure. The LTC continuum suggests that you position yourself with companies or products that can meet the new standards.

The LTC client continuum is in a constant flux as it responds to new terms, new legislation, coverage limitations, underwriting changes, medical breakthroughs and other market-driven demands. Sometimes, agents who have been in the business for many years fall into the trap of failing to hone their skills to keep up with the times. Stay focused and "tune in" to current events. Use this knowledge to provide "cutting edge" service and products to responsibly meet changing client demands.

The LTC Continuum is in a constant state of flux

The Long Term Care Medical Continuum

Long term care must also be evaluated in light of the LTC medical continuum. Residential care facilities and adult day care, for example, are increasingly covered in today's policies while earlier policies restricted benefit payments to only those facilities that offered Adult Day Care. Another example might be new generation policies that cover home care and special services, without which the insured would require institutional care. Agents need to understand how the policies they offer relate to the Continuum of Care from the standpoint of policy triggers, ADLs, mental deterioration, etc. This can only be accomplished by evaluating individual policies on a case by case basis.

You must constantly monitor policy benefits to make sure they are meeting the medical continuum. Here are some recent benefit trends shaping the continuum:

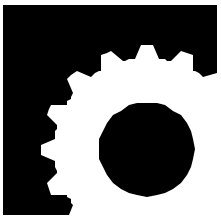
- Dependent spouse home care provisions allow the policyholder's spouse to concurrently receive home health care coverage during the same visit by the same provider. The purpose of this benefit is to protect the financial interests of the married couple by reducing their out-of-pocket expenses.
- Weekly home health care provisions change the *daily benefit* for home health care services to *weekly benefits*. Often times, an individual needs intensive nursing services in a short period of time which may exceed the daily cost cap. Now, the policyholder would have access to the entire weekly amount to pay for these same services.
- Flex fund benefits allow policyholders to use their "bucket of money" to cover a variety of LTC expenses that are not otherwise covered under the policy while he or she is living at home. An example might be reimbursement of home health care expenses that exceed the daily benefit amount.
- Enhanced elimination periods liberalize how days are credited toward the elimination period. In the case of multiple, but separated periods of care, for example, this provision would provide that each date of service would satisfy the elimination period regardless of whether it was accumulated under separate claims.
- Spousal survivorship / waiver provisions waive the policyholder's premium in the event that his or her spouse dies or goes on claim after a defined period. Conditions to waiver might include the need for both spouses to have policies in force for a certain period of time (say 10 years).

All of these continuum changes suggest that LTCI is becoming much more than an asset protection vehicle. Clients now need LTC coverage to satisfy their long term care lifestyle needs, e.g., home care as long as possible, companion shopping aides, etc.

More On The LTC Medical Continuum

The long term care medical continuum is also the ever-expanding and multi-faceted range of services needed by the long term care market. Today's continuum might consist of the following:

Chore services: Volunteers buy groceries, mow lawns, vacuum, run errands, etc.
Home visitors: Meals-on-Wheels, story reading, companionship, etc.
Senior centers: Social activities, dances, bus tours, etc.
Adult day care: Daytime activities, lunches, therapy, games, etc.
Home health care: In-home services by nurses, physical therapists and dieticians, etc.
Rehabilitation programs: Provide extensive physical therapy, occupational therapy and speech therapy.
Respite care: Individuals provide relief to aid primary caregivers.
Retirement housing communities: For the independent elderly, offering individual units, security, social activities, etc.
Continuing care communities and centers: Designed to meet residents' changing needs from retirement housing through skilled care.
Assisted living centers: Offer medical attention, as well as assistance with eating, bathing and other activities of daily living.
Nursing facilities / skilled nursing: Provide intensive nursing care around the clock.
Subacute care: Provide post-acute or heavy skilled care that is expected to be of shorter duration than usual skilled care.
Acute care: Surgical or hospital with lengths of stays limited by diagnosis-related insurance coverage.



#6--Responsible LTCI Agents Sell Only What They Know & Believe In What They Sell

Ask yourself these questions. Do you really know your long term care product? Is it worth the premium you are asking? Do you believe it is supported by a stable, long-term company? Would your mother or father approve of you selling it? If you can answer "yes" to these questions, you will surely be able to provide your client enough reasons to invest in a policy. Anything else is a *hard sell*.

Face facts, no matter how ethical and honest you are . . . people you have never met or see only once a year don't trust you (not yet anyway). They are skeptical and have doubts about your product and about cracking open their wallet and sending you away with any of their hard earned money. You have the same concerns every time you make a purchase from someone that you do not know . . . don't you?

Before you can convince a client, you have to convince yourself.

Unfortunately, there is no secret formula or catch phrase that will hypnotize your clients and make them believe everything you say. You won't prove your knowledge and prove you believe by talking the talk . . . instead, you convince your clients by walking the walk. You get them to pay attention by what you do and how you do it. Ask questions, listen to answers and transfer your feelings for you, your company, and your solutions. Be proud of what you sell and believe in what you sell. Communicate that to your clients and they will beat a path to your door.

Before responsible LTC communication can take place, you have to convince yourself it is the best solution for your clients. And, you can't sell what you don't know. So, here's a dose of basic LTC:

Defining Long Term Care

Long-term care is the kind of help you need if you are unable to care for yourself because of a chronic illness or disability. Section 7702B of HIPPA 1996 defines a “chronically ill” individual as someone unable to perform at least two activities of daily living for a period of at least 90 days and/or someone who requires “substantial supervision” to protect themselves from threats to health and safety due to severe cognitive impairment. Long term care services can range from help with daily activities of living, such as bathing, shopping or dressing, to skilled nursing care in a nursing home. Care can be provided by friends and family, local home care agencies, adult day care programs, nursing homes, and residential and retirement facilities.

The traditional long-term care policy is defined as any accident and health insurance policy or rider advertised, marketed offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital.

Many states have introduced "partnership" programs between the state and private insurance carriers. The goal of most partnership programs is to find a workable solution to the problem of financial impoverishment that happens when long term care expenses hit low-to-middle income families. In addition to traditional long term care benefits, these policies usually carry an asset protection feature that assures the beneficiary that he or she will keep a certain amount of assets and STILL qualify for Medicaid.

Long Term Care Services and the People Who Need Them

Long term care services might be needed by almost anyone. An accident or sudden serious illness could be the trigger as well as a slow progressive condition like rheumatoid arthritis, Alzheimer's / Parkinsons or cardiovascular disease. Conditions are likely to befell any age and gender although women seem to need them more than men for various reasons.

Long term care services can be purchased with insurance benefits, provided by government entities or paid "out-of-pocket". Some traditional long-term care policies ONLY cover services in a nursing home (termed intermediate care facility and skilled care facility) while others cover home and community-based services. In some instances, the home and community-based services, which often can help a person avoid going to a nursing home, are limited, so be sure to read the policy carefully.

Women are more likely to need LTC care. Men have more acute health episodes.

Policy benefits can be used to purchase Medicaid-eligible long-term care services which include the following:

(1) Long-term care services available under Medicaid home and community-based services provided by a licensed home health agency, and speech, occupational, and physical therapy and medical transportation;

(2) Long-term care services covered under the Medicaid home and community-based services waivers for the aged, the disabled, and HIV/AIDS victims, including homemaker, chore-housekeeping, personal care attendant, adult day care, assistive equipment, home renovation, home-delivered meals, and emergency response systems offered by Medicaid approved providers as part of an individual assessment and plan of care developed by a case management agency approved by the Department of Aging and/or the Department of Rehabilitation Services; and

(3) Other alternative services which are deemed by the state Medicaid agency as essential to prevent institutionalization and offered by appropriately licensed or approved providers.

Long term care services may "evolve" from emergent . . . to acute . . . to chronic.

Types of Care

Skilled Care

Skilled nursing care is care that can only be performed by, or under the supervision of licensed nursing personnel. Skilled nursing facilities must provide twenty-four (24) hour nursing service and must require that the medical care of every resident/patient be provided under supervision of a physician.

Intermediate Care

Intermediate care is that type of care that is not as demanding as skilled care but requires more attention than custodial care. Because the patient's condition is not as demanding as a skilled care patient the twenty-four (24) hour nursing program is not required. Because of their mental or physical conditions, patients in intermediate care facilities require care and services above room and board that can be provided through institutional facilities.

Custodial Care

An individual in need of custodial care typically would be in some need of help in personal needs such as dressing, bathing etc. Certainly, this type of care is no where close to the demanding needs required in a skilled care situation.

Hospital Based Nursing Facilities

These services are also known as extended care facilities and are actually departments located within hospitals. They provide the highest levels of medical and nursing care, including 24 hour monitoring and intensive rehabilitative therapies. They are intended to follow acute hospital care due to serious illness, injury or surgery.

One of the major differences between the hospital and nursing home facilities is that the hospital facilities are not meant to be a permanent residence but rather for a short term until the patient can be sent home or maintained elsewhere. It should be obvious that hospital based care will be very expensive as compared to other types of long-term services available.

Skilled Nursing Facilities

Non-hospital based skilled nursing facilities provide a relatively high level of nursing and other medical care, as well as a personal care and assistance. These type patients are typically in need of close monitoring due to illnesses or impairments.

Licensed nursing is available around the clock with at least one supervising registered nurse on duty at all times. Additionally, most other prescribed medical services can also be provided, including rehabilitative services. Depending on the seriousness of the illness, a stay in a skilled nursing facility can be for a short-term or even extended to a long-term stay.

Intermediate Care Facilities

These facilities provide less nursing and other medical care than the skilled nursing facilities. They are geared for long-term residents with chronic illnesses or impairments but whose conditions are as acute as those who would stay in the skilled nursing facilities.

Staffs are geared toward personal care and assistance with rehabilitative services optionally available. Typically, these types of facilities will not cost as much as the skilled facility and therefore the number of intermediate care facilities available will be limited.

Intermediate care facilities may also provide a combination of both skilled and intermediate services. However, because of the flexibility and diversification of services, the more serious patients may not receive the same degree of care that a dedicated skilled facility may provide. Additionally, the high cost of skilled medical care may be passed on to those who are not in need of those services.

Assisted Living vs. Nursing Home

Assisted living centers are a form of intermediate care facility that should not be confused with skilled nursing care. Assisted living facilities can take up a special wing of a building or they can be “mom and pop” operations as small as six beds in a private home.

The difference between an assisted living facility and a nursing home lies in the degree of assistance needed by the patient. Nursing home residents typically need help with four activities of daily living while assisted living residents need help with only two ADLs. Assisted living provides a place for people who are not typically bed-bound but can’t stay at home anymore because they need help.

Newer long term care policies provide assisted living benefits as a percentage of the nursing home benefit (usually half) although some offer equal benefits. Policyholders generally qualify for assisted living coverage where they are unable to perform two or more activities of daily living. In some cases, cognitive impairment may trigger coverage.

Assisted living is considered an alternative to nursing homes care and one of the fastest growing segments among long term care providers.

Home Care

Home care includes a multitude of medical and personal services that can be provided at home. The word “home” is usually used to the context of meaning the private home of the person or even the home of a relative or friend. Typical Home Care services can include the following;

- **Homemaker -** A home-care agency staff member who provides meal planning and preparation (including assistance with special diets), routine housework, shopping, and assistance with personal care. This is considered to be non-medical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.

  Specific components of homemaker service include the following:

  - ✓ Teaching and/or performing of meal planning and preparation
  - ✓ Routine housekeeping skills/tasks
  - ✓ Shopping skills/tasks
  - ✓ Home maintenance and repairs
  - ✓ Assisting with self-administered medication which shall be limited to reminding the client to take the medicine, reading instructions for utilization, uncapping medication containers and providing the proper liquid and utensil with which to take medications.
  - ✓ Assisting with following a written special diet plan and reinforcement of diet maintenance
  - ✓ Observing client’s functioning and reporting to the appropriate supervisory personnel
  - ✓ Performing and/or assisting with personal care tasks (e.g., shaving, shampooing, combing, bathing, cleaning teeth or dentures and preparation of appropriate supplies, transferring client, and assisting client with range of motion.
  - ✓ Escorting the client to medical facilities, errands, shopping and individual business

- **Health Care** - These are medically-related services prescribed by a physician including nursing services, physical, respiratory, or speech therapy, and performance or personal care and medication administration.

- **Personal Care** - assistance with personal needs such as hygiene, dressing, bathing etc. This can be performed by a Personal Assistant who would be directed by you or your representative to assist with household tasks and personal care as listed above. The person hired must meet specific requirements of the insurance companies.
- **Nutritional needs** - meal planning, cooking and delivery
- **Special needs** - transportation, telephone and companions.
- **Emergency Home Response System -** Communication devices which signal a network of emergency responders. The system must provide 24-hour a day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an emergency arise. An Electronic Home Response Center is part of a network of emergency responders.
- **Remodeling -** Modification of your home to enable you to be less dependent on direct assistance from others. Examples include, installation of ramps, grab bars, or widening doorways for wheelchair access.
- **Assistive Equipment -** Equipment with a useful life of at least one year, designed to increase independent functioning (e.g. wheelchair).
- **Other Approved Services -** Partnership Policies also provide alternate services deemed essential to prevent institutional care and offered by licensed or approved providers. These "other" services must be approved in advance by the Department of Public Aid and the insurance company.

Adult Day Care

Direct care and supervision of individuals in a community-based setting. Services include transportation to and from the adult care center, assistance with activities of daily living, meals and snacks, health and medication monitoring, and an activity program. These programs can be useful for working couples willing to care for an elderly parent who needs some form of supervision. Adult day care can also respond to a need for planned therapy or learning activities and better nutrition.

Adult care emphasizes both achievement and a continued effort to retain and enhance independence. For the elderly, adult day care enables them to live at home and to retain community contacts.

Alternative Care Facilities

Senior citizens needing daily living assistance are always looking for alternatives from having to enter a nursing home. Two of these alternatives include the Life Care Communities (LCC) and the Continuing Care Retirement Communities (CCRC).

Many communities require individuals to carry a Medicare-supplement policy in addition to Parts A and B of Medicare. This requirement, often written into the contract, ensures that the Retirement Communities do not have to pay for acute illnesses.

Some Communities also require that individuals carry long-term care insurance. Since these facilities aren't generally funded in advance, the policies help pay for resident's care. Some facilities that require long-term care policies want residents to buy the policies they have pre-selected. Others may require the purchase of a long-term care policy but don't specify the policy that they would prefer.

Life Care Community (LCC)

A Life Care Community is a living accommodation where one can expect to live an active, independent life for many years. Later, should additional care be necessary, it is available on the same premises at two different levels.

The first level, independent living, is something like living in a nice resort hotel. There are recreational facilities such as exercise rooms, swimming pools, crafts rooms etc. Balanced meals and transportation to local malls are even provided. Most people enter a LCC somewhere between the ages of 74 and 78. It is estimated that the average healthy resident can enjoy ten years or more of active, independent living before other care services are needed.

The second level is generally known as assisted living. It is sometimes referred to as custodial care. Residents at this stage of their life may need someone to serve meals, bathe, dress and even take care of medication needs. In many communities, a separate facility within easy walking distance is provided for those who need this kind of assistance.

The third level is considered to be skilled nursing and requires 24-hour care with a registered nurse present. At this level, the resident is under the care of his/her own doctor.

Continuing-Care Retirement Communities

Continuing Care Retirement Communities, sometimes called Life Care Communities, combine all three levels of care - independent living, assisted living and nursing home care in a single setting. Traditionally, such communities have required a sizeable entry fee, plus monthly maintenance fees, in exchange for a living unit, meals, and health care coverage, up to the nursing home level. In recent years some communities have begun to offer their services on a month to month rental basis with health care coverage being paid for at the time of need rather than on the basis of the coverage afforded by the traditional entry fee or 'life care' endowment. "

Today there are many "continuing care" communities, but very few actual "life care" communities. Some states have passed legislation that requires specific features be present before a facility can advertise themselves as a life care facility. Such as:

- Guaranteed health care coverage for life - no exceptions;
- A guarantee that if the resident's resources were exhausted that they could not lose their residence or their benefits(i.e. they had to be financially subsidized by the retirement community)
- The retirement community had to have a nursing facility within the community itself .
- The residence (apartment) that they occupied when they entered the community could not be taken from the resident for any reason.

Very few continuing care retirement communities meet these stringent requirements, although they may provide many if not all of the services and benefits of a true 'lifecare' community. Therefore strictly speaking a 'lifecare' community is always a "continuing care" community, but most CCRC's are not 'lifecare' communities and do not advertise themselves as such. Also A substantial percentage of CCRC's are now managed by "for profit" companies instead of the traditional religious non profit associations that dominated the industry prior to 1970. This has led to a number of interesting and innovative types of continuing care retirement communities in recent yearsToday, CCRCs are the fastest growing segment of the housing market for older Americans. In return for substantial entrance fees, these communities promise a place to live for the rest of your life, some, if not all, of your meals, and most important, nursing care, should the need for it arise.

Skilled nursing is provided round-the-clock on special floors or even in a separate building, if necessary. Not all residents will need nursing care, but for those who do, their care is funded with the fees paid by all the residents. In this sense, CCRCs work like any insurance policy. Premiums paid by all policyholders are pooled to pay benefits to those who suffer some misfortune. "

Entrance fees are high, and most people entering a facility use the equity in their homes to pay for them. Entrance fees average from about $50,000 to $75,000 for one-bedroom apartments to about $76,000 to $96,000 for two bedrooms.

Respite & Transportation Issues

This is a short-term substitute care for chronic individuals that relieves the primary caregiver. It is not a single, specific program but rather a service provided in a variety of optional settings. It gives caretakers of patients the opportunity to respond to their own needs or take care of personal matters. This is a very flexible program. This care can be delivered at home or in an institutional setting. Bottom line, respite can meet various objectives for the caregiver, the care recipient, and the community at large.

> *Example: Robert is a 73 senior who suffers from a combination of Alzheimer's and Parkinsons. Because of his physical and cognitive impairments, Robert needs substantial supervision. His wife Betty has elected to take of Robert at home with help from her family. Unfortunately, the sons are limited to helping ONLY on the weekends. This left Betty with a full 5 days of caregiving which at times was very taxing – both physically and mentally. To help break-up the week, Betty arranged for respite care for Robert during the middle of the week. This allowed her to get out for 4 hours or so to do shopping and just get away from the constant care that Robert needed. The respite caregiver was unskilled, but knowledgeable in the areas of supervising Robert during his meals (to prevent choking) as well as hands-on and standby assistance when he moved from his chair to the bed.*

The fate of elderly persons may very well depend upon the ability to get to shopping and medical appointments. Transportation to medical appointments is provided by adult day care centers and homemakers, and the homemaker service offers shopping assistance. Medical transportation is also available in many areas of the state.

Long-Term Care Insurance

Long-term care insurance is an extremely practical method available to cover the cost of chronic care. A recent survey by the National Association of Insurance Commissioners (1997) concluded that the top 3 reasons for purchasing LTCI was:

1) To avoid dependence on others and maintain independence.
2) To guarantee affordable services in a world of rising costs.
3) To protect assets.

While these issues are clear to consumers, there is a great deal of debate concerning long-term care insurance. The insurance industry claims that long-term care insurance is the method of the future to pay for long-term care. Critics claim that long-term care policies are deceptive, inadequate and too costly. Over the past five to ten years there has been a dramatic change in the quality and nature of long-term care insurance policies.

Most states have adopted laws and regulations concerning long-term care insurance which forced the quality of insurance products to improve. This is especially true since the introduction of the National Association of Insurance Commissioners Model Act and Regulation on Long-Term Care Insurance.

Long-term care insurance has become the fastest growing type of health insurance sold in recent years. Spurred by the pending "elder boom" and its promise of an enormous market, hundreds of private insurers have joined the field since 1987. Despite all the hoopla, however, private LTC still cover less than 5 percent of all long term care expenses. And, despite recent tax legislation favoring LTC deductibility, unless a major acceptance or government promotion of private LTC insurance occurs, it is likely that Medicaid and out-of-pocket costs will continue to fund over 80% of all LTC costs in the near future. Longer term, the burden will shift more to the individual where private pay, LTCI will play more prominent roles in LTC funding.

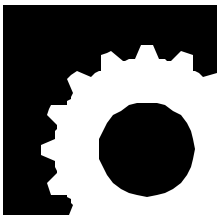
Most long-term care insurance policies pay indemnity benefits based on certain benefit triggers called ***Activitirs of Daily Living (ADLs)*** directly to individual policy holders. These payments enable insured patients to purchase nursing home care privately instead of relying on Medicaid. If everyone who can afford it were to purchase long-term care insurance, financing problems for nursing homes would decline, Medicaid costs would plummet, and both public and private patients would experience easier access to quality care.

Insurance companies promote long-term care insurance as a protection for assets that are built up over a lifetime. Another reason for insurance is to protect your assets for your spouse or family. Or you may simply feel more comfortable having a policy that helps you avoid nursing facilities by obtaining care at home. Private LTCI can also eliminate or reduce the chances of impoverishment or reliance on government programs or family members in the later years. There are those individuals that decide to buy a policy as a means of getting into a more desirable nursing home or any nursing at all -- Remember, not all institutions accept Medicaid patients.

Of course, one of the major problems with purchasing a long-term care insurance policy is whether an individual, such as a retiree, can afford the cost. For a portion of retirees, the answer is no. The average annual per capita income for someone 65 or over is about $17,000. If a 65 year-old with average income could pay about $2,000 each year for a good long-term care policy with inflation protection 12 percent of his/her annual income would be exhausted. Add other expenses and you can see that it may be quite difficult for some elderly people to handle these kind of premiums. What are some accepted benchmarks of LTCI affordability?

- Consumer reports says that anybody who can set aside $160,000 (1997) at compound interest solely to pay nursing home care may not need a policy at all.
- The National Association of Insurance Commissioner's Shopper's Guide says that if an individual's only source of income is a minimum Social Security benefit or Supplemental Social Security Income OR if someone has trouble stretching income to meet financial obligations such as paying for utilities, food or medicine, they should not buy a policy.
- NOLO Press says that if you have to pay more than 5 percent of your income for long term care policy premiums, it's a bad investment. NAIC uses a 7 percent factor.

Again, this is where agents must counsel clients on the need for "some" benefits or perhaps **NO benefits at all**.. Perhaps a policy with shorter policy benefits, a higher elimination period or fewer bells and whistles such as compound inflation protection. Some of these changes might offend LTC purists, but as we said, some protection is better than none.



#7--Responsible LTCI Agents Match Policy Features & Options To Client Needs

Once your client's needs and priorities are uncovered, the job of matching policy benefits begins. In the world of long term care insurance, no two policies are the same. In many cases, the changes from one plan to the next relate to the definitions of **"covered services"**. There are countless choices to make concerning benefits, length of coverage and services needed and purchasers are likewise varied in their needs and ability to pay.

Features of some long term care policies will be worth more to certain people. Some will demand quality care at any price. Others prefer a higher degree of self-insurance requiring only "basic" LTC insurance benefits. And, all agents should know that there are specific instances where clients should be advised to hold-off or completely avoid buying long term care coverage. In essence, there is no single approach to design or evaluate a long term care contract. Rather, the responsible agent should make a careful client suitability assessment followed by a needs analysis to target the most beneficial features and options.

The purchase of LTCI does not ensure that all LTC costs are avoided.

Also, as good as LTC coverage seems, it is extremely important for you to know and point out to your clients that ***the purchase of long term care insurance does not ensure that someone will avoid ALL long term care costs***. A person who owns a policy could still end up on an assistance program like Medicaid. How does this happen? Like other forms of insurance, people buy less than they need, or, they refuse an option like inflation protection leading to coverage short falls. There is also the possibility that an insurer waivers their specific condition or simply goes out of business.

Choosing the most workable long term care insurance policy is a process that starts with the knowledge you just acquired, followed by some detailed methods and queries:

- ***Obtain a specimen policy and read it.***
- ***Determine the daily or lifetime benefits needed. Does the policy match? How much does it cost to upgrade?***
- ***Determine how long benefits need to last.***
- ***Will benefits automatically increase or does the client have options to increase them.***
- ***Find out exactly how the policyholder qualifies for benefits.***
- ***How soon after an illness or chronic condition should benefits begin?***
- ***What services are needed and covered?***
- ***Should the policy be "tax qualified" or "non-tax qualified"?***

Let's discuss these topics in detail:

Specimen Policies

An insurance agent should never sell an important product like long term care without first obtaining and understanding a specimen policy from the insurer. One of the most important reasons to obtain them is the rapid evolution of products, policies and definitions, e.g., what is

an “applicant”, “certificate”, “group policy”, etc. Selling without one is like operating a computer without an instruction manual or help screens.

For example, a long term care policy that considers a person disabled if someone has to be present to assist when they get out of bed is different than a policy that requires “hands on” assistance to actually lift the person out of bed. One could trigger benefits, the other would not. While this may seem like “splitting hairs” to you, it is a big deal to a policyholder and caregiver who must spend thousands of dollars to hire help when a policy fails. He and his attorney may just as well ask ***you*** to pay these costs if they were led to believe they were covered.

A close review of a specimen policy would also uncover the basic purpose of the policy. For example, a stand alone home health care contract might easily be misconstrued as long term care coverage. A specimen policy would determine if these benefits continue or end when a policyholder enters a nursing home. Could you hear the client’s attorney asking you why you did not suggest nursing home coverage? As far-fetched as this seems, be aware that agents have been held liable for not knowing the basic features of policies they sell. Further exposure may accrue if there is a policy option that is widely available at a reasonable cost that the agent failed to present or offer to the client. The best way to cover all the bases is to know all the features and options as explained in the specimen policy. Do not depend on the insurance company literature or illustrations to give all the information needed to properly evaluate a policy. Obtain a specimen policy and review it carefully.

Daily Benefits Needed

Providers of LTC are responding to new state and federal legislation and added competition by expanding LTC benefits. The heart of these changes is the daily benefit. Amounts can range from $20 to $300 per day for a range of services. Important evaluation questions include:

- ***Is the benefit amount enough to meet the cost of local nursing homes or facilities near where your client plans to retire?*** *Costs can range from $90 in the mid-west to $300 in New York City. Be sure to advise clients that costs may exceed benefits.*
- ***Does the policy indemnify for a fixed daily amount or simply reimburse for actual costs?*** *Most policies are indemnity plans that can cover incidental costs versus reimbursement contracts that cover actual costs. Reimbursement plans generally pay less, but cost less.*
- ***What is the daily benefit for home care and assisted living?*** *Typical policies cover these conditions at 50 percent of nursing home benefits. Unfortunately, the cost of either can meet or exceed nursing home expenses.*
- ***What about weekly home health care provisions?*** *Some policyholders need intensive care services in a short period of time which may exceed the daily benefit amount. A weekly home care provision gives the individual access to the entire weekly amount to pay for such services / visits.*
- ***Can benefits be used as a pool of money for both nursing and assisted living / home care?*** *A pool of money may use the maximum benefits of the policy sooner but at least the cost of BOTH assisted living and home care is covered for the meantime.*
- ***Can the benefit amount be increased later? If so, will underwriting be required?*** *This can be a valuable option for meeting unanticipated care down the road. However, added benefits are usually associated with higher premiums, especially if the new insurance is written at the insured’s attained age.*
- ***Can the benefits be decreased if the cost of the policy becomes too much to pay?*** *Coverage will drop, but at least some benefits will be paid.*

Be sure your client’s budget can handle a 50% increase in LTCI premiums.

- ***Can benefits be purchased <u>jointly</u> for a married couple?*** *The discount is typically 10 to 15 percent.*

In many cases, one spouse or the other may be uninsurable due to illness or age. The well spouse should especially consider long-term care, since he is likely to survive the ill spouse and will, therefore, have no spouse to care for him. In addition, the well spouse would likely spend some considerable time providing care for the ill, uninsurable spouse.

The cost of long-term care insurance is most severe for married couples. Each may need coverage, and this doubles the premium amounts paid. Some insurers are introducing family policies that cover spouses. There is generally a price break, if both are in good health, because the odds are against both needing long-term care.

A new twist in the care of couples is the ***Dependent Spouse Home Care Provision*****.** This allows the policyholder's spouse to concurrently receive home health care coverage during the same visit by the same provider. It makes sense! Care for both spouses at the same time. Out-of-pocket expenses are reduced all the way around.

Another long-term care insurance policy is a life insurance policy with long-term care coverage as an integral part, not as an added rider. With this type of insurance policy, an individual can buy a paid up policy with one premium. The coverage is for two people, usually spouses. The life insurance does not pay out until both spouses die. After one spouse dies, the other still is covered for long-term care expenses.

> *Example: A couple purchased a long-term care insurance policy in 2001, paying a $50,000 single premium. He is 60, and she is 52. The original death benefit will be $165,000. Assume the premium earns 8.75 percent per year. Assume that in the year 2011, the husband goes into a nursing home that costs $3,000 per month. He remains in the nursing home for one year, accumulating a $36,000 bill, all of which would be paid by the insurance policy. Then he dies. His widow is still covered. In the year 2028, when she is 79, she goes into a nursing home, which at that time, costs $5,000 per month. She is in the nursing home for four years, at a total cost of $240,000. Again, all of the costs are paid by the long-term care insurance policy. In 2033, she dies. Even though $276,000 has been paid in nursing home costs, there is still $105,000 in life insurance proceeds for the policy's beneficiaries. If the tax laws in 2033 are the same as they are today, no income tax will be due on the $105,000.*

Let's look at some more policy benefits to assess:

- ***Is a <u>survivorship benefit</u> available?*** *Some insurance policies that cover both spouses have a* ***"survivorship" benefit****. Under a survivorship benefit, when one spouse dies, the other owes no further payments, as long as the policy has been in force for at least ten years.*
- ***Will benefits be paid if the caregiver is a friend or family member? What about caregiver training?*** *Some policies allow this under home care benefits. The daily benefit for informal care is typically one-half the home care benefit.*
- ***How much does home care coverage add to the premium?*** *Home care benefits are typically one-half the nursing home benefit but could raise premiums by 30 percent or more. Policies where home care benefits equal nursing benefits will probably increase rates about 50 percent.*
- ***Is the premium for benefits more than 5 percent of the client's income?*** *Some industry analysts believe that the cost of long term care should not exceed this threshold.*

- ***Are premiums guaranteed to stay level?*** *It's doubtful. Clients should know that rates can increase by state residency or by class of policyholder. Some say that clients should prepare for an average 50 percent increase over time. Remember, extremely low premiums today, might guarantee rate increases later.*
- ***Is there a limited pay or "paid-up" feature?*** *Nonforfeiture or paid-up features are an option that clients should know about. They can be expensive now but useful later, e.g., a working couple with strong income today can retire with a paid-up policy.*
- ***Is there a "flex fund" provision?*** *This is slightly different from a pool of money in that the policyholder may use these funds to pay for a variety of long term care expenses that are not otherwise covered under the policy, e.g., using flex fund amounts to satisfy some or all of the elimination period.*

How Long Will Benefits Last

Choosing the length of time that benefits should be paid is an individual choice. Companies offer, one, two, three, four, five or six years and lifetime options. In a perfect insurance world everyone would want lifetime benefits. But is the price worth it? A nursing home-only policy for a 65 year-old, for example, may run $1,400 - $2,000 per year with a lifetime benefit. A four-year benefit period is about 30 percent less and a two-year benefit would cost one-half the lifetime option.

When selecting a benefit period, keep in mind the following statistics from the an AARP June 1997 survey: Nearly 90 percent of all people who enter a nursing home between the ages of 65 and 85 stay an average of 2.5 years; The average duration of home caregiving is 4.5 years.

Here are some additional questions and comments to help you assess this category:

- ***Is there a restoration of benefits clause?*** *If a policyholder receives care in a nursing home and recovers, the policy benefits may be restored to the original level.*
- ***Does the insurer count days or years?*** *Most benefits are expressed in years but insurers actually count days. In some cases insurers will count three or four days as a week. This is a completely unacceptable condition.*
- ***Do benefits paid through an HMO count as a full day?*** *Although it is rare, some policies count a day of care provided through an HMO as less than a full day. This could be a bonus for the insured.*
- ***Do home health care and adult day care benefits pay for a full day?*** *This can be important to the relief and effectiveness of the primary caregiver.*

Can Benefits Increase or Decrease

After a client is convinced that long term care insurance is an essential part of their financial planning there are decisions to be made on the many optional benefits available.

- ***Do nursing home / home health care benefits increase automatically?*** *Nursing home costs have been increasing between 8 and 9 percent since 1985. A cost of $110 per day today will run up to $513 in 20 years at 8 percent inflation.*
- ***Is the increase based on the Consumer Price Index, Medical Price Index or is it fixed?*** *No ones knows the future, but if benefits at least kept pace with inflation the policyholder should have some form of additional protection against rising costs.*
- ***Is there a "cap" on the amount benefits can increase?*** *Beware of companies that "cap" their inflation increases to two or three times the base benefits.*

- ***Are future benefit increases available on demand?*** *Some policies offer the option to increase benefits every so often at the client's attained age. Look for additional underwriting and be alert to any condition that eliminates this option if it has been offered and refused by the policyholder a specific number of times.*
- ***What kind of inflation protection is offered?*** *Protection can increase at 5% compounded or 5% simple. The corresponding increase in premium would be about 60% and 50%. A daily benefit of $110 today will grow to $292 in 20 years at 5% compounded vs $220 under 5% simple.*
- ***What is the cost of waiting to buy inflation protection later?*** *Policies that allow the purchase of additional coverage later can be cheap today but expensive down the road. A 65-year old might pay only $770 today for a policy with optional increases compared to $1,598 for one with automatic protection. In 20 years, however, the policy with optional increases could cost over $5,000 compared to the same $1,598 for automatic benefit increase protection.*
- ***If inflation protection is too expensive for a client today, is it cheaper to just increase benefit levels?*** *Perhaps. A premium for higher benefits but no automatic inflation protection will most likely cost less today. The risk taken is that clients may be unable to afford the coverage needed in 10, 20 or 30 years or simply have to accept lower benefit levels than would have been provided with automatic protection. These are trade-offs that need to be discussed with clients.*

Optional benefits can go a long way to solving a client's long term care insurance needs and they should always be recommended. However, agents should be careful of riders that look too good to be true; they probably are. Additionally, it doesn't make sense to sacrifice good carriers and good base benefits for an attractive option with an inferior company with less than comparable base features.

If a benefit or service is not listed in the policy, there is no harm to ask for it to be covered.

How Do Policyholders Qualify for Benefits

In general, the longer the list of qualifying daily activities (ADLs) and the fewer a policyholder must fail, the easier it is to get benefits. Most policies will specify that the insured must fail two or three of these activities to begin receiving benefits. Agents should be aware that the number of activities may not be as important as the type. For example, with one company a policyholder must fail two activities in dressing and mobility. This could be harder to qualify than another policy requiring three activities; bathing, dressing, eating.

Here are some evaluation comments and questions:

- ***Are bathing and dressing on the list of daily activities?*** *If a bathing or dressing disability is a trigger of coverage, policyholders will have a much easier qualification and will qualify sooner since these are two of the first daily activities that chronically ill people are likely to fail.*
- ***Are activities explained in different ways than other policies?*** *Some define an eating disability as the inability to feed oneself while another may define it as the need for someone to watch over the party eating. Look for clarification on all activities of daily living as well as terms like: assisted living, walking or wheeling, cognitive impairment, ambulating, transferring, etc.*
- ***Does the policy assess physical activities on a "standby" or "hands-on" basis?*** *IRS 97-31 rules clarify the difference: "Hands on" assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. "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. More on this in Section 6.8. Suffice to say, policies that cover only individuals requiring "hands-on" assistance would generally provide fewer benefits than one that included "standby assistance".

- ***Will the policy pay on a "medical necessity"?*** *Patients can be too frail to care for themselves from a medical condition like coronary disease, yet still able to perform daily activities. "Tax qualified" plans do not recognize medical necessity.*
- ***Are there special underwriting definitions?*** *One company uses the term "standard" to describe its worst class. For another, it means mid-grade.*
- ***Is there "lifestyle" underwriting that will automatically cause an application denial?*** *One company says that anyone who needs assistance with housekeeping, shopping and household finances is simply unacceptable.*
- ***Does the policy require special equipment installation before benefits can begin?*** *Some insurers may require the insured to install grab bars or a shower stall in place of a tub before they will pay benefits. These restrictions are not favorable to the policyholder.*
- ***What are the measures of cognitive impairment?*** *Look for methods that fairly measure cognitive impairment using terms like thinking, reasoning, remembering, memory, etc. HIPPA provisions measure cognitive ability based on whether the individual needs "substantial supervision" to protect himself from threats to health and safety.*
- ***Is cognitive impairment measured separately from physical measures of ability?*** *A company that uses physical methods to determine cognitive assessment may overlook people who can pass the test or perform daily activities but forget how or why they did them. Worse yet, their mental impairment could become a threat to how they do them in the future.*

When Should Benefits Begin

The choice of an *elimination or waiting period* depends on a clients needs and ability to cover the early costs in a chronic illness. Elimination periods generally run 30, 90 or 180 days with options to lengthen this time more in exchange for reduced premiums. As with other forms of insurance, this trade-off can be attractive. Some would say, however, that the lower premium creates a "false economy" A policy with a 90-day elimination, for example, might cost $300 per year less than a policy with 20-day elimination. After 20 years, a policyholder would save about $6,000 in premiums, but with 5 percent inflation, the 70 additional days of care would cost over $20,000.

Others argue that a longer elimination may be the only way people can afford insurance and that a little "self-insurance" for a short duration is generally not significant when compared to long run premiums. The alternative, they say, could mean no insurance at all.

When evaluating long term care policies look for the definition of an elimination period. Can insureds accumulate days over a period of time? Are there separate eliminations for different services or providers? If so, a policyholder who needs both may create difficulties in qualifying for benefits. An ***enhanced elimination period provision*** liberalizes how days are credited toward the elimination period in that each date of service would satisfy the elimination period regardless of whether it was accumulated under separate claims.

Does the policy offer consecutive days for home health care or adult day services? If these services are used only a few days a week does the policy count consecutive days toward the elimination period?

What Special Services are Covered

- ***Does the policy pay for home care alterations?*** *Some will pay for stair lifts, ramps, grab bars, etc; allowing an insured to receive care at home.*
- ***Is there a return of premium or nonforfeiture option and how much does it cost?*** *Clients are always concerned about paying insurance premiums and getting nothing in return. Offering them this option may increase premiums by 30 to 50 percent, but they will be certain to get something out of the policy.*
- ***Is there a vesting schedule on any return of premium?*** *Return of premium riders typically start or "vest" after five years. Some return more as the years go by. The return of premium is paid upon termination of the policy by lapse or death.*
- ***Determine how the policy's nonforfeiture options work****. Nonforfeiture options will either return premiums or pay benefits. The benefit may be purchased as "full" (it accrues regardless of claims paid) or "limited" (claims are subtracted from any premiums or benefits paid).*
- *Nonforfeiture and return of premium options may be better suited to the policyholder who doubts he will use his coverage but still wants something out of the policy. He would have discretionary income and liquid assets to make the increased premiums. In essence, the cost of these additional options represent a potential loss in the time value of money.*
- ***Is there a cognitive reinstatement option?*** *Where mental impairment has set in, policyholders may forget to make premiums payments and risk cancellation. This clause allows reinstatement for up to five months so long as all back payments and proof of cognitive impairment is made.*

What about other useful policy features? *Some examples of options to discuss with clients include bed reservation (If an insured goes home, bed space is reserved in case he returns within a specified period) for nursing homes, waiver of premium, respite care and survivorship benefit.*

Tax Qualified vs Non-tax Qualified Policies

The advent of HIPPA (Health Insurance Portability and Accountability Act), also known as Kennedy-Kassebaum, has created a new evaluation procedure for agents to make: tax-qualified or non-tax qualified contracts. At the outset, it may seem ridiculous to want or recommend anything except a "tax qualified" policy. However, as you will soon see, nothing is "black and white" in the tax arena. Non-tax qualified policies may, in fact, be better policies. Then again, this has to be tempered with the "taxable uncertainty" surrounding NTQ policies. The IRS seems unwilling to take a position here and CPA's and accountant's are providing different stories on how premiums and benefits are being taxed. This makes NTQ policies dangerous territory for agent's to handle. However, there could be certain advantages of NTQ to consider. The bottom line? ALWAYS, ALWAYS advise clients to seek competent tax counsel when making LTC purchasing decisions.

There is nothing "black or white" in the tax arena.

Now to some analysis.

The first order of comparison between TQ and NTQ policies is the tax issue itself. Agents need to help a client determine whether the tax breaks associated with a tax qualified policy are meaningful to the client. Clients who itemize on their tax return have a potential need for tax deductions; those that don't itemize have little need for them. Remember also that the tax status of your client may change dramatically as he or she moves from full employment to retirement

The next order of analysis is benefits. Guidelines from the IRS have been helpful in establishing tax qualified status based on many "safe-harbor" definitions of terms like "substantial assistance", "hands-on assistance", "standby assistance", "severe cognitive impairment" and "substantial supervision". When insured individuals comply with these guidelines, certain payments received on account of a chronically ill individual from a qualified LTC insurance contract are excluded from income. In addition, certain expenditures incurred for qualified LTC services required by a chronically ill individual are deductible as medical care expenses.

Medical necessity means a doctor or qualified party has certified that a person's health will deteriorate without nursing or home care.

In general, tax qualified plans are, for the meantime, considered more restrictive than non-tax qualified policies. The basis for this evaluation is the requirement that two out of six activities of daily living must be failed to qualify for a tax-qualified plan while many non-tax plans allow two out of seven. Further, a licensed health care provider must certify chronic illness under tax qualified plans and ***"medical necessity"*** is not considered a trigger for benefits while it is quite common in non-tax plans.

The best example of how these restrictions may effect a policyholder was presented by Consumer Reports (10/97). Their discussions with one insurer uncovered an alarming result. The company estimated that under the tax-qualified triggers currently in place, 40 percent of its paid claims or home care would NOT have been paid; 20 percent would NOT have been paid for nursing home claims.

IRS Notice 97-31 provides very specific guidance relating to *qualified* long term care services and *qualified* long term care insurance contracts under sections 213, 7702B and 4980C of the Internal Revenue Code. Let's look at a few definitions that would be minimum requirements to establish *tax qualified status* for an LTC contract:

- **Substantial assistance** means hands-on assistance or standby assistance
- **Hands-on assistance** means the physical assistance of another person without which the individual would be unable to perform the ADL.
- **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
- **Substantial supervision** means continual supervision by another person that is necessary to protect a severely cognitively impaired individual from threats to his or her health or safety.

HIPPA allows up to a $2,500 deduction for premiums used to buy tax-qualified long term care insurance. However, since less than 30 percent of all taxpayers itemize (very few of them seniors), this deduction may not be a significant incentive to buy tax-qualified plans. Even among those who do itemize, the expense is deductible only to the extent it exceeds 7.5 percent of the policyholders adjusted gross income. However, new proposals feature an ***above the line*** tax deduction and tax credits for caregivers. Surveys show that LTC prospects will be more inclined to purchase if these types of proposals are passed.

Surveys show that LTC prospects will be more inclined to buy if proposed tax deductions are passed.

Scales tip slightly better toward tax-qualified plans when considering the taxation of benefits. Under the new law, tax-

qualified long term care policies are now treated in the same manner as health insurance contracts where benefits received are excluded from income. In the case of long term care, however, the amount of this exclusion is capped at $200 per day for 2001 and indexed for inflation in future years. HIPPA and the Internal Revenue Service have not ruled (why we don't know) on the taxation of benefits from non-tax qualified policies. Endorsers of tax-qualified plans will say that policyholders no longer need to worry about paying taxes on their benefits or having to buy additional insurance to pay for long term care expenses with some left over to pay taxes.

It is important that all agents make careful evaluation in replacing policies issued prior to 1/1/97 with newer policies. From all information we can gather, these older policies have been "grandfathered" and receive the same tax treatment as the new tax-qualified contracts. In any decision to replace one of these older policies, the loss of these tax considerations must be considered. Making major revisions to the policy to upgrade benefits or purchase options is considered a violation that will also jeopardize tax benefit status. However, policy upgrades that are already built-in to the policy, such as a non-forfeiture provision, are not considered a material change and would retain all tax benefits. Some older policies also have easier benefit triggers that clients may not want to replace.

The Tax Treatment for Individual Long Term Care Insurance Premiums

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), sometimes referred to as Kassebaum-Kennedy, contained a change in tax law for long term care insurance contracts that meet federal standards. In general HIPPA treats certain "qualified" long term care contracts the same as health insurance for tax purposes. The premiums for these contracts are deductible in whole or in part, the benefit payments are excluded from personal income, and the unreimbursed cost of qualified long term care services are deductible as a medical expense.

The federal standard also specify the level of disability required before benefits can be paid under a qualified contract to qualify for tax advantages. These standards conflicted with those that had been required in many states. Specifically, the federal law restricts the payment of benefits to an inability to perform 2 out of 6 ADLs, and a certification that services will be needed for at least 90 days. Certain states required companies to pay benefits when a person was impaired in 2 out of 7 ADLs and did not allow the application of a 90-day requirement.

There were other conflicts in regards to cognitive impairment, the severity of both the ADL and cognitive impairment triggers, and the type of assistance that could be provided under a tax-qualified contract. Some companies had been paying for home care when a person needed services, regardless of whether the 2 out of 7 ADLs or cognitive impairment trigger had been met. These payments and other benefit triggers or standards such as "medical necessity" for benefit eligibility are not permitted in a tax qualified contract.

Because the federal benefit triggers conflicted with certain state requirements for benefit eligibility, qualified contract have not been available in some states. Recently enacted legislation allows the sale of these tax qualified contracts using the federal standards for claims payment, but requires the concurrent offering of contracts that meet the more liberal benefit payment standards required in state law. Contracts that were sold under state law before January 1, 1997 are automatically granted the status of a qualified contract. These older contracts enjoy all of the tax benefits of a qualified contract, regardless of the construction, benefits, or standards in those older contracts.

Since 1997, every insurance carrier has been required to report to the Internal Revenue Serve on form 1099-LTC any benefit paid under a contract that was sold, marketed, or issued as long term care insurance. Companies are not required to determine whether the benefits were paid

under a qualified contract, and there are not yet any instructions for taxpayers about their use of these 1099s. The issuance of a 1099 form and the federal silence on the tax treatment of other long term care contracts has generated heated controversy among accountants, companies, agents and consumer groups.

While HIPPA specifically address the tax treatment of qualified contracts, it is completely silent on the tax treatment of contracts that do not meet the federal standards. Some argue that the law is explicit by implication and that all other long term care contracts will be treated differently for tax purposes. They believe that the benefits from such a contract will be taxable, but the expenses will not be allowed as a medical deduction because they are reimbursed expenses. Others argue that long term care benefits have never been taxed despite repeated requests to the IRS to clarify their status, and that the federal law does not change IRS silence on this issue.

It is impossible to know which of these interpretations is correct in the absence of some action by the Department of the Treasury or the Congress. This issue could be settled by one or more actions, and there are at least four possibilities: 1) Treasury could rule that all other benefits are taxable as income, and only the tax-qualified benefits are excluded from income; 2) No action or decision is made by Treasury or Congress, and the tax treatment of other benefits simply remain undetermined; 3) Congress could clarify which benefits are excluded from income, and which are taxable in new legislation; and 4) Treasury could make a compromise ruling that allows some benefit payments of unqualified contracts to be taxable while others are excluded from income.

Some companies and agents want to continue selling policies with more liberal benefit triggers. Agent selling qualified contracts are required by state law to offer both types of contracts to consumers. It is very important that agents understand some of the issues relative to contracts that are qualified, and those that are not. Following are some examples that illustrate the tax consequence for both a qualified contract and one that is not qualified. An example of a taxable benefit **without a deduction** for expenses is not included because few people believe this is a reasonable interpretation.

Let us first look at the deductibility of long term care premiums. The Act allows policyholders to include the premiums for qualified long term care insurance as an itemized medical costs on Schedule A of your federal income tax return, up to the limits shown below. The potential maximum tax savings for this treatment is also shown:

Long Term Care Insurance
Potential Tax Savings When Deducting
Long Term Care Insurance Premiums

Age	***Amount of Premium Deductible***	***Potential Tax Savings By Tax Bracket***			
		15%	***28%***	***31%***	***36%***
40 or less	$230	$35	$64	$71	$83
41-50	$430	$65	$120	$133	$155
51-60	$860	$129	$241	$267	$310
61-70	$2290	$344	$641	$710	$824
70 & Over	$2860	$429	$801	$887	$1030

A long term care policy with meaningful coverage can be purchased within these limits. However, we refer to the potential the tax savings because there are a number of limitations on the deduction that will preclude many policyholders from claiming the deduction, let alone

realizing tax savings. First, the right to deduct the cost of the premium only has value for policyholders who itemize their deductions on their tax return. Most taxpayers do not itemize as they take advantage of the standard deduction allowed by the Internal Revenue Service ($4,550 for single taxpayers; $7,600 for married, filing jointly for 2001). Nationally, less than 30 percent of all federal taxpayers itemize ("Statistics of Income", Department of Treasury). Even lower percentages of seniors itemize. More than likely because they do not have large mortgages on their homes.

Second, in order to be deductible, the cost of the qualified long term care insurance premium, plus other qualifying medical expenses, must exceed 7.5 percent of the taxpayers adjusted gross income (AGI). Many taxpayers do not have sufficient amounts of unreimbursed medical expenses to reach the 7.5 percent threshold. Unless the 7.5 percent threshold is exceeded, no deduction can be claimed. Only the portion of medical expenses that exceed 7.5 percent can be deducted.

We have included three examples to illustrate both the tax advantages and the limitations of premium deductibility. The first example (below) is a single individual (age 55) with an AGI of $60,000 who purchases a qualified long term care policy costing $1000 per year. The deduction is limited to $820. The individual is assumed to have sufficient deductible non-medical expenses to file an itemized return. In addition to the deductible long term care premium, the individual is also assumed to have paid $7,157 for qualifying medical expenses. In this example, the tax savings on the purchase of the qualifying long term care policy amounts to $224, the maximum he can achieve. However, you must consider underwriting risks when medical expenses are this high. The individual may not qualify for long term care insurance.

Example 1
Single Taxpayer, Age 55, No Dependents, Itemizes Deductions

Tax Item	***Federal Tax Before***	***Federal Tax After***
Adjusted Gross Income	$60,000	$60,000
Itemized Deductions		
Medical Expenses	$7157	$7977
Less 7.5% AGI	($4500)	($4500)
Taxes	$4236	$4236
Interest	$6824	$6824
Contributions	$1862	$1862
TOTAL	$15579	$16399
Personal Exemptions	$2800	$2800
Taxable Income	$41621	$40801
INCOME TAX	$8308	$8084
TAX SAVINGS		**$224**

In the second example, the individual has only $3,680 of medical expenses rather than $7,157 before the purchase of long term care insurance. All other factors are the same. If this were the

case, there would be no tax benefit from the deductibility of the long term care insurance premium.

Example 2
Single Taxpayer, Age 55, No Dependents, Itemizes Deductions

Tax Item	*Federal Tax Before*	*Federal Tax After*
Adjusted Gross Income	$60,000	$60,000
Itemized Deductions		
Medical Expenses	$3680	$4500
Less 7.5% AGI	($4500)	($4500)
Taxes	$4236	$4236
Interest	$6824	$6824
Contributions	$1862	$1862
TOTAL	$12922	$12922
Personal Exemptions	$2800	$2800
Taxable Income	$44278	$44278
INCOME TAX	$9050	$9050
TAX SAVINGS		**$0**

Example 3
Married Taxpayer at Age 61

Tax Item	*Federal Tax Before*	*LTC Premium*	*Federal Tax After*
Adjusted Gross Income	$75,000		$75,000
Itemized Deductions			
Medical Expenses	$4725	$2200	$6925
Less 7.5% AGI	($5625)		($5625)
Taxes	$4236		$4236
Interest	$6824		$6824
Contributions	$1862		$1862
TOTAL	$12922	$2200	$14222
Personal Exemptions	$5600		$5600
Taxable Income	$56478		$55178
INCOME TAX	$10217	$9853	$8084
TAX SAVINGS			**$364**

The third example is a married couple with an AGI of $75,000 who purchase a qualifying LTC policy. Their tax savings are calculated at $364

These three examples illustrate several things. First, the amount of tax savings can be nothing or at the very least modest. Second, note that as the AGI increases, it becomes more difficult to qualify for the 7.5 percent threshold. Third, the taxpayer must have sufficient non-medical deductible expenses to make it worth while to give up the standard deduction and itemize expenses; something most taxpayers do not have. And finally, the taxpayer must have enough other qualifying medical expenses, in addition to the qualifying long term care insurance premium, to receive the maximum tax savings available. This is something that many taxpayers do not have because of insurance benefits.

Had the individuals in these examples been renters without mortgage and real estate tax deductions, their deductions would not have exceeded the standard deduction. Accordingly, they would not receive any tax benefit from the purchase of a qualified long term care insurance policy.

With respect to premiums for non-qualified long term care insurance, they are not deductible. Therefore, there is no tax benefit arising from these premiums.

Tax Treatment of Individual Long Term Care Insurance Benefit Payments

Now let us turn to the tax treatment of the insurance benefits a purchaser of a long term care policy will receive as a result of filing a claim for benefits. Under the Act, the tax treatment of payments received under a qualified long term care policy are not considered to be taxable income and are therefore not subject to income tax except for certain per diem type reimbursements, then only if the per diem rate exceeds certain amounts.

The question naturally arises as to what is the tax status of benefits received under long term care policies that do NOT meet the federal standards as qualified contracts. For example, how should a policyholder report $35,000 received from the insurance carrier for reimbursement of nursing home expenses paid by the policyholder. The tax code and the Act are silent on how benefit payments made under a policy that is not a federally qualified contract should be reported. The insurance carrier is required to report to the Internal Revenue Service on ***Form 1099 LTC*** the amount paid for long term care benefits for the year that the payment was made. Congress was asked to address the reporting issue for payments received under a non-qualifying policy but chose not to, thereby leaving the tax status of these payments a matter of debate and disagreement.

Some argue that taxpayers rarely reported benefit payments by long term care insurers prior to passage of Kennedy-Kassebaum, and since the tax status of non-qualified policies was not addressed by the Act, nothing has changed. Therefore no tax needs to be paid on benefits received under non-qualified long term care policies. Others argue that passage of the Act changes things for non-qualified, as well as federally qualified policies. Benefit payments from non-qualified policies should now be reported as taxable income, but the taxpayer may deduct the expenses paid by the taxpayer for qualified long term care services (e.g., a nursing home stay) as an itemized medical expense. As a result, the taxpayer must itemize his deductions when filing his tax return. Under this interpretation, the reportable insurance payments would be largely offset by the deduction of the long term care expenses. However, the deductible medical expenses would not completely offset reporting the insurance payments as taxable income because of the 7.5 percent threshold for the deductibility of medical expenses. In addition, a portion of the taxpayers standard deduction could be lost as well as subjecting benefits received under Social Security to taxation, thereby resulting in additional income tax.

Some even make a harsher interpretation regarding the tax treatment of benefit payments received from a non-qualified policy. The argument is made that a policyholder's incurred expenses for long term care services cannot be claimed as an itemized deduction because

these expenses are reimbursed and a taxpayer is prohibited from deducting reimbursed expenses. However, the reimbursement payments received from the insurance carrier must be reported as taxable income. Under this interpretation, the purchase of a non-qualified long term care policy could result in a potentially large tax liability if benefits are received in the future. Based on discussions with a CPA, this last interpretation seems unlikely.

Since there are three interpretations of the tax consequences from receiving benefits under a non-qualified policy, lets discuss them. Under the first interpretation, nothing has changed, therefore there is no tax consequence. The beneficiary receives $35,000 for reimbursement of qualified long term care expenses. No increase in income tax.

For the second interpretation benefits received are included in taxable income but the expense is claimed as a medical expense. We need to look at another example, because different things can happen depending on the age and tax situation of the taxpayer. Example A shows a married taxpayer who has an AGI of $30,000 and is not receiving Social Security benefits. The taxpayer can also itemize deductions and has other medical expenses in addition to the nursing home costs. In his case, the receipt of the benefits and the corresponding deduction results in additional federal income tax of $397. He would also have to pay some additional state income tax. If we assume that there were no other itemized deductions, other than nursing home costs, the additional tax on the reimbursement of the nursing home costs would amount to $2,000. As we indicated earlier, there are too many variables to calculate the tax effect for all situations.

Example B illustrates the additional tax that would result if the taxpayer was receiving Social Security benefits amounting to $12,000, and he did not have enough other medical expenses to surpass the 7.5 percent limitation. In this example, the additional tax is $1,485.

Example A
Married Taxpayer Who Purchases non-Qualified Long Term Care Insurance and Receives Benefits Under Plan Compared to Qualified Plan
(This assumes that the benefits must be included in the Taxable Income)

Tax Item	*Qualified*	*Federal Tax Benefits Received*	*Non-Qualified*
Adjusted Gross Income	$30,000	$35,000	$65,000
Itemized Deductions			
Medical Expenses	$2588	$35000	$37588
Less 7.5% AGI	($2250)		($4875)
Taxes	$4379		$4379
Interest	$4800		$4800
Contributions	$1734		$1734
TOTAL	$11251		$43626
Personal Exemptions	$5600		$5600
Taxable Income	$13149		$15774
INCOME TAX	$1949		$2366
ADDED COST		**$397**	

Example B
The Example Above Assumes Taxpayer Is Not Drawing Social Security Benefits. If Taxpayer Was Receiving $12,000 of Social Security Benefits In Addition To The Above Income, Than The Effect Would Be As Follows:

Tax Item	*Qualified Plan*	*Federal Tax Benefits Received*	*Non-Qualified*
Adjusted Gross Income	$30,000	$35,000	$65,000
Taxable Social Security	$4000		$10,200
Itemized Deductions			
Medical Expenses	$1950	$35000	$36950
Less 7.5% AGI	($2250)		($5640)
Taxes	$4379		$4379
Interest	$6856		$6856
Contributions	$1734		$1734
TOTAL	$12969		$44279
Personal Exemptions	$5600		$5600
Taxable Income	$15431		$25321
INCOME TAX	$2314		$3799
ADDED COST		**$1485**	

The harshest interpretation could result in additional tax of $9,800 (28% of the $35,000 benefits received), before considering taxation of Social Security benefits. An example of this situation is not shown since it is considered a remote possibility. Publication 502 “Medical and Dental Expenses” issued by the IRS sheds some light on the situation, but is still subject to interpretation. The Publication states.

“If you pay the entire premium for your medical insurance or all the costs of a plan similar to medical insurance, and your insurance payments or other reimbursements are more than your total medical expenses for the year, you have excess reimbursement. Generally you do not include the excess reimbursement in your gross income. However, gross income does not include total payments in excess of the per diem limit for qualified long term care insurance ($200 for 2001).

This statement leads one to believe that reimbursements under non-qualified long term care policies are not includable in income.

Unfortunately, there is no way that we can give you an absolutely correct answer at this time. Only Congress, the IRS, or a tax court can give us an answer. In the meantime, you should advise the potential purchaser of a non-qualified policy to consult with his or her tax advisor to determine what his tax treatment would be for benefit payments.

SPECIAL NOTE: THE ABOVE EXAMPLES ARE PRESENTED FOR INFORMATION ONLY. THEY DO NOT REPRESENT AN OFFICIAL TAX OPINION. INDIVIDUALS SHOULD CONSULT WITH THEIR OWN TAX PREPARER / ADVISOR.

#8--Responsible LTCI Agents Expose The LTC Funding "Minefield"

Another title for this section might be "How The Government Prevents Your Clients From Getting LTC Benefits", or "Pay Your Own LTC Or Else". Indeed, the path to paying for long term care is littered with financial and social obstacles beyond the comprehension of the average citizen. It is a virtual ***minefield*** to negotiate. And, it is your job to educate clients that it isn't expected to get any better.

In the not-to-distant future, quality LTC will be the responsibility of the individual, not the government.

The unfortunate reality of long term care is that neither the government nor most people want to pay for it. Clients want to ignore the fact that "the long goodbye" of a chronic illness could wipe them out financially or cause them to rely on the charity of family members and others. And, the government is beginning to realize that if Medicaid costs keep going at their current pace, they will actually exceed all federal revenues by 2030!

In the not-too-distant future, quality long term care will be the responsibility of the individual. A major portion of this care can be financed through LTC insurance, but some may also be the responsibility of each client in the form of private pay – private investments and savings.

We need to discuss all these possibilities to arm you with the information necessary to educate your clients that a careful path must be chosen to avoid the obstacles and disappointments "planted" in the LTC funding minefield.

Too Many, Too Soon?

In her article *Long Term Care: The Perfect Storm,* author Carolyn Kates describes the demographic, technological and societal trends that are rapidly accelerating long term care funding and services to a "fearful collision".

In a nutshell, we are moving to a time when the number of seniors collecting benefits from government will grossly outnumber the number of people supporting it. One forecast suggests that at some point in the future, there will be only one taxpayer supporting 40 Social Security beneficiaries Outrageous! This is exactly the opposite of what existed at the start of the program!

Kates goes on to say that technological advances and healthier lifestyles are leading to longer life expectancies. Seventy years ago, the average life span was 63, now it is 76 and climbing. With people living longer, a greater stress is placed on government budgets.

Finally, Kates describes the societal changes that are making it more and more difficult for people who need long term care to rely on their familes for help. "High divorce rates, single parent households, two-income families and other developments have weakened the first line of care for aging or infirm--the traditional nuclear family".

Affordability

According to the *American Medical Association*, the elderly paid out more money to cover nursing home expenses than any other aspect of their health care. Even so, some can't meet the staggering costs on their own, and Medicare coverage is limited. Faced with an average outlay of $41,000+ a year in most states, and double or triple that in some urban areas, many of the elderly in nursing homes are faced with watching a lifetime of savings evaporate within a few years. Care provided in the home can be just as expensive with unlicensed health care professionals charging $120 to $180 per day for 24-hour supportive care. RNs or LVNs will bill from $35 to $70 for a two-hour visit.

The massive amount of care provided by family members and other unpaid caregivers adds another dimension to the social costs of long-term care. More than 70% of those receiving long-term care must rely exclusively on unpaid caregivers. Can baby boomers and other rely on their children for the same contribution of time and effort? Probably not.

So, one of your jobs is to convince prospects that the costs of LTC can go way beyond their resources. This isi not too difficult once you realize that the average citizen out here is not likely to handle a 96-month bout with Alzheimers at $112 per day. With inflation thrown in, the bill can approach $1 million!

Buy long term care insurance? Not everyone can afford long term care premiums at first blush. Of course, if you have had your client complete a client profile you would already know this. So, sometimes you need to be creative; look in places you might not ordinarily look to find the resources to get your clients covered. We will discuss these options later.

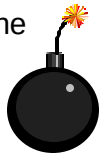
Of course, you don't always have to cover ***everything*** A lot of private pay people are just as likely to go for a bare bones plan with high eliminations or an "in sickness and in health" type policy that combines life or annuity product with LTC coverage. This way, they can do a little self-insuring yet cover the main bases. Documenting a client's preference for "minimal" coverage such as this is important to your long-term claim exposure.

Private Pay

Integrated somewhere in American values is the concept that people should take primary responsibility for their own lives and their personal expenses. We are encouraged to earn our own way. Health care provisions can be seen as a personal investment, planned and funded by the individual. Unfortunately, this is not a subject people like to discuss, much less set aside a percentage of their paycheck to finance.

The Government wants "out" of the long term care business.

That is why it is the job of agents in the U.S. to explain the need for private pay and LTC insurance. For example, it might surprise a lot of clients to learn that despite all the talk about Medicare and Medicaid, a lot of long-term care is paid privately (approximately 49%). This means that most patients pay for long-term care out of their own pockets, whether the care is skilled, intermediate or custodial.



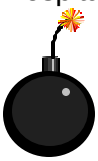
With government cutbacks can anyone expect this to improve? Not! Our government now spends close to $75 billion a year for long term care services. This can't go on. And, the fact that HIPPA created tax incentives to purchase LTC insurance is an important cue that it won't. ***The government wants out of the long term care business!*** More recent legislation outlining

"above the line" tax deductions and a $3,000 tax credit for caregivers is another important signal.

Medicare

A good portion of your discussions with clients will involve Medicare. Agents who work in the senior market must fully understand this area in order to explain benefits as well as what clients cannot expect it to cover.

It needs to be noted that there was never any provision in the Medicare Catastrophic Coverage Act to pay for the cost of long-term health care. In fact, benefit booklets explain that Medicare hospital insurance (Part A) helps pay for medically necessary care in a Medicare-approved hospital, skilled nursing facility, and hospice. Skilled nursing facility care is not the same as custodial nursing home care.



Skilled nursing care is acute care, while custodial is long-term care. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not certified by Medicare. So in conclusion, Medicare will provide for less than 2% of long-term care health payments. Medicare will, however, provide payment for health care for individuals over the age of 65 and certain individuals under the age of 65 with significant disabilities. Medicare is basically a health insurance program. The benefits available under Medicare are similar to those under most health insurance plans in the way they lack substantial or even modest levels of long-term care.

A Closer Look

When President Lyndon B. Johnson signed Medicare into law in 1965, he said, “No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the saving that they have so carefully put away over a lifetime.” Congress enacted the Medicare and Medicaid programs making health care available to a large number of people who previously did not have health care coverage.

Although Medicare gives a great deal of protection to 33 million older Americans, it pays less than half of the average older person’s health cost. Prior to 1980, Medicaid and Medicare reimbursed nursing facilities on a retrospective reasonable cost basis. In 1980, the Boren Amendment was passed changing the reimbursement method for these services. Under the Boren Amendment, a state plan for medical assistance must provide for payment of nursing facilities through the use of rates which the state finds are reasonable and adequate to meet the costs. The providers are required to operate efficiently, providing care and services conforming with applicable state and federal laws, regulations, and quality and safety standards.

However, the Boren Amendment has been repealed allowing states to decide how much to pay for services and hospitals and nursing homes. Critics say this has led to complexity and confusion which could be intentional. After all, if you control eligibility, you controls costs.

What Does Medicare Cover

Medicare does not usually pay for nursing home costs, but the federal Medicare Catastrophic Coverage Act (MECCA), enacted in 1988, adds confusion, since it allows Medicare to pay for a limited amount of nursing home costs that previously were, for the most part, paid by Medicaid. However, these benefits were only for patients who qualified for welfare benefits, since such long-term care costs were not deemed to be medically necessary.

Medicare only pays for "**Skilled Care in a Nursing Home"** or **"Intermittent Care in a Nursing Home or at Home"**. Medicare does NOT pay for intermediate or custodial care, such as that required for Alzheimer's patients. The following table will help put this into perspective:

BENEFIT	MEDICARE PAYS	YOU PAY
First 20 days	100% of Approved Amount	NOTHING
Next 80 Days	All but -$95.50 / Day	$95.50 / Day
Beyond 100 days	NOTHING	ALL COSTS

Source: 1997 Guide to Health Insurance for People with Medicare

As mentioned, Medicare pays for skilled care only. Medicare will pay the full cost to stay in a Nursing Home Facility for only 20 days. It will pay a part of the cost for the next 80 days, but only if you are receiving a "skilled" level of care. Medicare pays absolutely NOTHING after 100 days. Medicare does NOT cover custodial care orintermediate care, except for intermittent skilled services received.

Medicare, with its limited coverage, is not a solution for long-term care. It can afford some adjunct assistance in paying for initial admissions, and should not be overlooked as a source in the event that a current private pay resident enters a hospital and later re-enters the nursing facility, with needs that may fall within the health care guidelines.

Curiously, current federal laws seem to encourage skilled nursing facilities to refuse to submit Medicare claims. Consequently, the patient, his or her family, and their professional advisors should not be shy about pursuing at the very least the initial stages of an appeal.

Medicare Part A

While far from serving as long term care insurance, Medicare Part A covers some costs related to hospital stays and is available for people who are 65 years old and over. When all program requirements are met, Medicare part A will help pay the costs for medically necessary inpatient services customarily supplied in a hospital or skilled nursing facility and for hospice care for the terminally ill. Medicare Part A also pays the full cost of medically necessary home health care and 80 percent of approved costs for durable medical equipment supplied under the home health benefit. Medicare Part A covers only those services that are considered medically necessary and only those charges that are considered reasonable.

All persons age 65 and over who are entitled to monthly Social Security cash benefits or monthly cash benefits under Railroad Retirement Benefits are eligible for Medicare Part A benefits free of charge. Others may be eligible for Medicare if they pay a monthly premium. Persons age 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working does not affect the amount of future Social Security benefits.

Enrollees in Part A are automatically offered the option of enrolling in Part B. However, they do not have to accept Part B if they do not want the coverage. Part A is financed through the Social Security (FICA) tax paid by workers and employers. The Health Care Financing Administration enters into agreements with state agencies and with intermediaries to administer the Hospital Insurance Plan. State agencies survey institutions to determine whether they meet the conditions for participation as a hospital, skilled nursing facility, home health agency, or hospice. They also help the institutions meet the conditions for participation.

An individual does not have to pay a monthly premium for Medicare Part A if he or a spouse is entitled to benefits under either the Social Security or Railroad Retirement systems, if he has

worked a sufficient period of time in government employment to be insured, or if he is under age 65 and has met the disability program's requirements. Those who do not meet the above coverage requirement may voluntarily enroll in Medicare for a monthly premium determined by the number of quarters (less than 40) that they paid into Social Security or Railroad Retirement.

A dependent or survivor of a person entitled to hospital insurance benefits, or a dependent of a person under age 65 who is entitled to retirement or disability benefits, is also eligible for hospital insurance benefits. Additionally, a dependent or survivor is eligible for hospital insurance benefits if that person is entitled to a spouse's or widow's Social Security benefit.

A Social Security disability beneficiary is covered under Medicare after entitlement to disability benefits for 24 months or more. Those covered include disabled workers at any age, disabled widows and widowers age 50 or over, and beneficiaries age 18 or older who receive benefits because of disability beginning before age 22.

Hospital Benefits

Hospital benefits entitle an individual to 90 days of in hospital care for each benefit period. A benefit period begins when the insured enters the hospital and ends after he has been out of the hospital (or skilled nursing facility) for at least 60 continuous days. There is a deductible for each benefit period. In addition, the individual must pay a coinsurance amount for days 61 through 90. After exhausting 90 days of coverage, Medicare will pay for an additional 60 days of care in that person's lifetime. However, the insured may have to pay a coinsurance amount during these final 60 days of care.

Medicare Part B

Medicare Part B changes annually. However, it basically covers most reasonable and necessary medical services with little benefit in the long term care areas. An individual can receive this coverage once he turns 65, but he must pay a monthly premium. If he waits to enroll in Part B until after age 65, the monthly premium may be higher, since Medicare imposes a 10 percent premium penalty for every year that enrollment is delayed. However, if an individual is working and is covered under his employer's group health plan, he may delay enrolling without a penalty until seven months after retirement. This enrollment period is a seven-month period beginning on the first day of the third month before the month he attains age 65. For example, if the person's 65th birthday is April 10, 2001, the initial enrollment period begins January 1, 2001 and ends July 31, 2001

If a person decides not to enroll in the initial enrollment period, he may enroll during a special enrollment period beginning with the first day of the first month in which he is no longer enrolled in a group health plan by reason of employment, and the enrollment period ends months later.

Medicare sets approved charges for all of the medical services it covers. Medicare does not cover many common health expenses such as prescription drugs, routine checkups, vision and hearing care, custodial care, and dental care. It also does not cover experimental procedures. Medicare does cover biannual mammograms, tri-annual pap smears, or flu vaccines.

Under Medicare Part B, an individual must pay an annual deductible. Once the deductible has been met, Medicare generally will pay 80 percent of its approved charge for medical care. The following doctors' fees and services are covered by this portion of Medicare:

- Doctors' services are covered wherever furnished in the United States. This includes the cost of house calls, office visits, and doctors' services in a hospital or other institution. It

includes the fees of physicians, surgeons, pathologists, radiologists, anesthesiologists, and osteopaths.

- Services of clinical psychologists are covered if they would otherwise be covered when furnished by a physician.
- Services by chiropractors with respect to treatment of subluxation of the spine by means of manual manipulation are covered.
- Fees of podiatrists are covered, including fees for the treatment of plantar warts, but not for routine foot care. The cost of treatment of debridement of mycotic toenails is not included if performed more frequently than once every 60 days. Exceptions are authorized if medical necessity is documented by the billing physician.
- The cost of routine physicals, most vaccine shots, examinations for eyeglasses and hearing aids is not covered.
- The cost of diagnosis and treatment of eye and ear ailments is covered.
- Plastic surgery for purely cosmetic reasons is excluded. However, plastic surgery for repair of an accidental injury, an impaired limb, or a malformed part of the body is covered.
- Charges imposed by an immediate relative (for example, a doctor who is a son or daughter or brother or sister of the patient) are not covered.
- Radiological or pathological services furnished by a physician to a hospital inpatient are covered.
- Immuno-suppressive drugs used in the first year of transplantation are covered.

Accepting Assignment

Some health care providers take assignment which means that they agree to accept Medicare's approved charge as payment in full. Medicare pays 80 percent of the approved charge, and the individual pays the remaining 20 percent. Local Medicare carriers have a directory which lists all doctors and suppliers in the area who take assignment. If an individual wants to limit the amount he pays for medical expenses, he can obtain a copy of this directory and use it when choosing a health care provider.

Even when doctors do not take assignment, federal law limits the amount that they may charge Medicare patients. This limit is 15 percent above Medicare's approved charge. Some states have stricter limits with respect to what doctors can charge Medicare patients.

Payment of Claims

A Patient's Request for Medicare Payment form is used for submitting a supplementary medical insurance claim. This form must be submitted to the Medicare carrier in order for supplementary medical insurance to pay for covered services of doctors and suppliers. All Social Security offices and Medicare carriers and most doctors' offices have copies of this form.

If a doctor or supplier participates in Medicare or uses the assignment method of payment, he submits the claim. If the doctor of supplier does not accept assignment, the patient submits the claim, using the Patient's Request for Medicare Payment form. It doesn't matter whether all bills are from one doctor or supplier or from a number of different doctors or suppliers. A patient can send in the bills either before or after he pays them.

The itemized bill must show the following:

- The place where the patient received the services
- A description of the services
- The charge for each service
- The doctor or supplier who provided the services

- The patient's name and health insurance claim number

If the bill does not contain all of this information, payment may be delayed. It is also helpful if the nature of the patient's illness, that is, the diagnosis, is shown on the bill. A patient submitting a claim for the rental or purchase of durable medial equipment should include the bill from the supplier and the doctor's prescription. The prescription must show the equipment needed, the medical reason for the need, and estimate how long the equipment will be medically necessary.

Before any supplementary medical insurance payment can be made, a person's record must show that he has met a $75 deductible. Once a person has met the deductible, he should send in future bills for covered services as soon as he gets them so that Medicare payment can be made promptly. If all medical bills for the year amount to less than $75, supplementary medical insurance will not pay any part of that person's bills for the year.

If the person filing a claim dies and payments are due, special rules apply for services covered under the supplementary medical insurance plan. Hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency, or hospice that provided covered services. If the bill was paid by the patient or with funds from the patient's estate, payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person. If the bill has not been paid and the doctor or supplier does not accept assignment, the supplementary medical insurance payment can be made to the person who has the legal obligation to pay the bill for the deceased patient. This person can claim the supplementary medical insurance payment either before or after paying the bill.

The time limit for submitting a supplementary medical insurance plan claim is 15 months. For example, for services received between October 1, 1997 and September 30, 1998, a claim must be submitted by December 31, 1999.

If a person disagrees with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare, he has the right to ask for a review of the decision. The notice from Medicare advising a person of the payment decision also tells him about his right of appeal and how to request it.

If a person needs more information about his right to appeal, he should contact his local Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization (PRO) in his state. Peer Review Organizations assign committees to conduct reviews involving Medicare and its decisions.

A supplementary medical insurance claim may be appealed by the patient, the doctor, or the supplier who submits the claim. Medicare will notify the claimant of the decision made on the claim. If the person disputes the decision, he can ask the Medicare carrier for a review of the claim. If the claim is still disputed and if the amount in dispute is $100 or more, a hearing can be requested. Appeals can eventually be appealed to a federal court.

Medicare's Prospective Payment System & DRG

Under Medicare's ***Prospective Payment System***, first effective in 1983, and updated by the Benefits Improvement and Protection Act of 2000 (BIPA 2000), Medicare hospital payments are based on the *patient's diagnosis at the time of admission to the hospital*. The costs incurred after admissions are not relevant.

An incoming hospital patient is assigned to a ***diagnosis-related group (DRG)*** . The hospital's payment from Medicare is the flat amount that Medicare establishes for the DRG.

DRGs are based upon a system which starts with all of the possible diagnoses listed in the International Classification of Diseases, then classified into 23 major diagnostic categories, and finally divided into 477 distinct groups. If the patient stays in the hospital for 8 days but the relevant DRG says that 4 days is the standard stay for the patient's disease, then Medicare pays for only 4 days. On the other hand, if the hospital treats and releases in 2 days, the hospital still gets paid for 4 days.

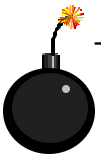
Of course, hospitals maintain that they care for a patient as long as it is medically necessary to do so, regardless of the Medicare DRG. But the DRG system clearly gives hospitals an incentive to curtail care in the following ways:

- Early discharge of patients
- Refusal to admit Medicare patients who's treatment and stay will probably exceed the average

Medicare does attempt to monitor quality care and access by entering into contracts with peer review organizations (PROs) in each state. These groups investigate and review hospital admission and length of stay practices. Patients who are denied admission have an option to appeal.

Medicare & Long-Term Care

Medicare is inextricably connected to long-term care by virtue of the fact that changes in the Medicare system of payments has lead to a boom in long-term care services. In essence, Medicare has promoted a system that gives hospitals an incentive to move patients out quickly, sometimes without regard to the patient's actual condition or need for continuing care. The Mayo Clinic coined this practice as the ***"quicker and sicker"*** release of patients.



Because hospitals release patients quicker and sicker, there has been a 40% increase in nursing home admissions since the start of the PPS and DRG payment system described above. The bigger problem is that when patients are released from the hospital to the nursing home, only 2% meet the criteria for payment of their nursing home stay from Medicare. It should be obvious to agents that this information is essential to the health care planning of their clients and the pending need for long-term care coverage.

Medicaid

As big as your job was to explain the Medicare "minefield", you have a bigger job with Medicaid. Clients do not understand it all and most still believe that it will somehow help them if they have a long term care episode.

The fact is, Medicaid is a needs based program providing of long-term nursing home care for those who qualify -- mostly the poor and indigent. Even though it provides approximately 45% of the funding for long-term care, qualifying can often be a major problem. As an example:

> *Let's suppose that Linda, a seventy-two year old single woman, lives on her fixed monthly pension of $890. Linda's health deteriorates, and it appears she must enter a nursing home. Linda's only other assets are savings of $21,000. Linda lives in an income cap state, and the maximum allowable income to qualify for Medicaid is $850 a month. Since Linda's income exceeds this amount, and since she can do nothing to change it, she cannot qualify, even after she spends her life's savings down to zero.*

Medicaid, can be considered both a companion and competitor of private long-term health care policies. Educating clients about the Medicaid "minefield" can be a very convincing way to motivate them to buy LTC insurance.

It is very important to note to your client, that the purchase of a long term care insurance policy does not ensure that he or she will avoid Medicaid when they need long term care. Whether that is to their advantage depends upon the particular circumstances. People who are unlikely to be able to afford premiums, unable to absorb even a moderate increase in LTC premiums may find Medicaid as their only safety net.

Problems In The Marketplace

There is a lot of discussions and accusations about the quality of care afforded a Medicaid patient and the problems associated with being a Medicaid provider. Consider these recent events:

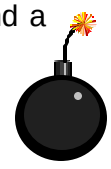
- Nursing home chains nationwide are reporting significant financial difficulties on the heels of more Medicaid patients and poor reimbursement levels. The Washington Business Journal comments ". . . Medicaid will eventually drag the assisted living (residential care homes) industry down the same tortuous path as it has done with the nursing home industry: low reimbursement (that often doesn't even cover the cost of providing care), mandated services, costly regulation, and oversight . . . "
- Many states reimburse nursing homes at a rate less than $80 per day. Stephen Morrisette, President of the Virginia health Care Association says "How many hotels can you stop at and get a room for that? And we provide not just a room but 24-hour nursing care and meals and therapy and activities."

- Sara Speights of the Texas Association for Home Care stated that "Agencies cannot deliver quality services and adequate care at only 30%-40% of costs. We estimate that about fifty percent of home care agencies in Texas will be forced to close their doors . . . "
- McKnight's Long Term Care News reported that 17% of all nursing facilities in Massachusetts filed for bankruptcy in 2000; 11% in California.
- Federal Medicaid Director Sally Rishardson said . . . "While we hope these organizations (nursing homes) will see their way through these difficult periods, we are nevertheless concerned that the quality of care residents receive in chain facilities . . . If financial difficulties persist, it is possible that some facilities may decide to withdraw their participation in the Medicare or Medicaid Programs".

It is evident from this information that low Medicaid reimbursement rates weigh like an anchor on nursing homes around the country. They drag down the industry's ability to pay acceptable salaries, hire competent people, and provide quality care. Many institutions simply don't like to take Medicaid patients.

Adding to the problem are the following Medicaid "minefields" your clients should know:

- The number of Medicaid-certified providers of long-term care services around the country is limited. So even if the individual qualifies for the program, it may be difficult to find a provider to use.
- Once someone qualifies as a Medicaid nursing home resident, the worries don't end. All of a sudden, the Medicaid resident, loses his or her ability to choosing a nursing home.



- Not all nursing homes accept Medicaid residents. Many facilities are for private pay residents only. One school of thought provides the rationale: If Medicaid doesn't reimburse for the full cost of care (in doesn't in most states), then private pay residents subsidize Medicaid

residents. Therefore, a total private pay facility might be able to provide care at a lower cost because the residents there are not subsidizing the expense of providing care to other residents.

- Not all nursing homes have room for a Medicaid resident. Most facilities allocate a certain number of beds for Medicaid, and private pay residents. In theory, a nursing home administrator may want a private pay bed to remain empty while a waiting list exists for Medicaid residents.
- If a Medicaid bed is not available at the time someone needs one, there will be a search for a Medicaid available bed. One could open up down the block from someone's favorite facility or it may be on the other side of town or even in the next county. People may have to wait at home or the hospital until a Medicaid bed becomes available.
- Let's assume everything works out as the attorney said it would—money is hidden, Medicaid is paying the bills, and the resident is in a great facility. What happens when this person must enter a hospital to recover from a heart attack, stroke, or broken hip? Medicaid will pay the nursing home to hold the bed for only a week or two. After that time, the recovering Medicaid patient, who left the facility of choice, again starts looking for a facility. A Medicaid resident will find it harder to get into the better facilities than a private pay resident.

- Once someone else pays the bills, the nursing home resident is at the mercy of the payor. Thus, it is not always desirable when Medicaid pays the bills and, as we discussed at the very beginning f this course, anyone interested in the quality of LTC system should not rely on the welfare support system alone.

A recent piece on the ***Mr. Long Term Care Website*** (*www.mrltc.com*) is a dramatic demonstration of the lack of choice when Medicaid is involved.

> *Mark is a 46-year-old with multiple sclerosis. For more than a decade, Mark's wife has been his primary caregiver. She too was suffering from fatigue, depression, insomnia and various chronic stress related disorders. In the last 12 months, Mark was in and out of the hospital with various infections, skin ulcers, etc. He was beginning to believe that he might never return home again. And, Mark knew his wife could no longer handle the emotional and psychological stress of 24/7 caregiving. The thought of life in a nursing home terrified him, but the real crisis had yet to reach shore.*
>
> *As it turns out, young, otherwise healthy, alert MS patients on Medcaid have extremely poor "placement rates". There wasn't a nursing home within 80 miles that would accept Mark. Their search expanded to homes within a 120-mile radius with nothing yet. Even when Mark is accepted, it would mean that he would only see his wife three or four times a month.*

The conclusion? If a patient doesn't have to rely on Medicaid when he/she first enters the nursing home, he or she may have a better choice of homes and perhaps higher quality service.

What Does Medicaid Cover

Unlike, Medicare, Medicaid is jointly funded and administered by the state and the federal government. Because each state administers the Medicaid program and is free to tailor its Medicaid rules within federal guidelines, the Medicaid program varies considerably from state to state.

In general, Medicaid pays for hospital, medical, prescription drug and "medically necessary" nursing home care. The Medicaid system was originally intended to be a

"safety net". It was established to assist families in crisis and help the medically needy who lacked access to medical care. Above all, it was designed as a ***short-term solution*** for health care. Use of the system, however, has been far different than was intended. The program now has the stigma of a social welfare program providing current, on-going and long-term health care for families and seniors alike. Combined with our rapidly aging population and the high costs associated with long-term care, it is easy to see why there is great concern.

Medicaid is a ***needs based*** program (the exact opposite of Medicare). Medicaid provides benefits only to those who demonstrate a financial need. This means that a patient cannot have more than a limited amount of cash or other available assets. States that operate their Medicaid programs this way are called ***Share the Cost*** states. Of course, there are exemptions and methods for families to restructure their assets to qualify for Medicaid benefits. This process is called ***spendown***. It is a complicated area, but essential to the understanding of Medicaid and long term care. We will discuss it more later.

Basic Services Offered By Medicaid

Federal law and regulations specify a list of basic services that must be included in any state Medicaid program. Those services include:

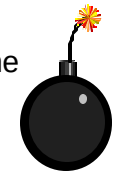
- Inpatient hospital services
- Outpatient hospital services, including ambulance services offered and included in the state's Medicaid plan.
- Physician services furnished in the physician's office, patient's home, hospital, skilled nursing facility, or elsewhere. Also, medical and surgical services furnished by a dentist where state law permits either physicians or dentists to perform such services.
- Laboratory and x-ray services
- Skilled nursing facility services for individuals 21 and over. Coverage does not include services in an institution for mental diseases or tuberculosis, but does include early and periodic screening, diagnosis, and treatment of individuals under age 21 for physical and mental defect.
- Home health care for persons eligible for skilled nursing facility services.
- Family planning services and supplies.
- Rural health clinic services, including ambulance services offered and included in the state's Medicaid plan.
- Federally qualified health center services.
- Services of certified pediatric or family nurse practitioners.
- Early and periodic screening diagnostic and treatment services for children under 21.

Medicaid Eligibility

To be eligible for Medicaid, a person can only have a certain amount of income and/or assets, i.e., "resources". In a nutshell, the system is designed to "impoverish" an individual before benefits can be allowed. It is no wonder, then, why people have turned, in record numbers, to lawyers and financial advisors to find ***loopholes*** -- ways to divest themselves of income and assets in order to qualify. This process is know as the ***spendown***. In fact, an entire industry has grown around strategies for spendown called ***Medicaid Planning***.

Before we get to specific spendown rules, let's look at basic eligibility tests – the starting point for anyone considering Medicaid assistance:

A Basic Need



To begin, an individual wishing to apply to Medicaid must be in need of care. He or she must be 65 or older, disabled in some way – blind, physically disabled, mentally disabled, etc. The disabled person may also be less than age 65 and qualify if they meet other income / asset eligibility categories.

A forty something year old blind or paralyzed person meets the category requirements. A seventy year old or sixty-six year old on the other hand need not be disabled except that she/he must need long term care and, of course, meet the income and asset requirements below.

Income

Generally speaking, for a person to be eligible for Medicaid he must spend all his income -- Social Security, pensions, interest, dividends, and so on -- on nursing home care before Medicaid helps.

The applicant will not qualify if her/his income exceeds an amount set by the state. This amount changes from time to time and varies from one state to another. If the income dollars, taxable or non-taxable, surpass the state limit, Medicaid will not be approved.

The income restrictions are severe. In some states, income is "capped" at a certain figure per month, even if all assets are "spent down" and even if this income doesn't cover the cost of the nursing home.

> *Example: Let's suppose that Joan, a 73-year-old single woman, lives on her fixed monthly pension of $925 per month. Joan's health deteriorates and it appears she must enter a nursing home. Her only other assets are savings of $25,000. She lives in a state that "caps" income with a maximum allowable income to qualify of $850 per month. Since Joan's income exceeds this amount, and since she can do nothing to change it, she cannot qualify, even after she spends her life's savings down to zero.*

Married couples are treated differently. Once a spouse is in a nursing home, each spouse's income is considered separately. This allows the healthy or "at home" spouse to keep their own income. Problems occur when a bulk of the income is still being received by the spouse in the nursing home. Where a couple is attempting to qualify for Medicaid, the ***name on the check rule*** is applied:

> *Example: Frank and Eleanor are married and receive income from several sources. Eleanor's Alzheimers condition was being handled by Frank at home with help from family members and incidental private care services paid for by Frank. As her illness worsened, Frank could no longer provide the level of care needed and Eleanor was admitted to a nursing home. Frank applied to Medicaid where his income was analyzed as follows:*
>
> *Income paid to Frank from his company pension plan was considered* **his** *income and not part of the Medicaid formula, i.e., the "name on the check" is Frank's so this income remains with Frank.*
>
> *Dividend and interest income on Frank and Eleanor's small stock fund and a small CD is paid to BOTH and there is no division or share indicated. This income is considered belonging one half to each. So, 50% of this income will not be available to Frank since the "name on the check" is BOTH Frank and Eleanor*

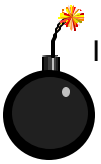
Eleanor also receives a check every month from a trust set up by her parents. Since the name on the check is her's, alone this income will be used to pay nursing care costs before Medicaid pays.

Still more can be kept, in certain areas, if a hardship will result. Additional expenses such as housing payments, taxes and utilities may increase the monthly allowance.

All of these guidelines and limits are a clear reminder that ***Medicaid benefit programs are designed for low income individuals.*** And, the "minefield" effect of complicated guidelines and eligibility rules is most likely designed to contain costs, i.e, the harder it is to qualify, the less people that do.

Assets

Asset qualification is the most difficult aspect when seeking eligibility for Medicaid. Most seniors have accumulated more in assets than their one-year income. Their home and savings are the key parts of eligibility.



In most states, the principal residence is exempt from asset eligibility determination IF a spouse or valid dependent lives in it or if the absent Medicaid recipient expects to return to it. You can be terminal and proclaim from the bed your expectation of returning and no one can nay-say you. (They can "nay-say" you all day, but they can't lift your Medicaid eligibility or, perhaps more important at THAT point, your house from your estate—at least ofr the moment).

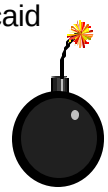
In addition, you can keep a burial plot, $1,500 in cash to bury yourself (government is certainly not in THAT business), life insurance up to $1,500 or less (not much) and any property producing income that you use to pay nursing home bills. You can keep personal jewelry, and one car usually.

Medicaid Spendown

The process by which medical and nursing home care reduces a person's assets to qualify for Medicaid is known as a ***spendown***. Some have referred to it as the "path to poverty". In essence, a person can't get assistance until virtually all assets are depleted. Certain assets are considered ***noncountable*** or exempt. They include:

- a house used as a primary residence.
- a car for transportation to work or medical services
- a wedding ring
- a cemetery plot
- household furniture
- cash surrender value of life insurance under $1,500
- real property if it is essential for support (land to grow food) or it produces income for one's daily activities.

Assets that are ***countable*** vary from state to state. The general rule is, if the principal of the item can be accessed (even if it cost a penalty to get), it counts as an asset for Medicaid purposes. Here is a short list of what counts:

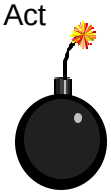


- cash, CD's and money market accounts
- stocks, bonds, mutual funds
- treasury notes and treasury bills

- vacation homes and second vehicles
- cash value life insurance and deferred annuities
- revocable living trusts

Certain other items are exempt because of their protection under federal law. These items include;

- Food stamp coupons
- US Department of Agriculture donated foods
- Supplemental food assistance programs
- Benefits received under the Nutrition Program for the Elderly
- Payments received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Tax exempt portions of payments made under the Alaska Native Claims Settlement Act
- Receipts distributed to certain Indian tribunal members
- Certain student loan funds
- Supplement security income payments received by recipients who do not reside in certain group care facilities
- Certain state provided assistance to senior citizens for property tax relief or other needs
- Payments made to veterans from the Agent Orange Settlement Fund
- Certain payments made by the US Government to citizens of Japanese ancestry who were interned during World War II
- Assets which are unavailable to the person.
- Finally, there is an asset disregard of $2,000 in cash or other assets.



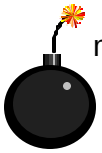
Medicaid rules do not also require the immediate impoverishment of a spouse. But, the limits of what can be kept may mean a lower quality of life than what he or she is accustomed to living.

In addition to exempt assets mentioned above, the amount a spouse can keep varies from state to state. The maximum is typically around $75,000. The amount that can be kept is determined by adding ALL available assets of BOTH husband and wife. If one-half of the total does not exceed the amounts above, the spouse can keep them. The rest must be sold and used to pay any medical bills before Medicaid will participate.

Giving Away Assets & Income

Transferring assets or income in order to qualify for Medicaid is a topic of much discussion. There are five obstacles that your clients must consider before considering this strategy.

<u>It's complicated</u>. The process of divesting may require an irrevocable trust and legal property transfers. To stay within the law and avoid financial penalties will unquestionably require the services of an elder attorney. The costs and paper maze will sidetrack most. Transfers may also have serious negative income tax consequences.



<u>It requires advance planning</u>. OBRA '93 established a 36 month "look-back". Assets given away within three years of applying for Medicaid are assumed to be transferred to avoid payment of medical expenses. The look-back is 60 months for transfers of income or principal to an irrevocable trust. The penalty for either is a period of ineligibility equal to the amount of the "illegal" transfer.

Example: In anticipation of filing for Medicaid assistance, Dick transferred $30,000 to his son in October 2000. In May of 2001, Dick entered a nursing home and entered his

formal application to Medicaid in July of the same year. Since an uncompensated transfer (gift) occurred 9 months prior to Dick's application for Medicaid, he will be subject to a period of ineligibility (because it is within the 36 month look-back period). The period of disqualification is $30,000 divided by $3,262, the average private pay rate (This rate changes each year). Dick will be ineligible for 9.19 months.

It can be a criminal offense. HIPPA, effective January 1,1997, has made it a misdemeanor punishable by a fine of $10,000 or one year imprisonment, or both to " . . . ***knowingly and willfully dispose of assets (including any transfer in trust) in order for an individual to become eligible for medical assistance (Medicaid)."*** Since no amendment was created, this law eased substantially for seniors, i.e., "grandma will not go to jail". However, it is a still a felony for a service provider or professional, such as an insurance agent, to help someone transfer assets. The fine is $25,000 or five years in prison or both.

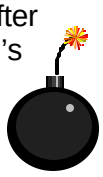
It is only cancelled out. In the end, Medicaid recipients who temporarily avoid spending their own assets or income must still pay it back because OBRA '93 requires ***estate recovery***. Every state is required to pursue the estate of a deceased Medicaid recipient to recover any assets not subject to probate. They have a right to lien property and seek recovery from assets in which the recipient had any interest at the time of death. Even a life estate in a former house that was transferred to a child years ago could be attached.

There is loss of control and choice. When all assets are out of the individual's control he is finally eligible for Medicaid, but at what cost? If he recovers, there is little to come back to enjoy. Further, as a Medicaid patient there are few choices as to doctors, facility location and upgrades. Some facilities do not accept Medicaid and ones that do may not be located near family and friends. Also, there is a remote chance that rates paid by Medicaid . . . typically lower than private pay . . . result in fewer service upgrades, furnishings, etc.

The thrust of all these efforts is clear and chilling: Congress wants middle class citizens to buy long term care insurance and stay away from Medicaid.

Medicaid Trusts

It is important for insurance professionals to understand that clients are no longer able to shelter nonexempt income and property within trusts as a way of establishing Medicaid eligibility. Rules on these trusts and annuities were filed January 1998 as Director Letters #95-75 and #96-68 (now Section 50489 of Title 22). These regulations impact all trusts established on or after 8/11/93 containing the income, property or property rights of an individual or individual's spouse.



Now, if an individual or spouse creates a trust, Medicaid counts as currently available anything contained within that trust (if not normally exempt; such as a home) regardless of when or whether distributions can be made and ***regardless of any special use limitations.*** This means that no matter how remote the possibility of a distribution may be, it will be currently counted for purposes of establishing eligibility for Medicaid. In addition, anything that cannot be released under any circumstances is subject to a "transfer-of-property penalty" which means that an individual may be ineligible for nursing facility care for the number of months that the property could have paid for their care at the average private pay rate.

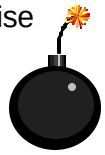
There is one exception: trusts established for a disabled individual by someone other than him where there is specific language contained in the trust requiring repayment t DHS for the cost of medical assistance upon the death or earlier termination of the trust.

Annuities And Medicaid

Using annuities to protect assets from the nursing home expense has become very popular. Two recent books on the subject, The Medicaid Planning Handbook by Alexander A. Bove, Jr. and Avoiding the Medicaid Trap by Armond Buddish, specifically discuss the use of annuities to avoid Medicaid seizure. In fact, two insurance companies have designed deferred annuity products with features that are implemented at the appropriate time to get around Medicaid rules.

Although the Kennedy Kassebaum Bill continues to sanction annuities as a tool in the Medicaid spendown scenario, there are many potential disasters with using annuities to shield assets. Following are some parameters to remember:

- Many states' rules for Medicaid differ greatly. It is important to learn as much as possible about your own state's specific rules.
- The annuity must be annuitized prior to applying for Medicaid. Many consumers who own deferred annuities will not remember that they must annuitize the policy prior to applying for Medicaid. Once the Medicaid applicant reveals that their annuity is a deferred annuity, then it's too late. Medicaid (Social Services) will order the policy owner to either cash in the annuity for spend-down or simply disqualify the applicant for having assets that exceed the qualifying amount.
- If you purchase an annuity for the purpose of protecting your money from nursing home spend down, there is no guarantee that Medicaid will not simply change their qualification rules in order to disqualify such Medicaid applicants. The government is an expert at changing the rules.
- Under the Kennedy Kassebaum and OBRA '93 Act, an annuity must have life expectancy payout rates that are in accord with the latest social security mortality tables. Many insurance companies' payout rates are not compliance.
- Some annuities will not allow you to annuitize the first year. Therefore, if your situation should require annuitization during the first year, you would simply be out of luck! (There are other annuities that will not allow annuitization for 5-15 years.)
- If a deferred annuity is purchased to shield assets against Medicaid, the purchaser will often make a spouse the annuitant, so that in the event of nursing home confinement, the deferred annuity can be annuitized with income going to the spouse. However, if the annuitant predeceases the annuity owner, the death benefit is triggered. In some cases, a surrender charge is charged upon the death of the annuitant. In addition, the owner of the annuity will receive notice from the IRS for the taxable gain, not a pleasant experience. Finally, since the spouse is usually the primary beneficiary, the proceeds will be made payable to the contingent beneficiary. This is most likely the children and not the owner of the policy. This scenario could cause exercise of your E&O.



- Many purchasers do not understand how Medicaid actually works and therefore are not qualified to engage in this type of planning.
- OBRA 93 established and mandated a 60-month look back for deferred annuities. Many State Medicaid offices use this provision to initiate or trigger the ineligibility penalty period, creating an array of problems that may ultimately be attributable to ownership of a deferred annuity.
- Using an annuitized annuity to shield assets loses its glitter when it comes to single individuals, since the annuitized income cannot be directed to another individual as with married couples and the income stops should the income recipient die.
- What happens when the annuitant simply dies? You cannot attempt to qualify for medicaid by annuitizing your policy with the intention of passing excessive monies to your heirs. Under

the Estate Recovery rules passed by OBRA 93, any income that continues to heirs after your death could be subject to recovery by Medicaid.

- It is worth considering that if you annuitize based on your life expectancy, the interest rate provided by the company may be quite low!
- If the annuity owner has to enter a nursing home because he has become incapacitated or mentally incompetent, who can make the decision to either gift the annuity policy or simply annuitize it? No one can, unless there is a durable power of attorney which grants such power. Even having a durable power of attorney is no guarantee, since many documents do not contain the requisite language for gifting or annuitizing such a policy.
- You cannot use a section 1035 exchange to avoid some of the problems mentioned above (see, for example, items 4), 5), and 6) because this procedure requires that the owner and annuitant in the successor contract remain the same.

In short, the advice to anyone considering the purchase of an annuity to shield their assets from Medicaid is: Let the buyer beware!

Example: John wants to reside in a nursing home that costs $3,500 per month. In order to pass Medicaid qualification tests, he uses a significant portion of his assets to purchase an immediate fixed annuity that pays $1,200 per month for life. John's only other income, from Social Security, is $950, making the monthly income total $2,150. However, in order to qualify for Medicaid, his monthly income must be less than $2,050 in his state.

According to the Medicaid eligibility rules, Bill now has too much money coming in. In the process of "ridding" himself of much of his assets, he has established a guaranteed income that is too high and that he has no way of reducing. Even worse, this amount of income very likely won't be sufficient to cover the cost of his current medical expenses. In short, not only has Bill failed to qualify for Medicaid coverage, he has also locked himself into a situation in which his current income is not enough to meet the medical expenses that he alone is obligated to pay.

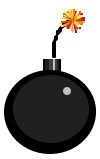
Medicaid Estate Recovery

Federal law requires each state to recover the costs of nursing facility and other medical services from the estates of Medicaid recipients. This means that every state is federally mandated to recover from Medicaid recipients who receive services at the age of 55 or older, or in a nursing home, in order to help pay Medicaid covered expenses for the increasing number of individuals needing medical care.

Example: Mr. Roberts, a widower, left his only property, a house valued at $175,000, to his son. At the time of his death, Medical had provided $24,000 for his nursing home care. In addition to this claim, there was a total of $10,000 in funeral bills and costs for probating his estate. Mr. Roberts' son received $141,000 ($175,000 - $24,000 - $10,000 = $141,000) after all the claims were paid.

Recoveries from a deceased recipient's estate will include all medical expenses paid by Medicaid These expenses include:

- Health insurance premiums (including Medicare),
- Nursing home services,
- Home and community based services,
- Hospital services,
- Prescription drug services, and
- All other Medicaid covered services.



Food stamps, emergency assistance and cash grants are not Medicaid costs, and will not be recovered under this process

How do clients know when Medicaid intends to try to recover from their estate? Medicaid should provide notice that the Estate Recovery Program exists when they first apply for Medicaid. When Medicaid is actually trying to get recovery, it must notify the legally authorized representative of your estate. If there is no representative, they must try to notify known family members or heirs.

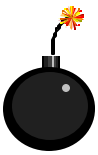
Before 1993, Medicaid could only recover from your estate if it discovered that you had owned assets during the period in which you received benefits and that those assets would have made you ineligible for Medicaid. In 1993. Recovery powers were greatly expanded for people who receive Medicaid after October 1, 1993 and who die after that date.

Medicaid can now try to recover after a client's death in these additional situations:

- If the client is 55 years old or older when they receive Medicaid; or
- If the client received Medicaid under a provision that disregards certain assets because they have purchased a long-term care insurance policy, e.g., A State-Approved Long Term Care Partnership Program

Frequently Asked Medicaid Recovery Questions

What portions of your client's estate are protected from recovery by Medicaid? If they own a joint tenancy in real estate with someone else, that real estate cannot be recovered by Medicaid. If they have sold or transferred property to someone without keeping any interest in that property for themselves, that property is also protected for recovery purposes.



NOTE: If clients transfer any property for less than its fair market value, they could have trouble getting Medicaid for nursing home or other long term care for three years after transferring the property.

If clients own any personal property , such as a car or a bank account, in joint tenancy with someone other than their spouse, a blind or disabled child, or a child under 21, Medicaid may try to recover against that property. It is not clear whether Medicaid can recover personal property held in joint tenancy.

Can Medicaid recover from a spouse's estate? No.

What are the so-called "lookback" provisions? OBRA '93 established a 36 month "look-back". Assets given away within 36 months of applying for Medicaid are assumed to be transferred to avoid payment of medical expenses. The look-back is 60 months for transfers of income or principal to an irrevocable trust. The penalty for either is a period of ineligibility equal to the amount of the "illegal" transfer

What is the treatment of property transfers made during the Medicaid "lookback" period? If the transfer in means an outright gift or sale at less than "fair market value", Medicaid will calculate the period of ineligibility for nursing facility level of care.. It will be the number of months resulting when the 'net fair market value" of the transferred is divided by the monthly average private nursing facility costs (ADPPR).

Are "exempt assets" protected against Medicaid Estate Recovery? No, even the home, if it has not been previously transferred, is part of the estate against which Medicaid has the right to

recover the cost of Medicaid benefits received after the recipient is age 55. Such recovery will not occur until after the death of the community spouse and/or there are no more dependents.

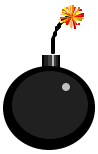
Are there any other protections? Yes. If a client dies leaving a "dependent," Medicaid will not file a claim against their estate. A dependent is a surviving spouse, a child under the age of 21, or a child who is blind or permanently or totally disabled. If clients leave an estate that will be probated , any claim for recovery from their estate must be filed within four months after death . If, at the end of that four-month period, a surviving spouse or disabled child is still living, or if there is still a child under 21, Medicaid will not try to recover from the probated estate. If an estate will not be probated , Medicaid will not try to recover from it if, two years after death, the surviving spouse or disabled child are still living, or if there is still a child under 21.

A client's estate can also be protected if Medicaid's actions will create an "undue hardship" on someone who survives him or her. Medicaid will look at the following circumstances to decide whether undue hardship exists for the survivor:

- Whether the property was the primary residence of the person claiming undue hardship;
- Whether that person used personal resources to maintain the property, pay taxes, etc.;
- Whether that person lived on the property and provided significant care so that you could remain at home for a longer period of time;
- Whether that person had entered into a contract with you in which the residence was held as security or in which the residence was supposed to be transferred to that person for value already received by you;
- Whether you had promised that the residence would belong to that person after your death and the person had relied on that promise and would be harmed if the promise were not met;
- Whether that person is a resident and co-owner of the property; or
- Whether the property produces income necessary for that person's support.

Medicaid Liens

Liens against the real property of a recipient may be filed when the state determines that the recipient cannot reasonably be expected to return home. The purpose of the lien is to recover any payments made by the State on behalf of the Medicaid recipient. A lien does not change property ownership. However, it does represent a debt that must be satisfied when the property is sold, transferred, or the recipient dies.



Written notice will be provided ninety (90) days prior to filing a lien. Medicaid recipients or their personal representatives will have an opportunity to present any objections during a hearing process.

Automatic statutory liens are also imposed against judgments, awards and settlements in lawsuits when the state has provided medical assistance to a recipient for which a third party is responsible.

Medicaid and Long Term Care

Medicaid has become a public assistance program . . . welfare . . . that combined pay for a majority of all current nursing home patient days in the United States. Some states are spending more money on Medicaid than on education prompting national debate on how to finance long-term care. The program has a dismal reputation for access, quality, reimbursement, discrimination and institutional bias. Nevertheless, citizens, private attorneys and even public entities such as state Long-Term Care Partnerships encourage

middle class people to virtually impoverish themselves in order to gain access. This process is referred to as ***Medicaid Planning***.

The government wants to stop the practice of transferring assets and other abuses of the Medicaid system. That is why a flurry of legislation has created tax incentives for citizens to buy their own, private long-term care insurance. Additionally, rules have been established that make it a crime to transfer assets to avoid paying for long-term care expenses.

On the industry side of the scales, nursing homes that accept Medicaid, are now required to notify new residents who pay with private funds at entry that they might have to move if they eventually run out of money and need to rely on Medicaid. Up to now, nursing homes took private payers, and kept them when they could no longer pay, shifting them to Medicaid. They felt it was "bad public relations" to kick these patients out. Nursing home giant Vencor tried this a couple years ago and suffered a huge scandal, together with falling share values.

The new law may furnish nursing homes with yet another incentive to leave the Medicaid program and another argument convincing prospects for long-term care that if they want quality care, they must insure it on their own.

Since no other payment source for custodial long term care service has surfaced, the Medicaid program has become the largest payor for these services when people cannot afford to pay. With the significant costs associated with receiving long term care services, many people who were otherwise middle-income find it necessary to apply for Medicaid.

> *Example: Mr. Smith worked for the school district for 42 years! He isn't poor or impoverished.". You even know that Mr. Smith gets $1500 per month in retirement and was proud of a small savings and some investment he had. It just does not sound right, does it? But you also know they had to put Mr. Smith in a nursing home over a year ago.*
>
> *You have never thought much about how he has been paying for it. You know now, because of this training, that Medicare and health insurance pays nothing toward custodial care. Sadly, Mr. Smith did not know it either.*
>
> *Well, Mr. Smith is paying for it out of his retirement, savings and investments. The nursing home runs $3,600 per month. With $2,100 per month being paid in a co-pay, it is not going to last long. What will happen to Mr. Smith when he does not have the extra money to supplement his retirement to pay for the nursing home? Another scenario that could have landed Mr. Smith in this frustrating situation is one where he purchased a $50 a day without inflation protection, long term care insurance policy 10 years ago. At that time the cost of care was around $65-70 a day. Mr. Smith thought he could manage the other $15-20 a day and still have money left at the end of the month for personal items. The cost today is $120 a day. Mr. Smith has to co-pay $70 a day or $2,100 per month. Remember, Mr. Smith only gets $1,500 per month. Mr. Smith will have to spend all his assets and "impoverish" himself. When this happens to Mr. Smith, he falls into the category of "medically needy". Who would have thought this possible?*

You have no idea how often this situation happens. It can play out in a variety of ways but it happens more than we would like to see and to people we never would have expected. Good planning can keep it from happening and that is part of what you are here to learn. It is also your job to let them know.

Medicaid Conclusions

The U.S still lacks a universal system for medical and long term care and Medicaid is NOT it! Medicaid programs pauperizes families who must use it, and encourage the non-poor to try methods (some now considered a crime) to transfer assets to qualify.

Medicaid was created as a public welfare program for the indigent funded by Federal, state and local governments. Some of the benefits go to families and dependent children but a huge and growing portion is for the aged, blind and disabled. One private study indicates that over 25 percent of Medicaid funds were for nursing home costs in 1995 alone.

The problem is obvious. A huge portion of our senior population has been caught "off-guard". Their longevity combined with escalating costs of long term care has created a need to try and capture the benefits of Medicaid. If they don't, a reasonable stay in a nursing home could impoverish their entire estate.

It is a small wonder, then, why these people have turned in record numbers to lawyers and financial advisers to find Medicaid ***loopholes*** -- ways to divest themselves of income and assets in order to qualify for Medicaid.

Privately funded long term care insurance is seen as a substitute for some form of national long term health plan. But it may come too late for anyone who has accumulated a modest nest egg. They may not be able to afford the premiums and they can't go it alone. Finding a way to qualify under Medicaid is, for them, a viable option.

As discussed, Medicaid programs can vary from state to state. Therefore, the insurance professional, when marketing long-term care insurance in more than one state, must become familiar with the Medicaid programs in each of those states

It is recommended that any Medicaid plan should be reviewed at least every two years to see if it is the best plan in light of current state law. Make sure you are aware of the planning options available and seek the necessary advice in carrying out the "best plan for you". This will be well worth the time and expense and it can be thought of as a part of the cost of "health care insurance".

A Word of Caution

The Medicaid system is basically a form of welfare. The rules can and do change frequently. Consequently, advising persons about Medicaid carries with it a certain amount of risk. "Grandfathering" of an existing situation under which one may qualify for Medicaid when the rules change is uncertain. When consulting with a client on Medicaid, agents are urged to disclose to the client the risks, and to continually keep abreast of changes in the law. Because the Medicaid program varies and constantly changes, the information contained within this chapter is intended to be illustrative in nature.

Medicare Supplement Insurance

There are many gaps in coverage left by Medicare such as limited benefit periods, deductibles, coinsurance and exclusions that can be filled with a private Medicare supplement policy . . . sometimes called ***Medigap Coverage.*** Unfortunately, like Medicare this conventional insurance restricts coverage to skilled care . . . and not chronic conditions.

Aggressive medigap plans extend coverage to “at-home recovery” (short term assistance with activities of daily living) and skilled care may provide for items like IV’s, bedsore care and physical therapy. But once health progress stops, the condition is termed ***chronic*** and no longer covered. That is why someone like an Alzheimer’s patient is considered under these plans to need little or no skilled care. He is not covered by Medicare or a supplement plan yet cognitive impairment may limit his abilities to perform simple activities such as bathing or eating. Patients like this move through the evolution process . . . from acute to chronic conditions leading to the need for nursing home care or advanced home health assistance. The Health Care Administration estimates that Medicare and private insurance like Medicare supplement plans provide only 12 percent of the nation’s total nursing home care expenses.

There is a common misconception that supplemental health care insurance policies (known as Medigap insurance policies) will cover long-term care. Supplemental policies cover no further than the primary insurance, in this case Medicare. The supplemental policies merely cover the deductibles and the co-payments of covered Medicare expenses.

Senior Hmo’s

In lieu of Medicare and/or a Medicare supplement policy, a popular choice is the managed care plans which are often called ***HMO’s or Coordinated Care Plans.*** Most of these plans collect a fixed monthly payment from the government, regardless of the patient’s health, and must promise to cover all patient needs that would have been paid under Medicare. To contain costs, many of these groups contract with specific health care providers and clinics to offer Medicare services. In some cases, manage care groups provide a bit more than Medicare or supplement plans as an incentive to switch. Unlimited prescriptions drugs and some respite care are a couple of examples that have been used to attract Medicare enrollees. Currently, about 15 percent of the people eligible for Medicare choose managed care plans. Congress is happy about this because the government’s monthly commitment is fixed and these private concerns are far better at cost containment than Medicare.

The concept of senior managed care is being tested in some our country on a grand scale. The primary advantage to this type of system is that it is a prepaid health care plan that promotes wellness and preventative medicine.

The predicted effects of managed care tend to offset the advantages of a more traditional comprehensive health care program. Under a managed care program, doctors are salaried, and their earnings are not affected by quantity of care. Therefore, there is no incentive to overtreat patients. As a result, waste and unneeded services are minimized. The purpose of managed care is to promote cost effectiveness of medical services.

It must be emphasized that while senior HMO’s offer a few more frills than Medicare, they do not cover long term care. Services such as nursing homes and home health care are excluded for chronic conditions.

In-Home Supportive Services

The In-Home Supportive Services (IHSS) program is administered by the various county Departments of Social Services under guidelines established by the state. IHSS provides assistance to eligible aged, blind and disabled persons who are unable to remain in their homes safely without assistance. Most people are eligible for IHSS when they meet eligibility criteria for the Supplemental Security Income / State Supplementary Program (SSI/SSP) for the aged, blind and disabled.

The services available through IHSS are domestic services such as heavy cleaning, mea preparation and clean-up, laundry services and reasonable shopping.

What are other eligibility criteria for IHSS?

- You must be a citizen of the U.S. or a qualified alien.
- You must live at home (acute care hospital, long term care facilities and licensed community care facilities are not considered “at home”).
- Personal property may not exceed $2,000 for an individual or $3,000 for a couple.
- Depending on the amount of your income, you may be required to pay for a portion of your IHSS benefits (share of cost).

How does the IHSS program work?

- A county social worker will interview you at your home to determine your eligibility and need for IHSS. Based on your ability to safely perform certain tasks for yourself, the social worker will assess the types of services you need and the amount of time the county will authorize for each of these services.
- If you are approved for IHSS, you must hire someone to perform the authorized services
- If your county has contracted IHSS providers, you may choose to have services provided by the contractor
- The current IHSS hourly rate set by State law. Currently, about $6.00 per hour.

Alternatives to Funding Long Term Care

The rather long discussion we just presented should give a clear picture about the "government minefield" concerning the financing of long term care. Not everyone will qualify for Medicare or Medicaid assistance. Likewise, there will be plenty of clients you encounter who cannot afford long term care insurance premiums at first blush. So, sometimes you need to be creative; look in places you might not ordinarily look to find the financial resources to get your clients covered.

Let's see how you can make LTC insurance happen for these folks!

Accelerated Death or “Living Benefits”

Life insurance that provides accelerated death benefits to pay medical expenses first came on the scene in 1988. Since then, they have been offered by over 100 insurers; enjoying a 228 percent increase in policies sold. As of 1994, these policies represented just under 12 percent of the total market. More companies are modifying existing policies in order to add these riders. Typically, the basic premium cost will be increased by 5-15 percent to pay for the rider, although some riders can increase the cost of a basic policy by as much as 33 percent.

In recent years, insurers have been offering long term care-specific riders as accelerated death benefits. Despite this improvement, these policies ***should not be sold as long term care insurance.*** A long-term care rider will pay some of the policy’s death benefit while an individual is still alive. For example, suppose a person has $300,000 worth of life insurance coverage. Assume he spends three years in a nursing home. Since he has a long-term care rider on that life insurance policy, $75,000 is paid out for nursing home costs ($3,000 per month for 25 months) while he is still alive. When the insured dies, the beneficiaries will receive $225,000 instead of $300,000. When he taps into the long-term care living benefits, he is using the cash value that would ordinarily belong to the beneficiaries.

Long-term care riders often pay ***living benefits*** when a serious illness occurs, even when no nursing home care is needed. For example, victims of strokes, heart attacks, cancer, coronary artery surgery, and renal failure can collect benefits while they are still living. Sometimes the policy holder can receive as much as 25 percent of the policy's face value up front, rather than in regular monthly payments.

These riders have limits. They may not cover nursing home stays outside the United States or long-term care resulting from alcoholism, drug addiction, or attempted suicides. The long-term care riders usually cover nursing home care only after a stay in a hospital or in a skilled nursing home where medical treatment is dispensed. Most nursing home residents enter the homes directly, not after a stay in a hospital or skilled nursing homes.

The money available for nursing home benefits on a long-term care rider is normally two percent of insurance coverage per month. By this rule, a $100,000 policy would pay $2,000 per month. However, if the policy is over $150,000, the policy holder may get less than two percent. For example, suppose the policy holder has a $300,000 life insurance policy with a long-term care rider, and he is confined to a nursing home. This insured may get two percent of the first $150,000 ($3,000) plus one-half percent of the next $150,000 ($750) for a total of $3,750 per month.

Also, some policies place a limit on the monthly payment amount. Some policies permit the policy holder to collect 100 percent of the amount of the life insurance, while others cap it at 50 percent. Most polices require that the policy holder pay at least for the first 60 days of nursing home care before a long-term care rider kicks in.

With some riders, the policy holder will have to make out-of-pocket payments for at least 180 days before he can collect. Some long-term care riders will not pay until the policy holder has been paying the extra premium for at least three years. For example, if an individual buys a long-term care rider in 1997, he may not be able to collect before 2000, 2002, or some other date.

Most long-term care riders will pay for skilled care or intermediate care nursing home stays. However, some riders do not pay for custodial care. Others will pay only after a specified number of days in a hospital or a specified number of weeks in a skilled care or an intermediate care home. While receiving benefits from a long-term care rider, the policy holder is not obligated to keep paying premiums if the rider has a waiver of premium feature.

The problems with funding long term care coverage through an accelerated death benefit policy are obvious: Benefits may be slower than a stand alone policy, benefit triggers can be tricky and there is typically no inflation protection other than by expensive inflation riders. Furthermore, the death benefits that could have gone to an insured's estate are usually "eaten-up" in long term care costs thus defeating the purpose of buying a life insurance policy.

It is significant to note that the tax treatment of accelerated death benefits has changed as a result of HIPPA (Health insurance Portability and Accountability Act). Signed by President Clinton in 1996, this new law provides for ***tax free treatment of accelerated death benefits for terminal and chronically ill people paid directly by insurance companies***. This should serve as another reason for the seriously ill to make use of accelerated provisions in their life policies for current "living benefits", including long term care where permitted. Caution must be advised, however, in how one defines terminal or chronic illness to the satisfaction of the Internal Revenue Service.

Viatical Settlements

A viatical settlement is a transaction whereby a non-related party purchases all beneficial interest in a life insurance policy insuring the life of a terminally ill person. Since many long term care patients are terminal, they may consider selling the proceeds of their life insurance policy before they die to use the funds for current, more pressing medical needs and expenses. Or, using the funds to purchase long term care insurance.

The theory behind these transactions may sound gruesome but can be beneficial for both parties. Think of it, by the time a terminally ill person considers "selling" his or her life insurance policy, they are typically on their "last leg", financially speaking. The income realized from the sale of the life insurance policy can be ***very welcome***.

The mechanics of the transaction are fairly simple. A third party "broker" or viatical company pays the terminally ill person a percentage of the death benefit and becomes the owner and beneficiary of the policy. The terminally ill person receives a lump sum of money to use ***now***. When he dies, the proceeds of the policy go to the viatical company. Viatical companies are usually funded through investors and buy all kinds of policies, term, whole life, universal life, group life, etc. The policy must have been in force for at least two years and not be subject to a contestability period. In some cases the viatical company even continues paying the premium on the policy to keep it going. Also, viatical companies are known to work with a combination of ***accelerated death benefits AND viatical settlements*** to net an even greater sum of cash for the seller of the policy.

More and more, people diagnosed with other terminal illnesses are turning to viatical settlements to meet their financial needs -- ***including long term care***. The list includes terminal sufferers with cancer, "Lou Gehrig's Disease, cardiovascular illness and more. As a matter of fact, the statistics point to a larger market for viatical settlement from terminally ill patients with cancer who, in 1995, represented 78 percent of all hospice care admissions versus AIDS at only 4 percent. The industry is expecting more cases from non-AIDS related illnesses as more people learn about the product.

A real boost to viatical settlements should also come as a result of HIPPA (The Health Insurance Portability and Accountability Act) of 1996 which allows people diagnosed with a terminal illness to sell their life insurance policies to viatical settlement companies for a ***tax free lump sum payment***. This tax free provision will apply ONLY to people whose life expectancy is less than 24 months and the purchasing company must be licensed by the state in which the viator (seller) resides.

Policies of all sizes are viaticated and twenty-one states have adopted all or a portion of the regulations for viatical settlements set forth by the National Association of Insurance Commissioners. And the Viatical Association of America has established minimum standards of consumer protection for its viatical company members.

Life Settlements

In theory, life settlements work the same as viaticals: A policyowner agrees to sell his or her policy for an agreed upon sum of money to a third-party funding company who then becomes the new owner and beneficiary. The difference is that life settlements do not depend on the insured being terminally ill. Instead, older policyowners are considered (as young as 65 years of age). The funding company simply "banks" his deal on the proposition that the insured has a life expectancy of "x" and he will get the full amount of the policy proceeds back at his death. Th insured can use his funds to pay medical or long term care or buy a long term care insurance policy.

The Health Insurance Portability and Accountability Act of 1996 makes the proceeds of a life settlement TAX-FREE for individuals who are terminally or chronically ill.

Single Premium Life / Fixed Annuity and LTC Rider

We call these "in sickness and in health plans" because they involve the combination of long term care insurance funding is available in a specially designed life insurance policy or annuity that combines tax deferred cash values, a death benefit and long term care insurance. Issues ages can be as low as 40 years and joint policies can also be written if certain parameters are met.

The typical policy is designed around a single premium deposit (minimums of $10,000) with an average amount being $50,000 and even $100,000. It would not be uncommon for people to transfer the funds in a large CD to this product providing they are not in need of the monthly interest for living expenses.

One product approach builds on the single premium investment . . . let's use $50,000. For a single female aged 65 who is underwritten as "preferred" a death benefit equal to $110,000 is available to the named beneficiaries. The company also credits a current rate of return on the single premium which is then reduced slightly (say 1.5% to 2%) to cover the next benefit which is long term care. On the same $50,000 single investment, the company offers a ***pot of money*** equal to double the death benefits ($220,000 in this case) to provide convalescent care for at least 4 years. This includes a nursing home daily benefit of $150, a home health benefit of $75 per day and an adult care daily benefit of $37. These benefits begin after a 90 day elimination period and would continue as long as the insured remains eligible and until exhausted. If long term care expenses did not use all of the "pot of money", the excess remains available thereby extending coverage into 5 or more years. Other features include 24-hour liquidity for other emergencies and a cancellation guarantee that promises the insured the original premium deposit, less any amounts paid for convalescent care benefits.

Newer versions of this product are available with annual installments, say over 10 years. One company suggests that clients make the annual payments through their children by gifting the $10,000 or $20,000 each year. The client remains as the insured of the contract with the children as owners and beneficiaries. The client's estate is reduced by the gift amount . . . thereby reducing the taxable estate. Likewise the policy proceeds are not part of the estate. When a long term care need is presented, the proceeds "kick-in". If they are never needed, the children receive a tax-free death benefit. ***Always check with an estate / tax advisor before implementing any such plan.***

Other variations of this product offer an ***independent rider*** that does not effect the life insurance policy or its cash values. Any benefits paid for long term care such as a nursing home would not reduce the death benefits or cash values of the policy. Of course, there would be maximum daily and lifetime benefits associated with such a contract and a client should expect to pay considerable more for the privilege.

Still other variations include a universal life policy where up to two percent of the death benefit can be accelerated each month to pay for long term care expenses, following a 90-day waiting period. As benefits are paid, the policy's death benefit and gross cash value are reduced.

Who would use these policies? Anyone who cannot see themselves paying years of long term care premiums for coverage they may never use. And, if the long term care benefits in the policy are not needed; a sudden death, for example, their heirs are at least entitled to the policies death benefit.

Of course, without inflation protection, even the long term care benefits in the examples above can be eroded quickly. If such protection is available as an additional rider it should be considered. The result will probably be a significant reduction in the current interest rate or higher premiums and only a comparison analysis with a stand alone long term care policy can ferret out its feasibility.

One bright light here is the effect of HIPPA. Prior to the new health care legislation the gain in cash value within these types of policy were tax deferred but taxable when long term care benefits were paid. Now, these benefits will be tax-free as long as they do not exceed the greater of $175 per day ($63,875 annually) or actual costs.

Annuities

For years, the insurance industry has designed annuity contracts that appeal to the liquidity needs of seniors and other market groups. Most new generation annuity policies, for example, offer ***free withdrawals*** that allow the owner to withdraw 10 percent or 15 percent of the account value every year. These withdrawals can be used for any purpose including medical costs and long term care.

More significant are the ***nursing home and terminal illness waivers*** found in many competitive annuity products. Now the contract owner can withdraw . . . ***penalty free . . .***large portions of the account value (usually up to 50 percent) without penalty or surrender charges so long as the proceeds are used for nursing care or terminal illness expenses.

Drawbacks to both long term care riders and annuity coverage should be noted: Benefits paid may be less than the standard long term care policy, particularly in areas such as home health care and assisted living. Similarly, the duration of payments will most certainly be limited. And, without inflation protection, the proceeds may do little to cover actual LTC costs. "Pot of money" approaches will most likely be exhausted in a matter of years or sooner and few, if any, can be expected to provide lifetime benefits. Then again, such long term benefit durations in stand alone long term care insurance, while available, are very costly leading to few takers anyway.

Reverse Mortgages

Another form of possible income is through a reverse mortgage in which you can withdraw the equity in your home in the form of a loan and use the money for living expenses. Typically, the loan proceeds are paid out monthly, but other arrangements can be made. The loan balance increases each month as payments are received. Additionally, interest is added to the growing balance.

Many seniors in this country work diligently to make sure that when they retire they own their home "free and clear". If medical expenses start piling up, many can find themselves in a situation where they are ***house -rich*** but ***cash poor***. The reverse mortgage is an excellent way for these older homeowners to convert home equity into needed cash without immediately selling the home.

In the typical reverse mortgage transaction, a lender agrees to pay the homeowner a specified payment each month. The balance owed the lender grows as more monies are disbursed to the homeowner. The total accumulated balance is considered a loan against the homeowner's equity but no repayment is required until the borrower dies, moves or sells the home. If there are two spouses who own the house, there is no repayment due until the last surviving borrower dies or sells or moves from the home.

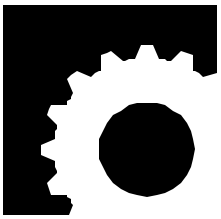
Most lenders who participate in reverse mortgage plans require the homeowner to be 62 years of age or older. Homes must be single family (not condominiums unless they are FHA-approved). There are no income qualifications and little, if any, credit requirements because the owner is not going to make any payments. The maximum loan amount varies per locality, from $67,500 in low-cost rural areas to $151,725 in costlier housing markets. The amount also varies on the client's age. Payments are based on actuarial tables. In addition to the full loan amount, the borrower is liable for fees, points, closing costs, insurance premiums, plus all interest. Interest and closing rates are generally higher than those in conventional mortgages. Liability to homeowners is limited to the value of his home, i.e., they can't be made to pay from other assets. Some reverse mortgage financing programs are FHA-insured, however, many lenders require no insurance -- they are simply banking on the owner's large "pot of equity" to secure the deal.

The proceeds from a reverse mortgage can be used for any purpose, including long term care expenses and they are tax free to the homeowner.

Sale Leasebacks

Another method seniors use to tap the equity in their homes is called the sale leaseback. Here, the owner sells his home and leases it back from the person who bought it. Like the reverse mortgage, the owner now has access to the equity in the home in the form of a lump sum or by monthly mortgage payments from the new buyer. In essence the buyer in these transactions is buying a ***life tenancy***.

Unlike the reverse mortgage, there are some potential negative tax consequences that make the sale leaseback tricky. Installment payments in a sale leaseback deal are ***taxable income*** and may be subject to BOTH capital gains and income taxes where the IRS views the transaction as a bona fide sale.



#9--Responsible LTCI Agents Know All They Can About Underwriting

Underwriting and how premiums are determined (ratings) is a very appropriate topic for a course on good habits. Why? Because as many as 30% of your applications could be rejected due to ***medical underwriting***, i.e., health questions and uncertainties. Although some insurers are now offering risk-rated premiums, LTC underwriting is tougher than other markets. Further, if you continually submit higher-than-normal amounts of LTC applications that are rejected, your income suffers and your clients suffer an emotional downer. Likewise, if you do not follow some basic suitability rules and sell people policies they cannot afford (***suitability underwriting***), you will experience a higher-than-normal ***lapse rate*** among clients who buy now and later drop their policies. You will lose thousands of dollars in trailing commissions, future business that same client may have generated for you and in some states you may be "categorized" as an irresponsible agent leading to fines, penalties and possible loss of license.

About 30% of your LTCI applications could be rejected due to medical underwriting.

Ratings should be of interest to you because it is the system insurers use to "price" policies. Why should you be concerned about premium stability after you have sold a policy? Well, for one thing, you might be sued for not disclosing the possibility that rates for the class of policies you sold can increase. Rate increases are also harmful to your future business. Not only can they cost you a client, but they create the need for new selling requirements be added to the already existing minefield of disclosures you must present to your clients. As of the writing of this sales system, for example, the NAIC (National Association of Insurance Commissioners) is recommending that a special disclosure be added showing your insurer's rate increase history and a signed acknowledgement that rates on his policy can increase in the future. What is your company's rate increase history? By the way, are you making sure that your clients understand that even though their long term care premiums may not increase due to age or physical condition, they are part of a ***class*** of policy holders that can increase?

Underwriting Measures Risk To Benefits

Underwriting is not an exact science. It is very subjective. Also, long term care underwriting is different than life insurance or general health insurance underwriting. One thing is certain about long term care, however; there is a much higher risk to insurers because of the low cost of premiums weighed against potentially high benefit payouts. Think about it, would you be willing to guarantee to pay up to $100,000 per year to reimburse potential long term care costs that you know are going to effect about 60% of the population? What would you charge for this service? $200 per month; $300 per month? Furthermore, what if a state agency told you that even though you want to charge more for this service, you must payout at least 60% of the premiums you collected in benefits before you could raise your rates, would you want to get involved?

These are the conditions that insurance companies must comply in order to get long term care products approved. In addition, since long term care is a relatively new product, it is

transforming itself on a continuing basis. Older policies, for example, covered only the cost of nursing homes while current versions dabble in home care services and adult day care.

New and evolving products are challenging for insurers especially when policies sold years and years ago have yet to file claims. Such is the nature of long term care where policies sold to a client at age 60 may never be used until age 85. Can you imagine trying to plan for these events? To add to the problem, much lower policy lapses are occurring than anticipated. One of the dirty little secrets of the insurance industry is that insurers actually rely on a certain amount of insureds to drop their policies before any benefits are paid.. If it doesn't happen, they can raise rates anyway and have for an entire ***class*** of policyholders.

Long Term Care Is Different

When you stop and think about it, there are many reasons that long term care underwriting is more difficult than health insurance. Let's look at a few of the differences:

Characteristic	***Health Insurance***	***Long Term Care***
Frequency of claim	Higher claim frequency due to many doctor visits and prescriptions	Lower utilization because claimants are reluctant to use institutional care. Home care options may change this over time.
Average claim amount	Claims are generally lower and fewer because most claims involve low cost doctor visits.	High average claim amounts because benefits are for expensive care for extended time periods
Benefit period duration	In most instances, benefits periods are significantly less than one year.	Benefits usually extend beyond one year.
Data reliability	Health insurance claims have a long history with very reliable data.	LTCI is relatively new and claims data is still being developed.
Premium payment period	Premiums are typically paid through group insurance plans or during the working-life of an individual.	Most insureds are purchasing this coverage in the 60's and 70's. Most premiums will be paid during fixed income years.
Premium ratings	Premiums are usually sold on an attained-age basis reflecting risk at a particular age and NO prefunding of risk for older ages.	Premiums are usually sold on an issue-age basis reflecting higher premiums that have already prefunded for the higher risk of claims at older ages.

Considering these differences, it is easy to see why LTC underwriting changes and suitability requirements are in a constant state of flux.

Underwriting Problems

Insurers are not always the "victim" in the underwriting process, sometimes they ARE the problem. Early policies, for example, were sometimes approved on a ***post claims underwriting*** basis (now illegal). The company accepted applicants with little or no real health underwriting, but when individuals attempted to file claims, the company engaged in vigorous investigations of the individual's health in an attempt to demonstrate that he or she did not adequately disclose health conditions on the application. The company would then rescind the policy instead of paying the claim alleging misrepresentation of a health condition on the part of the applicant. The company used a vague or confusing health questionnaire to aid in this

practice. These tactics were only used by a few less than reputable companies and are now prohibited in most states.

There have also been many publicized, criticized and possibly abusive rate increase tactics in the LTC industry. Insures promise they will not raise premiums due to age or health, but that does not guarantee that the premium will stay the same for the entire class. And, it happens more than you think. Lawsuits have been filed in North Dakota and Florida over long term care premiums that have increased as much as 700%, even though the products were promoted as having level premiums. Granted, this is unusual. Rate increases in the 25% to 50% range are more apt to occur. Either way, rate increases especially hurt seniors (your customers) on fixed incomes. Since it may take many years for rates to be raised, people who originally bought on non-fixed incomes typically transition to fixed incomes. They are affected too.

There are also complaints that long term care underwriting criteria has "misdirected" younger buyers. One report claims that workers in their 50's have less than a 1% chance of needing long term care. And, when the time comes that they will really need their policies, they will be inadequate due to the ravages of inflation. Of course, what is missing here is that "money pays the premium, but health buys the policy".

Underwriting Factors You Can't Ignore

A new effort to simplify the application and approval process is underway featuring easier-to-understand policies and applications, "bundled benefit packages" which give consumers three or four good policy choices and "express" applications where a simple application pre-qualifies the insured and third party representatives complete the application with the client over the phone.

Even when these policies become widespread you will need to face the fact that between 10% and 30% of your clients will be rejected. Long term care underwriting is tough! But, before you start complaining, you need to understand that a consistent, fair process of evaluating potential long term care insureds is your best guarantee that the company you represent is going to be around long enough to actually pay your client benefits. Some recent events involving a popular LTC insurer have brought underwriting to the forefront. Rampant sales and minimal underwriting practices have brought this company to the brink of liquidation. High claims have depleted company reserves to less than half required by state regulators. Lawsuits have been filed which may involve agents. Besides the embarrassment and financial exposure of a situation like this, no agent wants to hear that a policy sold to a client at age 60 is worthless at age 80, ***when he really needs it***.

How can you improve the underwriting process for you and your clients?

- Read carefully the General Underwriting Guidelines from your insurance company.
- Obtain a specimen policy and clear-up any questions you have before submitting an application.
- Spend at least 50% more time n applications than you do now. Strive for accuracy and completeness fewer rejections and quicker processing.
- Submit your applications in a timely manner. Most companies consider apps stale dated if submitted after 30 days.
- Allow underwriting time to process applications: you're to the only customer. Underwriters review each application individually -- if it fits the required guidelines, it will be issued. It usually takes up to 45 days to receive an insurer's decision.

Spend at least 50% more time on applications now than you have before.

- Know whether or not your state has special rates, disclosures forms, etc. Use the proper paperwork, especially if you work in more than one state.
- Provide underwriters as much information on the prospect as possible. You are legally bound to make personal observations about mobility, living conditions, attitude, etc., on a separate piece of paper. Anything less could result in an insurer claim against you for breach of duty. Anyway, why would you waste your time trying to get an obviously unqualified individual approved.
- Make sure the paramed exam has been scheduled and the confirmation number has been recorded on the application before submitting the policy for approval.
- If an Attending Physician Statement (APS) is necessary, get the name of the applicant's personal physician who has the insured's medical records. Call the physician's office and ask how much the fee for an APS is and include this information with the application. Sometimes, the physician's fee is more than the check sent by the insurance company. A delay to send more money can slow the entire process.
- Make sure all sections and questions on the application are completed.
- Don't ask for benefits or riders that are not available for the plan selected.
- Be aware of issues limits.
- While individuals with certain controllable conditions, such as diabetes, might not qualify for the best rates at a top-tier company, an agent who knows the market may still be able to write a policy at standard rates with a top-notch company. Also, there is nothing wrong with calling underwriters and making a case for a client with a stable condition

What Are Minimum Underwriting Requirements?

These will vary from company to company. However, you may see guidelines such as this:

- Applicants age 40 to 69: Applications will be verified by telephone. If high benefit limits are requested, a paramed exam may be required. After reviewing results, underwriters may decide whether an Attending Physician's Statement (APS) will be necessary.
- Applicants Age 70-84: A LTC paramed exam will always be required, and at the underwriter's discretion, an APS may also be ordered. If high benefit limits are requested, an APS will always be required. Certain coverages like unlimited or lifetime benefits may not be available at all to these individuals.

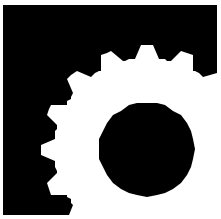
How can you know if your insurers are doing their job?

Make sure that minimum sales requirements are being met:

- Applications should contain clear, unambiguous, short questions designed to ascertain the health condition of the applicant. Questions shall be limited to yes or no answers. If a question asks for the name of a prescribed medication or prescribing physician, then any mistake or omission shall not be used as a basis for denial of a claim or recision of a policy or certificate.
- The following warning should always be printed in a conspicuous place on the application: "Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."
- If an insurer does not complete medical underwriting and resolve all reasonable questions arising from the information submitted with an application before issuing the policy, then the insurer may only deny coverage for a valid claim based on convincing evidence of fraud or material misrepresentation.
- No long term care policy may be field issued.
- A copy of the complete application should be delivered to the insured at the time of delivery of the policy or certificate.

Your state may also go beyond these requirements and need a checklist of required documents and disclosures such as outline of coverage, receipt of a LTC shoppers guide, a suitability worksheet, replacement policy guidelines and/or specific terminology concerning preexisting conditions, etc.

How else can you help your clients? Stay abreast of the news. Watch your company ratings and their reserves. Inform clients of any changes and discuss the need to move, if possible, and when necessary. Of course, most states have state guaranty funds that can help preserve your clients coverage. However, the guaranty systems are a last resort system with limitations. Further, most states do not permit agents to use state guaranty fund information as an incentive to buy LTC or any other form of insurance.



#10--Responsible LTCI Agents Study The Selling Mistakes of Other Agents

It is predicted that long term care insurance will be one of the most highly litigated products in the insurance industry. Why? Some policies selling today can and will fail to meet client needs when they need them. Face it, with a product as new and complicated as long term care, and the time that passes before they are used, there is a lot that can go wrong. This is all the more reason that your clients need to "lean on you" for your advice. You must be knowledgeable in your product, sell only what you understand and be certain it meets the stated needs of your client to the best of your ability.

LTC clients need to "lean on you" for advice. Sell only what you know.

A proper attitude about this responsibility is not only prudent, but important to your success. No agent can really prosper and move forward if he leaves a trail of dazed and unhappy clients behind. Understanding the mistakes of others and not making them yourself is probably the best way to assure this doesn't happen. You have several ways to evaluate your selling performance, our advice is to let one measure be the problems you avoid in helping clients acquire one of the most valuable insurance protections they will ever own: LTC insurance.

Likewise, it does little to build a thriving LTC insurance practice only to have it all taken away from a single lawsuit. When you avoid the legal problems in selling insurance, you are protecting your own future as well.

LTC Insurance: A Bad Image?

Since the first long-term care commission check was cashed, complaints have been made against sellers and selling practices. Even the most reputable insurers stand accused. Perhaps the nature of long-term care policies confuses both agents and buyers, leading to false impressions. Perhaps some unethical agents are drawn toward policies sold to the elderly because they are often vulnerable to scare tactics and pressure pitches.

A U.S. House of Representatives investigation into the regulation and selling of long term care policies found more serious defects:

- Purchasers do not understand how limited the coverage purchased is.
- Policies seem to be drafted more with an intention of limiting claims than to restricting claims to valid circumstances.
- Policies reflect illusionary benefits for home care.
- Sales presentations are poor in quality and misleading.
- Sales are made to persons who cannot afford to keep the policies in force for more than a few years.
- There is an absence of non-forfeiture values and consequent loss of benefits by most purchasers.
- Policies are marketing with fixed benefits and rising premiums.
- There is inadequate and misleading information about inflation protection.

- Benefit provisions are inappropriately extrapolated from Medicare supplement products and acute medical care.
- There is inappropriate taxation by the federal government
- There is inadequate technical information on solvency standards.

In 1991, two congressional committees, the Select Committee on Aging and the Committee on Small Business, combined to publish a report on long-term care insurance. The committees found that agents' knowledge of long-term care product was "appalling" and characterized such insurance as "not a good buy" (at the time) because the policies would not pay when people most needed it.

The industry and government is working on some of these deficiencies, and to their credit, policies have come a long way since the first-generation products of the 1980's. As far as what agents can do, help may lie in filtering out who needs long term care coverage and full disclosure of its limitations.

Let's look at some practices that have and continue to cause problems for consumers and the industry alike.

Selling Practices

Thousands of people sign up for long term care insurance policies each year with only the vaguest idea of what they are buying. That is because agents and brokers choose the company, the policy and made decisions about the size of the benefits, when benefits should begin, how long they should last and what extras to tack on.

While it may seem that an agent is simply doing his or her job in advising clients on these decisions, he is also assuming liability. And, the fact is that some agents can "embellish the facts", distorting the true value of their product, or worse, ignore important benefit options. Again, more legal exposure since ALL options must be presented to clients.

Here are some mistakes agents make in the marketing of long term care: They are what errors and omission nightmares are made of . . .

A False Need

Agents have a tendency to focus on the disasters that can befall a purchaser such as a dozens of years in a nursing home or how the government will abandon them rather than demonstrating the client's own needs and the true purpose of long term care insurance: the protection of assets.

Other agents will promise the world; saying that long term care is insurance that "makes sure you have good care" or that the fact that a long term care policy is a "ticket into nursing facilities that are overloaded with patients". Of course, these claims are not exactly correct.

Medicare and Medicaid

Medicare and Medicaid have very specific limitations when it comes to long term care coverage. However, some agents bend the facts even more with undocumented claims like "Medicare and Medicaid will not cover you when you're sick, they kick you out on the street. That is why you need this policy".

Inflation Protection

Agents have a tendency to minimize inflation coverage because it is expensive and makes for a harder sell. It is also the most important option that can be offered a client who may not need his long term care benefits for another 20 years.

Agents have been known to "trash" inflation protection saying things like "Only people who are failing in health take inflation protection"; or "Older people are less vulnerable to inflation. They are going to die before it doubles. Nursing home costs won't double in 10 years."

Product Features

Armed with product knowledge, an agent can make any policy sound better than another, or make them sound all the same. Agents have said things like "It's not important to compare benefits, because policies are all the same. Agents have said things like . . . "It's not important to compare benefits, because policies are all the same, so go for price". Or, how about "The best policies are those guaranteed renewable, our policy is one of the few that will never cancel". In fact, all LTCI policies are guaranteed renewable.

At the opposite extreme are agents with little knowledge of their product saying things like "other policies require that you be in the hospital for three days before they pay, ours does not have that clause." That's a condition for Medicare skilled nursing, not long term care insurance. Other agents could probably not define assisted living or the level of disability the insured must have to qualify for benefits. In most cases this is because the agents failed to read the policy. The most important duty of an agent selling long term care is to secure a "specimen policy" and know his product features.

False Protection

LTC policies often include wording about covering "reasonable charges". It is a huge mistake, but agents often ***assume*** this means their clients are covered for a lot of things . . . when they are not! Do reasonable charges, for example, include ancillary costs like dressing supplies, wound care or assisted living facilities expenses when attached to a nursing home? How about therapies, tube feedings, durable medical equipment, hair care and telephone calls? Anything less than answers about these benefits is leading the client to believe they are covered. Are you doing your job?

Likewise, an agent may secure a policy for his client with nursing home benefits of $112 per day when in fact, nursing homes in the area where the client lives charge $200 per day. Ignoring the difference can mean the client is grossly underinsured and you could be potentially liable if it is determined that an insured relies on your for regular or critical insurance decisions.

Premium Manipulation

Too often, agents "size-up" a client and tailor a policy to the premiums he thinks they can pay. This can result in excess coverage or less coverage than a client needs. For example, techniques like lowering daily benefits, high deductibles or long elimination periods and less than full inflation protection will lower the premium dramatically. Unfortunately, clients only discover they are in trouble when an LTC claim is presented.

High Pressure Tactics

Agents have been accused of creating false impressions or urgencies to sell a policy. It is true, for example that "money pays the premium, but health buys the policy". Just don't use it like a

big stick at every turn. Another technique is the confidence factor . . . "Our company has 25 percent of the market; we must meet our obligations to be in this position." Or the popular claims statement, "The company doesn't even review your application. We've never denied a claim."

Remember, the vast majority of long term care prospects today are senior citizens. If an agent takes advantage of their age and lack of cognitive skills to make prudent decisions he is violating his ethical obligation to find a suitable product for his client. Beyond this, he is "crossing the line" into legal and fiduciary breaches that could cost him his license or result in a costly action for bad faith.

Insurer Problems

Agents are not the only weak link when it comes to selling mistakes. Insurance companies have made their own share of blunders. Here's just a few . . .

Post Claims Underwriting

There are and continue to be many abuses by insurers. A prime example of early problems in the long term care field was North Dakota's experience with Providers Fidelity Life Insurance. An investigation in 1987 revealed that Providers Fidelity was engaging in several prohibited practices, including ***post claims underwriting***. The company accepted applicants with little or no real health underwriting, but when these individuals attempted to file claims, the company engaged in vigorous investigation of the individual's health in an attempt to demonstrate that the individual had not disclosed all of his or her health problems on the application. The company would then rescind the policy instead of paying the claim, alleging misrepresentation of a health condition on the part of the applicant. The company used a vague and confusing health questionnaire to aid in this practice. In addition, the company attempted to deny claims to victims of Alzheimer's disease by using the mental illness exclusion. When pressure was brought to bear against Providers by state regulators they tried to cancel all of their policies in North Dakota without notifying the Department of Insurance. Needless to say, they were unsuccessful, all policies were ordered reinstated and monitored to this day.

Rate Stability

Another "black eye" for the long term care industry targets premium increases. Companies are unwilling to guarantee long term care insurance rates far into the future because they have too little data to accurately predict how many people will file claims, how large those claims will be and how many people will let their policies lapse. So, how come most policies today have rate guarantees? Because, insurers promise they will not raise premiums due to age or health for existing policyholders, but that does not guarantee that the premium will stay the same. While insurers do not raise individual policyholder premiums they can and do raise rates for policyholders as a class. A class of business might be considered all retired teachers in the state of California who are over the age of 73. The most painful example involves 6,000 people holding policies from United Equitable, an early seller in the business. In some states, these policyholders have experienced rate increases of 100 percent or more.

Many states do not track premium increases but they have been estimated to be between 25 and 100 percent since the 1980's on average. Worse yet, because insurers may raise rates in one state and not another, and because there is little information on the subject, it's impossible to pinpoint companies most likely to raise rates. That makes things tough for consumers and agents alike. In effect, there is no real rate history. Agents should caution clients that premiums may rise as much as 50 percent.

The National Association of Insurance Commissioners has recently proposed substantial changes be adopted in the area of rate stability. In the near future, it is likely that special disclosure information be provided regarding historical rate increases for each LTCI company as well as signed acknowledgement of potential rate increases.

Policy Lapses

Policy lapses are yet another sad tale in the marketing of long term care insurance. It is been said by some that the industry's "dirty little secret" is that most companies issuing policies do not expect them to remain in force long enough to benefit the purchasers. Lapse rates for long term care insurance are just starting to be tracked by some states. Industry estimates are somewhere between 5 percent and 30 percent of all long term care policyholders drop their policies each year. A company with a low premium may almost assuredly be counting on many policies to lapse before benefits need to be paid. If not, they may have to raise rates. Therefore, if the policy you are offering has some of the lowest rates available, you should assume that some premium increases will be required along the way. Experts advise that a client's budget be able to handle increases of at least 50 percent over the long haul.

Agent Beware

The line between legal responsibility and agent misconduct can often be very, very thin. Few agents can say they have never gone out on a limb, looked the other way or fudged just a little when selling and serving a client. These indiscretions, hopefully tiny and few in number, usually lead to nothing. But when something goes wrong an agent's biggest fear comes true . . . a malpractice lawsuit.

The selling of long term care is one of the most complex areas of insurance marketing. There are still many unknown factors about long term premiums or benefits; the clientele are typically old and forgetful and the proof that you did a good or bad job may not surface for 20 or 30 years; all of which promote the possibility that a lawsuit could land in your lap at anytime, up through your own retirement. That is why agents must practice due care at every moment and through every phase of the long term care sale.

A few ways to minimize conflicts between yourself, clients and your carrier include:

- Select product that is suitable for your client.
- Know the product you are selling, including all reasonably priced and widely available options the policy offers.
- Be sure coverage is adequate at the time of sale.
- Be wary of "special agent relationships" that may define you as a fiduciary to the client.
- Avoid ***dual agency*** status where you have defined yourself as an "expert" or having special knowledge.
- Develop ***standard operating procedures*** to handle all clients the same.
- Consult an attorney or capable advisor before giving clients advice in areas of taxation, estate planning, asset protection, financial planning, etc.

Since long term care is a recent product there are few legal cases to relate. However, this will not stop the malpractice attorney. He will use other cases, in other areas of life, health and even casualty insurance to prove his case. For that reason, the savvy agent should know his legal responsibilities and duties.

Basic Agent Duties

The agent / broker generally assumes duties normally found in any agency relationship. The primary obligation here is to select a company and coverage and bind the coverage (if the agent has binding authority, i.e., property/casualty agents). However, since clients typically request coverage, the basic duty may expand to include the agent deciding whether the requested coverage is available and whether the insured qualifies for it (Harnett, Responsibilities of Insurance Agents - 1990). The mere existence of an agency relationship, or the simple selling of insurance, imposes no duty on the agent/broker to advise the insured on specific insurance matters (Jones vs Grewe --1987. In other words, in the eyes of the law there is a big difference between an agent who "sells" long term care and one who does "long term care consulting".

Duty also DOES NOT require the broker/agent to secure complete insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are widely available at a reasonable cost (Southwest vs Binsfield - 1995). Remember options like inflation protection, non-forfeiture, assisted living, cognitive reinstatement, benefit riders, etc. If they are widely available at a reasonable cost, you should be advising your client they exist and offer them in your presentation.

An agent's duty to provide correct coverage is not triggered by a client's request for "full coverage" because that request is NOT a specific inquiry about a specific type of coverage (Small vs King - 1996). In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a specific type of coverage, the agent is responsible to see if it is available and determine if the client qualifies. Is a senior asking you to suggest appropriate coverages for him at his station in life a specific request? If your business with a client covered everything but long term care are you liable for his long term health bills?

An insured is entitled to rely on an agent/broker's advice on the meaning of policy provisions. In Stivers vs National American Insurance - 1957, it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent "is in patent conflict with the terms of the policy". Clearly, there is much to say about "bending" the meaning of long term care contracts to fit the sale. Suffice to say, this case will apply to anything an agent says that conflicts with the policy or advertising.

It is a clear legal responsibility of agents to understand the difference between two products that he is attempting to sell (Benton vs Paul Revere Life - 1994). Whether an agent has an affirmative duty to inform a client of possible gaps in coverage depends on the relationship of the parties, specific requests of the client and the professional judgement of the agent Born vs Medico Life Insurance Co - 1988). Once again, the law is saying that there are no excuses for agents not understanding the policies they sell. Further, if the relationship you have with your client goes beyond agent/client contact, you could be liable for any gaps in coverage that might develop.

Once a policy is issued, traditional theories of legal conduct provide that an agent does not have the duty to ferret out, at regular intervals, information which brings the policyholder within provisions of a policy (Gabrielson vs Warnemunde - 1988). In essence, it seems the courts have been more concerned about general agent duties to inform clients of appropriate coverage at the time of sale. Recent departures from this opinion include a case where an agent was found liable for failing to determine that the insurance policy was no longer needed by the client (Grace vs Interstate Life - 1996). In another example, an agent assured his client that the limits of the policy continued to meet his needs when they actually fell short (Free vs Republic Insurance - 1992), i.e., agent duties may also include informing clients their coverage is

appropriate after the sale. Although each case stands on its own, the underlying determinant of "after sale" duty may be the "special relationship" that exists between client and agent, e.g., an agent handling the client's business for an extended period of time may assume a higher standard of care.

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. When a lawsuit arises, however, it is the client's burden to show that greater duty is the result of an express or implied agreement between agent and client (Jones vs Grewe - 1987) where the agent has taken more responsibility. In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed.

Records and Standard Procedures

One of the first things a malpractice looks to establish in a case against you is that you did not follow some form of standard operating procedure in dealing with his client. Your client files, which he will always force you to produce, are evidence that you handled his client in an organized manner. This is why it is extremely important that you be consistent in your approach to ALL clients. For example, if you require your clients to sign a letter of understanding about your services, but fail to do this for a particular client or series of clients, your procedures are compromised and potentially useless in your defense.

It is critical for you to be consistent in your handling of all clients.

Consistency in your presentation is also important, but you must also be able to individualize facts, figures or circumstances to reflect your client's situation. Documenting the outcome of your client meetings is also a great way to later justify your recommendation to purchase a particular option or their refusal to take it. Maybe you simply discussed an option, but recommended he discuss it with his accountant or attorney. Here again, documentation in your files or a written acknowledgement by your client will go a long way in court if something went wrong.

Some or all of the clients you sell to are senior citizens who are apt to forget discussions or remember them completely different than you. Your records will be valuable to prove your actions to them as well as to satisfy complaints from people that support them like their children or advisors. One possible precaution might be to involve some or all of your client's support people.

Prohibited Marketing Practices

The list of things you should NOT do in selling long term care insurance could easily fill a book. In a nutshell, an LTC agent has the duty of honesty, good faith and fair dealing. In addition, he must make sure to avoid any of the following acts related to unfair practices, unfair methods of competition or unfair and deceptive acts:

- Making unfair or inaccurate comparisons.
- Advising or selling excessive insurance.
- Falsifying records for purposes of defrauding any company or person.
- Misrepresenting insurance company assets.
- Misrepresenting terms of a policy.
- Rebating-giving something of value in order to induce someone to buy insurance.
- Defamation of any insurance company.
- Using unverified numbers in advertising or financial standings.

- Inducing a person to let their existing policy lapse.
- Implying that a policy is in some guaranteed by a federal agency or state body.
- All conversations regarding insurance must be identified by the agent as being "insurance" and cannot disguise the product.
- Sales promotions cannot be misleading in any way.
- The agent must fully disclose the name of the insurance company represented at all times.
- Agents must insure that when making presentations, in any type media, that the materials being used are truthful and all reacquired information is being disclosed.

Agent vs. Professional

Despite rules which seem to offer reasonable protection of the agent producer, it should be made clear that agent wrongdoings outside the agency contract and other torts, WILL subject the agent to additional liability exposure, and it is easier than you think to step outside your agency agreement. If you read any book on agent liability, you will learn that a "dual agency" is a situation where the agent first represents the client as agent, then switches to agent of the company when business is placed. Now consider that dual agency , and the added liability it creates, also occurs when an agent assumes non-agency duties by agreement or simply by professing to have special expertise. A slogan on a business card, letterhead or company brochure such as, ***"John Smith, Long Term Care Specialist"***, may be sufficient to establish you as an agent and an expert in the eyes of the law. When dual agencies such as these exist, the agent may be held liable for a breach of fiduciary duties owed directly to clients (Sobotor vs Prudential Property & Casualty - 1984) and, perhaps, contract and statute duties to the insurer. (Kurtz, Richards, Wilson & Co vs Insurance Communicators Marketing Corp - 1993).

It is clear that activities beyond the scope of an agency contract can be dangerous to your financial health. If you go there you need to proceed cautiously. This is NOT an indictment of any agent who seeks to improve his practice by becoming a true insurance professional, complete with degrees and designations. The existence of these honors, by themselves, is not the problem nor a target. As a matter of fact, some feel that the presence of these awards may inhibit a client's willingness to file a claim. Rather, it is the agent who, regardless of his degrees or credentials, professes to be an expert but fails to deliver. In essence, we are talking about failed promises. Agent wrongdoings in this area represent the majority of ALL insurance conflicts.

If you are somewhat confused about this agent / professional controversy you are not alone. There are many agents of professional status, such as CLUs, CPCUs, CICs, AAIs, ARMs and more, who practice due care for all the right reasons. Most stay clear of conflict by managing it. There may also be an entire army of extremely qualified agents who stay clear of professional designations for fear that the added exposure can't be managed. Perhaps there is room toward the middle. A position we call ***responsible agent***. These individuals also practice due care, yet operate strictly within the bounds of agency. They accurately describe policy options that are widely available, but "pass" on outside inquiries, not because they don't know, rather the request goes beyond the scope of their authority. They do not profess to be experts but know their product better than anyone. Their goal is simply to be the most responsible agent possible.

What Policies Say vs What They Mean

No matter how clear the language, all policies will contain areas of ambiguity. The universal rule of policy ambiguity, generally upheld by most state courts, goes something like this: If the policy could imply to a reasonable or average policy holder that coverage is in force, yet that

exact language does not exist in the policy, then coverage DOES extend to the policy holder. Agents may easily be involved in claims resulting from contract ambiguity.

Client Understanding and Reading of Policies

In days gone by, courts required people to be accountable for their actions. Clients were required to live up to the terms and conditions of a policy even though they did not read them or fully understand what they read. Agents have been cleared in many policy conflicts simply by pointing out the applicable clause or meaning. Consumer groups kicked and screamed and pushed for simplified wording.

Today, policies are indeed more user friendly and the courts are still sympathetic to consumer confusion about their policies. Now, policy conflicts are determined by whether it was reasonable for a certain client to have read his policy and/or understand its meaning. The decision can be based on how simple or complex the policy is written or the client's level of sophistication (Karem vs St Paul - 1973 or Greenfield vs Insurance Inc - 1971). Each case stands on its own.

Minimum Standards

Courts have upheld that even though a policy does not promise to expressly act in good faith and fair dealings, it is the minimum that policy holders can expect. Agents owe a duty of good faith and fair dealings to their clients and their insurer (American Indemnity vs. Baumgart - 1982).

Selecting the Right Insurer

Uninsured seniors and boomers constitute a lucrative market. As a result, hundreds of insurance companies now offer long-term care policies. There are many types of policies to select from and a variety of insurance companies offering these policies. We already described policy choices in detail (Habit #7). Let's look closer at how you can select a carrier.

Too Good To Be True

It is an old-age adage, but it has never taken on more meaning. Agents might be advised to at least be suspicious of a company offering a "better deal" than anyone else. It is common sense that something along the way will suffer as it did in the case of some life companies that invested in junk bonds and many casualty companies who participated in deep discount premium wars where expenses and claim costs at times exceeded income. This can only represent a degenerative financial condition for the insurer.

Recent problems with a popular LTC insurer is evidence that easy underwriting, combined with a "killer product" is too good to be true. The insurer is close to liquidation and the protection of thousands of policyholders is at question.

Also remember that insurance professionals, as salesmen, want to believe something is a better product or a better company. By their very nature salesmen often "get sold" as easy as some clients. It would be wise to be critical of all brochures and analysis distributed by a carrier which portray it to be the "best" or "safest".

Size of Company

Statistically, fewer failures have hit companies with assets greater than $50 million. It is thought that larger companies have more diverse product lines, big sales forces, better management talent--in essence, they are better equipped to ride out financial cycles. In recent wide scale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over $600 million category. However, another advisor feels that a small, well capitalized company can deliver as more or more solvency protection as a large one suffering from capital anemia.

Lines of Business

An agent may not have many choices over the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider evaluating multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line. An example could be a life company that also writes health insurance as a direct line or business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect ALL lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

State Admitted

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume.

Mergers

Insurance ratings are sacred territory. A rating drop against Mutual Benefit Life triggered a run on that insurer which caused its conservatorship. This news and the overall crisis of confidence surrounding the insurance industry has prompted insurers to consider many options to shore up these ratings. One option is the merger. The combining of companies can be critical to retaining policyholders, attracting new customers and maintaining investment capital sources. Some experts believe that consolidations in the insurance industry will become more commonplace in the future. One source estimated that the current number of life insurance companies--estimated at 2,000--will merge down to an eventual 200 insurers by the year 2000.

Parent & Holding Company Affiliation

Who or what kind of company owns the insurer that is considered. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the agent's insurer recently created an affiliate and are the assets in this affiliate some of the non performing or under performing investments of the original insurer? Is a merger in the offing that might mingle your client's A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Name recognition can go a long way in giving a client a high level of comfort. In the early 1980's, for example, Cal Farm Insurance, a B rated company, was proud to point out that it was owned by the California Farm Bureau, a 100 year old company. By the mid 1980's, however,

Cal Farm Insurance was liquidated by the California Department of Insurance for overextending itself on financial guarantee bonds that it could not pay. Because the claimants were considered to be sophisticated investors, they received only 25 cents on the dollar and forced to foreclose on the properties behind the financial guarantee bonds by themselves. The California Farm Bureau was not considered as a source to pay any deficiencies.

Other abuses have occurred with a slightly different twist. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non-insurance" parent. Further, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes including sale and leaseback arrangements and the securitization of future revenues.

Using the Rating Services

There are many different ways to develop rules of thumb using rating service information. One approach might be to delineate a "range of acceptability" among specific rating companies. For example, if an agent were ultra conservative, he or she may set a rule that all his chosen companies must be in the top two categories of the four major rating services:

A++ or A+ from A.M. Best
AAA or AA+ from Standard & Poors
Aaa or Aa1 from Moody's
AAA or AA+ form Duff & Phelps

A slightly less rigid approach would establish a minimum rating requirement of NOT lower than the fourth category from any of the major companies:

A- from A.M. Best
AA- from Standard & Poors
Aa3 from Moody's
AA- from Duff & Phelps

Or perhaps, an agent might decide that a company must only meet one or more requirements from three of the four major rating companies. A word of caution is in order regarding ratings. Agents who do not find a company rated must investigate the reason. If the company has not been around long enough to rate, it may be better to avoid doing business unless a reinsurance contract with respectable contract is in force. Or, it may be necessary to ask the insurer or the rating company is a rating was issued but suppressed from being published. Currently, only Standard & Poors and Duff & Phelps will suppress a rating.

Variations in Ratings

One major rating agency suggests a way to determine if an insurer is running into difficulty is to monitor several ratings. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. A recent example is United Pacific Life. In 1992 they were rated A-plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

Government Regulations

In addition to agent due care issues just discussed, there are a myriad of common practice rules and regulations that guide the marketing of insurance and long term care policies.

The problem for regulators is how to strike a balance between protecting consumers and nurturing a new product. Proponents of strict regulation fear that if tough regulations are not imposed, consumers will not be protected against inferior products and fraud. Opponents of strict regulation argue that officials do not have enough information or experience to regulate intelligently and that flexibility is needed to prevent financial losses that may discourage the industry from providing further coverage.

Most long term care regulatory activity has focused around the National Association of Insurance Commissioners' (NAIC) Model Act adopted in 1987. Almost 30 states have adopted statutes and regulations patterned on NAIC Model Standards.

The NAIC Model Standards afford a number of protections to consumers, including:

- Preexisting condition exclusion periods of longer than six months are prohibited.
- Policies may not be individually canceled due to the age or diminishing health status of the insured.
- Purchasers have a 30-day free look period during which they may return the policy for a full refund.
- Policies may not exclude coverage for Alzheimer's disease.
- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Prior hospitalization requirements are prohibited
- Conditioning eligibility for benefits provided in an institutional care setting on the receipts of a higher levels of institutional care ("step-down") is prohibited.
- Significant minimum standards for home health care benefits are prescribed, including prohibitions against typing benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.
- Individual policies must be guaranteed renewable and group products must provide for continuation or conversion of coverage. The commissioner has the discretion to approve cancellation on a statewide basis under stringent circumstances (i.e., the book of business threatens to bankrupt a company).
- Purchases must be offered the opportunity to purchase a product with inflation protection.
- Protections against post claims underwriting are prescribed, including a requirement that insurers keep records of policy rescissions and report them to insurance commissioners.
- Individual policies must meet a 60 percent loss ratio.
- A detailed outline of coverage must be delivered to all prospective applicants for long term care insurance at the time of initial solicitation.

The Consumer's Right To Know

Beyond rules and regulations that say you must do a good job, agent's should ***want*** to do a good job to protect consumers and their clients alike. A consumer Bill of Rights for buyers of long-term care insurance has often been suggested. Such a Bill of Rights has been developed with contributions from consumer and industry representatives. When an insurance agent is marketing a long-term policy to a consumer, he must remember that the consumer has the right to know the following features and/or his rights with respect to a long-term care policy:

- That the company is licensed by the Office of the State Insurance Commissioner to sell long-term care insurance in that particular state and that the policy being offered has been approved.

- Whether the policy qualifies as a medical expense for federal tax purposes. (Only unreimbursed medical expenses greater than 7.5 percent of adjusted gross income can be deducted.)
- That the insurance agent must give the consumer a copy of the "Shoppers Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners. This guide includes a suitability worksheet to help consumers decide if long-term care insurance is a wise choice.
- What the premium cost will be and if there are any other out-of-pocket costs associated with buying and using the policy such as waiting periods, deductibles, or copayments. The consumer also has the right to know that premiums can increase over time.
- The places where covered benefits will be provided such as at home, in a nursing home, assisted living facility, or adult day care center.
- What benefits are covered, how a policy holder will qualify for benefits, and when benefits would end.
- Whether the policy includes inflation protection and how much this optional benefit costs.
- That an application for long-term care insurance can be denied and that the company must give the individual, in writing, the reason for the denial. At the policy holder's request, the insurance company will notify the doctor if the denial is due to a medical condition. (Denial by one company does not necessarily mean denial by another company.)
- That the policy holder can cancel the policy in the first 30 days and receive a full refund. The consumer does not have to give a reason for canceling the policy. He also has the right to know what will happen if he must cancel the policy after the first 30 days.
- The consumer can file a complaint with the office of the State Insurance Commissioner if a claim for covered care is denied, if he feels harassed or pressured by a sales agent to purchase a policy, or if he has any other concerns about the insurance, the agent, or the company

Regulation of Long Term Care Insurance

Many of these early "selling mistakes" have already been addressed in modern long term care policies. This new generation product has taken criteria to new levels based on some of the enforcement and legislation discussed below.

If certain requirements are met, recent legislation has made it clear that long-term care insurance contracts will receive some tax benefits it did not have before. These tax concessions are meant to be an incentive for private individuals to buy long term care coverage in hopes to mitigate the burden on public sources such as Medicaid. Whether this will happen or not remains to be seen since the tax benefits, as you will see, are not exactly inspirational to the masses. Some may even consider them worthless. The point is, however, the government has taken steps to direct the movement of the funding of long term care from the public sector to the private sector.

The ***Kennedy Kassebaum*** welfare and health care reform legislation also known as the ***Health Insurance Portability and Accountability Act (HIPPA)*** was signed into law by President Clinton in August, 1996. This law represents sweeping legislation affecting the way millions of Americans get their health insurance and it effects the marketing and use of long term care policies. The federal government is clearly giving private long-term care insurance its stamp of approval. Finally, there are tax breaks for long-term care insurance. As a result of the passage of the Kennedy Kassebaum bill, premiums paid for long-term care insurance will receive tax favored status.

In a 1995 Federal Health Care Financing Administration survey, nearly three quarters of the respondents who had already decided not to purchase long-term care protection indicated they

would have been inclined to buy long-term care insurance had the premiums been tax deductible. With the new Kennedy Kassebaum law, tax favored status for long-term care has arrived.

For federal tax purposes, long-term care insurance is treated like accident and health insurance. Long-term care insurance premiums is considered to be a medical expense and will qualify as an itemized deduction up to a defined limit, based on the age of the policy holder. In addition, long-term care services are considered a medical expense. Generally, medical expenses can be claimed as itemized deductions to the extent they exceed 7.5 percent of adjusted gross annual income.

There is anxiety about health insurance coverage which stems from the very nature of today's employment-based system. Typically, workers and their dependents are covered by an employer-based health insurance policy only as long as they remain with the same employer, or for just a short time afterwards with COBRA coverage.

If a worker is laid off or if he takes a job with a different employer, the family may encounter preexisting condition exclusions associated with a new health care provider. If the worker joins a firm with no group insurance plan and buys his own coverage, he receives no tax advantage for purchasing his own policy, compared with the tax relief he gains if his employer obtains and owns the coverage. The Kennedy Kassebaum bill is intended to address a recurring and legitimate concern among millions of working Americans who:

- Currently have employment-based health insurance
- Face the threat of losing private health insurance when they lose or change their jobs
- Try to obtain coverage when they have a preexisting medical condition.

The passage of the Kennedy Kassebaum bill is seen as a change in the federal government's attitude toward the financing of long-term care. This new tax favored status appears to be an indicator that the government recognizes its inability to cover the costs of long-term care through entitlement programs such as Medicare and Medicaid. It further address the reality point that old-fashioned, personal responsibility should play a role in the funding of long-term care.

The following are some of the key provisions of the new Kennedy Kassebaum law:

- Tax favored status will be granted to all existing long-term care insurance policies issued before January 1, 1997, if they have complied with state standards.
- Tax favored status will be granted to all long-term care insurance policies issued after January 1, 1997, that meet federal standards outlined in the new law.
- Costs incurred for long-term care insurance premiums and unreimbursed services after January 1, 1997, will be tax deductible as medical expenses, with indexed limits based on age (except if services are provided by a relative). This exclusion is capped at $175 per day on per diem contracts. This amount will be adjusted for inflation annually. It also means that company paid premiums for long-term care can be excludable from income tax for the employer.
- Long-term care insurance policies issued in 1997 can be exchanged until January 1, 1998, on tax-free basis for policies that meet the new guidelines.
- Employer provided long-term care insurance is not taxable to employees. For tax purposes, long-term care coverage is considered the same as nontaxable employer provided accident and health insurance. However, this exclusion is not available if the long-term care coverage is provided as flexible spending arrangement. Amounts spent for long-term care expenses are deductible as medical expenses.

- Medical expenses are only deductible to the extent that they exceed 7.5 percent of adjusted gross income and are not otherwise reimbursed by insurance. Allowing long-term care costs to be deducted as medical expenses is a significant tax benefit to elderly persons requiring long-term care.
- Policy holders are not taxed when they receive benefits under long-term care insurance contracts. However, if the amount received is a per diem amount and it is not spent for long-term care expense, the maximum that can be received tax free will be $175 per day.
- Premiums paid by individuals for long-term care insurance are deductible as medical expenses, subject to the 7.5 percent of adjusted gross income limit. However, there is a cap on the amount of premiums that can be deducted. The cap ranges from $200 a year for a person under 40 to $2,500 a year for a person over 70.

Issuers of long-term care insurance contracts are required to satisfy certain provisions of the ***Long-Term Care Insurance Model Act*** and model regulations promulgated by the National Association of Insurance Commissioners, as adopted as of January, 1993. The policy requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization.

Both federal and state governments are given sweeping powers with respect to the inspection and overseeing functions of insurance laws. These levels of government have the power to regulate rates; to require and standardize disclosures, which allows consumers to compare goods, services, securities, life insurance policies, etc.; to establish rules for nonforfeitability; and to regulate policy limitations and exclusions, extensions of benefits, renewability features, coverage issues, policy lapses, preexisting conditions, and other issues.

At the federal level, Congress has stated all those engaged in the business of insurance are subject to the laws enacted by the individual states in which the insurer may solicit business. The authority provided here at the federal level is in addition to any existing powers of the individual states. The various states' insurance codes provide many incentives for the insurance industry to treat consumers fairly and to assure ethical behavior on the part of insurers and agents.

In addition to general consumer protection legislation and insurance consumer protection legislation enacted at the federal level, the states have enacted their own insurance codes which specifically address the practices of insurers and their agents. For example, most states have some form of Unfair Competition and Unfair Practices Act. Sometimes, these statutes are referred to as deceptive trade practices, unfair trade practices, or unlawful trade practices. Regardless of their name, these statutes provide for private causes of action for insurance consumers who are injured because of an insurer's misrepresentation, breach of warranty, unconscionable conduct, or other unfair practice.

At the state level, states are headed by a Department of Insurance, headed by an appointed Commissioner of Insurance, who is empowered to execute the laws of the state relating to insurance. The Commissioner is required to certify that the assets of an insurance company doing business within his state are adequate to support the volume of policies in force and that the company reserves are sufficient to meet the legal requirements. The Commissioner is also authorized to conduct investigations of insurance companies and agents operating within the state in order to ensure compliance with the state's laws. Insurance companies and their agents are required to assist the commissioner as necessary and to give full access to their records.

In addition, insurers must submit to the Commissioner actuarial information which includes claim experience data to sufficiently explain how the rates for policies are calculated.

Compliance

Congress has designed detailed and complex rules for life insurance companies that issue tax favored long-term care contracts. In order to qualify for favorable tax treatment, policies sold after 1996 must contain a number of consumer protection standards. Consumers must be given "Shopper's Guides" and an outline of the coverage. Deceptive sales and marketing practices are banned. Policies must contain specific features and cannot be canceled by the insurer except for nonpayment of premiums. Failure to satisfy the requirements in the new law can result in a penalty tax equal to $100 per policy per day.

Coverage

Every insurance policy is a legal contract developed by teams of skilled lawyers working and modifying the document over a period of many years. Every time a new court decision alters existing law, trained contract specialists modify the contract in order to assure compliance with new developments. Understanding what a policy means and comparing the policies of different companies require an understanding of the jargon of the insurance industry and a familiarity with insurance law.

If a potential policy holder has any doubts what the contract means and whether or not it will protect him after paying his premiums, an insurance agent has the responsibility for informing his client. The key to having a satisfied client is to encourage him to read the insurance policy carefully. Courts have declined to rule that a misleading advertising brochure was actionable but held that what was needed to determine the relationship between the consumer and the insurance company was to be sure that the consumer read the policy. Agents should always read and have available specimen policies for this purpose.

Replacement Guidelines

In order to identify replacements, insurers must inquire about replacement in their policy applications, as required by the replacement rules. Typically, the insurer asks the consumer and the agent to certify whether any existing insurance is to be replaced or changed. Unfortunately, these terms are not especially meaningful to most people. Producers and company personnel are expected to accurately determine whether the transaction constitutes a replacement. Once it is determined that a replacement is involved, the insurer and agent have certain obligations.

If a long-term care policy is replaced with another, insurers must: Offer to check the policies for duplicate coverage. Warn the policy holder in writing not to drop any policy until the free look period is over. Give credit for time spent under the previous policy toward satisfying waiting periods for coverage of preexisting conditions.

State-Specific Disclosures

The list of forms and disclosures you must present your clients is sometimes overwhelming -- this is a complicated product! For the most part, your carrier should provide you these documents and keep you informed as to how and when to use them. Here is just a short list of documents you may need to handle:

- Tax Qualified and Non Tax Qualified Comparison

- Outline of Coverage
- Resource Disclosure (Places or government agencies to advise consumers)
- The Long Term Care Insurance Shopper's Guide
- The Long Term Care Personal Worksheet
- Long Term Care Suitability
- Replacement of accident and sickness / LTC insurance
- Rate Stability (history of premium increases / potential future increases)

E&O Insurance

In closing, we would like to discuss the importance of errors and omissions insurance. Like other professionals, LTC insurance agents should carry their own errors and omissions insurance. One author suggests that the highest level of agent ethics occurs when errors and omissions insurance is purchased for the protection of clients. While this is indeed a noble gesture, it is more likely that agents purchase these policies for more selfish motives. After all, having read this section on mistakes made by other agents, it is clear we have entered an era of high accountability and cannot hope to survive a major claim without this protection. In some states, for example, the punitive awards can be as high as three times the amount of compensatory awards (some policies do not cover punitive damages).

Faced with these kinds of actions, insurers, who many times foot the bill for agent mistakes, are less timid about suing their agents and brokers for any malfeasance. Of course, to some extent, the very existence of errors and omissions insurance may be a factor in an agent being named in litigation that he may otherwise have avoided. In a case involving several security salesmen, for example, a pre-trial judge asked for a show of agents who did NOT have errors and omissions insurance. They were excused from the case! This could happen again, or not at all. Who wants to take the chance?

There is no standard errors and omissions policy. Most policies are written on a ***claims-made*** basis rather than on an ***occurrence basis***. Claims made means the insurer is ONLY responsible for claims filed while the policy was in force. For LTCI policies, this represents a real problem where policy benefits, or the lack thereof, do nto surface for 30 or 40 years – well after an agent leaves the LTC business, moves or retires. Even death is not an excuse, where a "hot shot" attorney can file his client's claim against the agent's estate!!

E&O policies today also have some very significant limitations, caps, gaps, consent clauses and relatively high deductibles. So many loopholes, in fact, that an agent is likely to feel the financial impact of any litigation almost immediately and under certain conditions may receive NO protection whatsoever. Some older style policies even require the agent to pay the entire claim before the errors and omissions insurer has any obligation at all. These are referred to ***indemnification policies.***

Exclusions

In many instances, the choice of a errors and omissions policy doesn't center on the limits or features an agent wants, rather it comes down, for many, to what the agent can afford. Unless agents find a way to finance the huge premiums, through banks or association groups, this often leads to the agent accepting many ***policy exclusions.***

Aside from the primary limits of the policy ($1 Million seems to be the limit of choice for most agents) the ***cost of defense*** is the most important exclusion to watch. Does your errors and omission policy ***include defense costs as part of the limit***? If so, the amount of money available to pay monetary or punitive awards will be significantly reduced. Defense costs can

also be ***limited to a percentage of policy limits***. Here, when the number is reached, ***you*** start paying for the balance of defense costs. Obviously, the best errors and omission plan will pay for all ***defense costs in addition to policy limits***.

The ***claims made*** exclusion is the next consideration. If you have one, you will be covered for only the claims that occur while the policy is in force. If so, how will you handle a claim problem that occurs down the road, say at retirement, when you have dropped your policy? Actually, you may have little choice in the matter since most policies today are written on a claims made basis versus an ***occurrence basis***. However, there are endorsements, discussed later, that can help protect you in the "down the road" scenarios.

In addition to the claims made limitation, there are many other important coverage ***exclusions*** an agent must consider, such as: insurer insolvency, receivership, bankruptcy, liquidation or financial inability to pay; acts by the agent that are dishonest, fraudulent, criminal, malicious or committed while knowing the conduct was wrong; promises or guarantees as to interest rates or fluctuations of interest rates in policies sold, the market value of any insurance or financial product or future premium payments; activities of the agent related to any employee benefit plan as defined under ERISA; agent violations of the rules and regulations of the Securities Exchange Commission, the National Association of Security dealers or any similar federal or state security statute; violations of the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA); discrimination or unfair competition charges, violations of the Racketeer Influenced Corrupt Organizations Act (RICO), and structured settlement placements. Policies that will refuse to pay if you have used an insurance carrier with less than an "A-" rating from AM Best.

In most of the instances above, the standard agent's errors and omissions policy ***WILL NOT PAY*** a claim. In the case of an insolvent company that retains client's money or refuses to make good on a claim, the agent ***WILL NOT*** even be defended according to specific terms that exist in most policies.

Also, be aware of ***specific limitations***. You may not be covered by errors and omissions in the following areas: punitive damages, business outside the state or country; failure to give notice if new employees or agents are added to your staff; fraudulent or dishonest acts of employees or agent staff; negligence may be covered, but bodily injury and property damage may not; judgements -- some policies only pay if a judgement is obtained against you; some exclude contractual obligations in the form of "hold harmless" clauses (watch them); outside services like the sale of securities, real estate or notary work.

Most errors and omissions policies are far from perfect. However, before losing interest in buying this valuable coverage, you should consider the high costs, and lost production time, associated in the defense of ***even one*** protected client claim and any subsequent judgement requiring an agent to pay any deficiencies and possible attorney/court fees. The cost of the average errors and omissions policy is cheap when compared to these costs.

If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy ***options*** that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits ($1 million minimum), the availability of prior-acts coverage, coverage carrier solvency and "tail" coverage so you and your estate can remain protected in the future.

Obviously, the concerned agent would do better to avoid malpractice claims at the outset by doing everything possible to investigate safety and solvency of any proposed carrier, acting professionally, keeping current, due care, etc. Further, there is no substitute for operating in a prudent, ethical manner rather than rely only on an errors and omission policy. After all, can

there be any point to work and build a practice to lose everything to the dissatisfaction of one client?

E&O Claims

If you feel you have a potential errors and omissions claim, you should first review your policy to follow the reporting requirements that need to meet. Most E & O carriers want you to report an incident right away. However, it is important to know what your company determines to be an "incident". Is it an actual claim? Is it a threat of a claim? If in doubt, you might want to call the company anyway and discuss it with them.

Generally, it is in your best interest to cooperate fully with the company by assisting in any evidence gathering and witness lists. However, this same spirit of cooperation does NOT always extend to your client. Most errors and omissions insurers do NOT want you or any staff member to make any voluntary admission of guilt to the client. Never blame the insurance company in any way or make any statement that might lead them to believe that the situation will be cured. While you can be cordial and calm in dealing with the client, be careful NOT to give any advice, legal or otherwise. If you are absolutely positive the claim is wrong, you can deny it, but never offer to settle.

If the situation involves a claim between the agent and a represented insurance company, the same precautions must be taken. In essence, you can't afford to "prejudice" your case in any way. Violating this errors and omissions contractual promise is the sure way for coverage to be canceled.

Cooperation also extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you do no agree with, and the case ended with a higher judgement that the settlement, you could be held liable for the difference as well as any amounts that exceed policy limits.

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