Understanding Your Long Term Care Policy

Understanding a Long Term Care Insurance Policy: What You Need to Know Before You Make Plans to Use Your LTC Policy

If you have long term care insurance you need to familiarize yourself with the policy so that you know what is covered and how to collect benefits when the time comes. You could make some innocent but very costly mistakes if you don't know the who, what and how of these policies.

When you need help understanding a long-term care insurance policy, probably the best person to explain your policy is the company representative who sold the policy. You will certainly want to get your questions answered by someone who works for or represents the company. If the person who sold the policy is no longer with the company you can ask to meet the local or regional sales supervisor, who can give you the same information.

Here's what you will want to know about your LTC policy:

1. How do you qualify to begin receiving long term care benefits?

Most modern long term care policies have two potential benefit triggers: **(A)** The policy holder must require assistance with two or more "activities of daily living" (ADLs). ADLs are eating, bathing, dressing, transferring (moving from bed to chair) toileting and continence. Your policy will specify how many ADLs you must need help with before you qualify. Most newer policies require that you need help with two of these activities. Or, the second trigger is:

(B) Cognitive Impairment in which memory, judgment and reasoning ability are reduced to the point where you need supervision for your safety. Cognitive impairment usually "stands alone," meaning that no other triggers are necessary to qualify for benefits.

(C) Who must certify that you qualify for benefits because of either physical or cognitive impairment? Often there is a document that must be completed by the

policy holder's physician. Almost always the insurance company will send a nurse or case manager to make an assessment.

2. How much and how does the long term policy pay? How are benefits calculated?

(A) What is the daily amount the policy will pay? What is the ultimate value of the policy (is there a maximum amount the policy will pay)?

(B) Does the policy pay differently depending on where the care is being provided? Some policies pay a lower daily benefit for at-home care than they do for care in a facility.

(C) How is a "day" defined (does having help for part of a day equal a "day," or only a partial day)?

(D) Does the daily and total benefit rise with inflation?

(E) What is the Deductible (or Elimination) Period? This is the number of days you will have to pay out-of-pocket for covered care before your policy begins paying. Does the policy begin calculating the elimination period from the first day the policy holder qualifies for benefits and receives care, or does the policy only count the days the policy holder actually receives care? Counting only the days on which the policy holder actually receives care means that the elimination period can stretch many months longer than anticipated if care is only received one or two days per week. **(F)** If you are receiving benefits from your long-term care insurance, must you continue to pay premiums, or can you stop paying premiums so long as you are "on claim"?

3. Where can you receive covered care?

The best policies cover care at home, care in an assisted living facility, care in an adult day program, and care in a nursing home. Many older policies restrict care to nursing homes only.

(A) Are there rules about the size and licensing status of an assisted living residence? Must it be licensed by the State and have a registered nurse on duty? Are there any restrictions about the size of an assisted living residence (i.e., must have at least 10 residents)?

(B) What are the rules for receiving benefits while attending adult day care? Must the facility be licensed? Must there be a nurse on staff?

4. Who can provide covered care to a policy holder at home?

Does your insurance policy require that caregivers be licensed? Must they work for a licensed home care agency? Will care provided by an unlicensed private caregiver be covered?

5. What documentation will you have to submit to the long term care insurance company in order to make a claim?

(A) Do you have to be approved for benefits before you begin paying privately to meet your elimination period requirement? How often will you have to submit documentation?

(B) Can the care provider, i.e., the nursing home, assisted living facility, day care or home caregiver submit bills directly to the insurance company, or must you pay for care up front and submit claims for reimbursement?

7. What are the limitations and exclusions of your policy?

What is not covered or only partially covered? This may be the most important question of all.

Your long term care insurance agent should be able to go through your policy paragraph by paragraph and answer all your questions. Take notes, and make sure you have a company-issued glossary of terms that tells you how the insurance company defines things.

It's a good idea to review a long term care policy every few years. Just as we review our life, health and automobile insurance, we should review our long term care insurance policy just to be sure we understand it and that it still meets our needs.

What Is A "Long-Term Care Waiting Period?"

Unfortunately for all of us, there is no official and universal definition of a "waiting period," an "elimination period," or a "deductible period" for long-term care insurance. Each company providing this kind of insurance can choose which words they will use and how they will define them. This is something that not very many

prospective buyers of long-term care insurance understand, and it's something that far too few agents explain.

First, the insured person must be evaluated by the insurance company (either in person, by phone, or by medical documentation). Only after the insurance company certifies that the insured is eligible to receive benefits does the elimination period begin.

In order to receive credit during the elimination period, the insured person must often be receiving paid care from caregivers who meet the insurance company criteria (i.e., a licensed home care agency, or a certain kind of long-term care facility, and so on). Going without care during this time, receiving care from family members, or receiving care in a hospital, doesn't always count toward the long-term care insurance policy waiting period. It depends on how the policy is written.

Among the many ways a LTC insurance company can define "days of care," the most common are:

1. The actual days, and only those days, on which the individual receives care. If the insured receives care three days a week, then he or she only receives waiting period credit for those three days;

2. Some companies will give credit for an entire week if care is received on a certain number of days in that week;

3. Some (fewer) companies will count every day the insured is "qualified" to receive care, whether care was received or not.

Many agents are not as well trained as they should be, and any verbal explanation they give you is not binding on the insurance company. If the language in your Long-Term Care policy is confusing (most are) ask the company for a written explanation. You may or may not get it, because the lawyers are in charge of everything that goes out in writing, but it certainly can't hurt to ask. If you can't get a clear explanation of any part of a policy you are considering, then it might be a good idea to keep looking.

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