

# LONG TERM CARE

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# Long Term Care

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## A. A FINANCIAL ABYSS

The U.S. population is getting older. In 2010, slightly under 46 million Americans were 65 years of age or older. In 2030, that number will reach almost 60 million -- 1 in every 5 of us.

Put another way, the percentage of elderly among the American population in less than 40 years will be the same as the percentage of elderly in Florida today. As noted in a recent study in the *New England Journal of Medicine*, almost half of the people who turned age 65 in 1990 will spend some time in a nursing home.

According to the 2010 census, approximately 580,000 Kentuckians, or 13.3% of the Commonwealth's population is 65 years or older; 25,000 to 30,000 Kentuckians reside in a nursing home.

This all has ramifications on the U.S. medical system both in terms of acute (short-term) and chronic (long-term) care. From 1988's 2.0 million Americans in nursing homes, the number will almost double to 4 million in the year 2018. All told, 6.2 million elderly people needed long-term care services in 1990, a number expect to reach 9 million by the year 2011.

The average nursing home stay is about 30 months, or 2-1/2 years. More than half of all nursing home patients stay less than 3 months, and about 1 in 4 stay for more than a year. The latter figure is often referred to as "custodial care."

The average cost of nursing home care for one year: \$72,000 to \$80,000.

Although this figure tends to be higher in New England, few people anywhere can afford \$2,000/month for nursing home care without soon draining their bank accounts and selling their homes.

Moreover, it is not just the ailing who stay in nursing homes. Approximately 61% of all residents entering a nursing home do so without a prior hospital stay.

The big picture is even more expensive. In 1980, just 20 years ago, Americans spent \$20 billion on nursing home care. By 1989, the figure more than doubled to \$47.9 billion -- a 140% increase in nursing home spending in 11 short years!

As explained later in this text, Medicare (for the elderly) and Medicaid (for the indigent) do not come close to paying this bill. Neither program is intended to cover continuous custodial care.

So, who foots the bill? As the following table indicates, most of the expenses are paid out-of-pocket by the patients or their families:

<i>SOURCE OF PAYMENT</i>	<i>PERCENTAGE PAID</i>
Out-of-Pocket	50%
Medicaid	40%
Medicare	5%
Other	5%
<i>Source: American Health Care Association</i>	

Medicaid picks up over 40% of the tab, although this figure is somewhat misleading, if not downright bizarre. Since Medicaid is designed for welfare families, the elderly whose bills are paid by Medicaid are, obviously, living in poverty.

No doubt, you have read that Americans over age 65 are the financially best off segment of our population by age. What explains the large number of Medicaid recipients?

Medicaid requires elderly patients to "spend down" their assets before the program kicks in to pay nursing home expenses. Some elderly do so by signing them over to their children or others (the federal government has tightened up on this as discussed later in this text). Some elderly people, however, literally sell everything, pour the money into nursing home care and let Medicaid handle the bills after they are financially non-existent within a few months.

A "few months" is not an exaggeration, either. More than half of all unmarried persons who enter a nursing home fall below the national poverty line within 13 weeks. The national poverty line is defined as a monthly income of \$581 for a single person, \$786 for a married couple.

About 65% -- 2 in 3 -- of all Americans who would enter a nursing home and attempt to pay for their own care would become eligible for Medicaid within 1 year, according to a Harvard University study.

Most people view Medicaid as a medical welfare program for the truly indigent of the U.S. living in such areas New York City's South Bronx or Chicago's West Side or Roseland. This is not how most people view their grandparents.

The insurance industry has attempted to respond to this crisis through the creation of Long-Term Care (LTC) policies and "Living Benefits" riders to life insurance contracts, which are the subject of this continuing education course. First, however, a review of Medicare and supplemental "Medigap" insurance is in order.

## **B. MEDICARE CAN'T DO EVERYTHING**

One of the most common misconceptions among prospects is that Medicare will handle the majority of long-term nursing home costs. As we have seen, the program covers only about 5% of the national nursing home tab. Private health insurance, including Medigap policies, cover and additional 5%. Let's review the Medicare system and see why percentages are so low.

A Great Society program of socialized medicine, Medicare is available to:

- Persons age 65 or older,
- Persons receiving Social Security Disability Benefits for more than 24 months, regardless of age,
- Persons with end-stage renal disease (kidney failure) regardless of age,
- Survivors and dependents of such persons may also qualify.

Medicare is divided into 2 parts:

- Part A  
Hospital Insurance

- Part B  
Medical Insurance

Among the facilities and services covered by Medicare:

Hospitals	Home Health Agencies
Hospices	Ambulance Service
Outpatient Rehabilitation	Physical Therapy

Nursing home care is covered under Parts A and B, but only to a limit. Nursing home covered by Medicare must be certified by the program as a skilled nursing facility (SNF). This entails meeting state and local licensing requirements and additional stringent federal mandates. Local social Security offices maintain lists of Medicare-certified providers.

An SNF is neither intermediate nor custodial nursing home care. SNF refers to a special facility that may be part of (or separate from) a hospital that offers skilled nursing and rehabilitative services. For Medicare to pay, the patient must enter an SNF within 30 days of discharge from the hospital for continuing treatment of the condition that caused the hospitalization. Also, the hospital stay must have been for at least 3 days.

Custodial Care is what most people view as typical nursing home care offered on a long-term chronic basis. Medicare pays only for acute care -- also called restorative care -- which is short-term medical care and treatment.

Custodial Care is defined as assistance with activities in daily living, or ADLs, which are discussed later in this text. Such activities include dressing, eating, toiletry, bathing and walking. Medicare covers none of this. Medicare only covers skilled care provided on a 24-hour basis. Medicare does not cover the bills of patients needing care only once or twice weekly. Finally, Medicare must approve the patient's stay.

These facts will unnerve your prospects:

- Only 3 in 10 nursing homes qualify as an SNF,
- About 1/3 of those qualify as Medicare approved,
- Only 15% of all U.S. nursing homes meet both qualifications,
- Some facilities have a 6 to 9 months waiting list (for Medicare to pay, the patient must enter within 30 days of hospital discharge),
- Only 61% of nursing home patients were hospitalized immediately before entering a nursing home,

Even if the patient enters a certified SNF, Medicare does not pick up the tab for very long.

Medicare divides benefit periods into spells of illness that last from the day the patient is admitted until date of discharge. If a nursing home is certified as an SNF, Medicare will pay the full cost of the first 20 days in each benefit period. From the 21<sup>st</sup> to the 100<sup>th</sup> day of SNF care in a particular spell of illness, the patient must pay a certain amount per day as coinsurance. Medicare coverage completely expires after the 100<sup>th</sup> day of SNF care per benefit period. (Remember that the average nursing home stay is 465 days!)

<b>DAYS IN SNF</b>	<b>MEDICARE PAYS</b>	<b>PATIENT PAYS</b>
1-20	100%	NOTHING
21-100	All but \$152.00/day	\$152.00/day (\$12,160.00 max.)
101 & over	NOTHING	100%

If the patient is readmitted within 60 days of discharge, those days are added onto the days of the initial spell of illness. Thus, two 55-day stays within 2 months will push the patient into the reduced benefit period of 21-100 day and no-benefit period of 101 days and more. If the 2 stays were more than 2 months apart, the policyholder would have 40 days at no cost and a total cost of \$10,640.00 on the other 70 days (70 x \$152.00/day deductible).

On the other hand, if the next hospitalization begins more than 60 days after the last one, the next hospitalization is not considered by calendar year, but by days between hospitalizations.

Not every need of the patient is covered by Medicare.

Among SNF services **covered** by Medicare Part A:

- Semi-Private Room (Private room if medically necessary)
- Meals (including special diets)
- Skilled nursing care (given or supervised by a registered nurse)
- Pharmaceuticals, supplies & equipment
- Blood transfusions (except the first 3 pints)
- Medical Social Services
- Physical, Occupational and Speech Therapy.

Among SNF services **excluded** by Medicare Part A:

- Doctor's services while patient is in and SNF (covered by Part B, along with surgeons' and Osteopaths'; services provided in an SNF),
- Extra charge for private room (unless medically necessary),
- Luxury room items such as TV or telephone,
- SNF stays longer than 100 days,
- Custodial Care (explained earlier).

### **C. ARE MEDIGAP AND MEDICAID ALTERNATIVES?**

As we have demonstrated, Medicare does not even come close to paying many nursing home patients' bills. It is not designed to do so.

After you review the facts with your prospects, many of them will reply that their "Medigap" will fill the long-term nursing home hole left by Medicare. Wrong again. Although many Medigap policies do a good job of filling various coverage holes, almost none will fill those related to long-term nursing home care.

Effective July 30, 1992, by federal law, Medicare supplement policies sold in the U.S. are limited to 12 standard benefit plans. Plans C-L through J pay only the skilled nursing facility care coinsurance amount (\$152.00/day for days 21-100). After that, nursing home care must be provided through long-term care insurance.

### **MEDICAID**

A Great Society socialized medicine program for the indigent, Medicaid pays for nursing home custodial care, but only after financially draining the patient.

Eligibility requirements for Medicaid vary among the states, the normal Medicaid recipient must qualify for public assistance (AKA, welfare, Aid to Families with Dependent Children [AFDC] or Supplemental Security Income (SSI) for indigent people who are 65 years or older, disabled or blind.

To qualify for Medicaid, an applicant must fall below the State's limits on income and financial resources. A Kentucky applicant may be allowed to keep his home. "Resources" include cash, bank accounts, stocks and bonds, and life insurance cash values. Applicants receiving income (e.g. Social Security, pensions, other income) are allowed to keep only \$40 per month for personal needs; the rest is paid directly to the nursing home. Pretty horrible, isn't it? For most people, Medicaid is not an attractive option to pay nursing home bills.

According to the much-repealed Medicare Catastrophic Act of 1988 (although this part of the act remained), a non-

institutionalized person (whose spouse is in a nursing home) is allowed to keep a basic income of 150% of the U.S. poverty level. Again, the national poverty level for a single person is a monthly income of \$581, for a married couple it is a monthly income of \$786.

The non-institutionalized spouse (community spouse) may keep an even larger amount, if the income is solely in his/her name or he/she has inordinate utility and housing costs. The maximum monthly income received is \$1,769 (annually adjusted for inflation). Some institutionalized spouses can keep "shelter allowances" to cover housing costs as well, although a discussion of that is beyond the scope of this text.

It should be noted that a community spouse and the institutionalized spouse can retain combined total resources of \$72,740. Upon receiving Medicaid, the institutionalized spouse has 6 months to transfer resources to the community spouse. These arrangements are inspected annually by the Kentucky Department of Social Insurance.

To quickly latch on to Medicaid, some relatively comfortable people were rumored to "spend down" (i.e., give to relatives) their assets to become indigent and eligible. To end this charade, the Medicare Catastrophic Coverage Act of 1988 denied Medicaid eligibility to people making a prohibited transfer of resources.

Such a transaction includes disposing of Medicaid-type resources for less than their market value 30 months before the date the individual applied for Medicaid or the date the individual began receiving care, if earlier. When a person makes a prohibited transfer, Medicaid eligibility is denied for the lesser of 30 months, or the number of months' care that the transfers would have purchased. This is subject to change based on new legislation in the past few years.

Without effecting Medicaid eligibility, the applicant may transfer his/her home to a spouse, child (if the child is blind, disabled or under 21 years of age), a brother or sister with equity interest in the house (was living there at least one year before care began), an adult child who lived in the house and provided care that delayed entry into a nursing home for 2 or more years. Resources other than a home may be transferred to a non-institutionalized spouse or a child who is blind or mentally retarded.

Medicaid, of course, will pay such Medicare costs as co-payments and Part B premiums:

If Your Yearly Income is:			You Pay IN 2014
File Individual Tax Return	File Joint Tax Return	Filed Married & Separate Tax Return	Part B – Monthly Premium
\$85,000 or less	\$170,000 or less	\$85,000 or less	\$104.90
\$85,001-\$107,001	\$170,001-214,000	N/A	\$146.90
\$107,001-\$160,000	\$214,001-320,000	N/A	\$209.80
\$160,001-\$214,000	\$320,001-428,000	Above \$85,000 Up to \$129,000	\$272.70
Above \$214,001	Above \$428,000	Above \$129,000	\$335.70

This includes the daily co-payment amount (\$152.00) of Medicare patients during days 21-100 in SNFs (2014). All things considered, Medicaid is not an unrealistic method of long-term care.

## **D. LONG-TERM CARE INSURANCE**

Although every carrier's LTC policies are different, there are some commonalities that apply to a majority. With this in mind, let us discuss the basic nature of LTC insurance.

LTC policies will often be issued on an age basis, such as coverage for policyholders aged 55-79. Few policies cover persons under 40, since the program is designed for nursing home care for the elderly rather than AIDS sufferers. LTC policies covering persons more than 79 years of age often come with great restrictions and waiting periods.

With few exceptions, LTC policies are offered on a "guaranteed renewable" basis to a stated age, often 79. Some are renewable for life. Guaranteed renewable refers to the right of the policyholder, not the carriers, to cancel the policy. The carrier cannot change coverage, either, although it retains the right to adjust premiums (for all insured of the same class).

Rarely are LTC policies offered on a "non-cancelable" basis, wherein the policy cannot be canceled and the premium can never be raised. Some policies are offered on a conditionally renewable basis, wherein the carrier can refuse renewed coverage after a certain age for reasons stated in the policy. The carrier can adjust premiums and benefits on a class basis.

*By Kentucky Law, LTC policies can only be issued on a guaranteed renewable or non-cancelable basis. [806 KAR 17:081 (3) (1)]*

The majority of LTC policies are underwritten on an application basis; some require certification from the attending physician. Conventional life underwriting methods are employed when LTC coverage is by rider to a life policy.

Most LTC premiums are level throughout the duration of the contract. Of course, carriers reserve the right to adjust premiums in almost all cases. A few carriers provide a form of "term LTC" where premiums rise at certain ages, not unlike term life insurance. Some companies raise premiums every 5 years, the "stair-step approach."

*By Kentucky Law, an insurer cannot increase premiums on the basis of age for insureds over age 65. [806 KAR 17:081 (3) (6)].*

Most LTC policies do not require the payment of any fees, except the premium. Most also provide for waiver of premium, anywhere from 60 to 180 days after confinement. Some LTC policies provide a discount for married couples applying at the same time -- 10% is typical.

### **BENEFITS**

As in any other form of insurance, higher benefits mean higher premiums. Ditto, the coverage varies widely among carriers. Usually it is expressed in maximum daily benefit amounts for nursing home or home healthcare.

An LTC policy sold alone might offer a base daily benefit of \$20/day, increasing in \$10 increments (at the policyholder's option) to a total of \$150/day. As a rider to a life policy, a monthly, not daily, benefit is usually determined as a percentage of the death benefit, say, 2%. If covered at all, the benefit for home healthcare or adult daycare will be as a percentage of the maximum daily benefit, usually 50% and 25%, respectively.

Benefit lengths can also vary, although one basic rule never varies, "The longer the benefit period, the higher the premium." Length will range from 1 to 12 years. Lifetime benefits are also available.

Elimination periods -- waiting periods -- are also varied. Similar to a deductible in other forms of insurance, the elimination period is the specified number of days of care that elapse before coverage kicks in. The period will range from 20 to 150 days, although there are exceptions in both directions.

Some LTC policies provide a "restoration of benefits" wherein full benefits are restored after the policyholder has been out of the nursing home for a given number of days, often 180 days. The majority of LTC policies do not offer this provision.

All Kentucky LTC policies must offer inflation protection, which is important, since the cost of nursing home care is growing faster than the general rate of inflation. This is discussed later in this text under Kentucky Law 806 KAR 17:081 (7).

## **REGULATIONS**

The National Association of Insurance Commissioners (NAIC) looked at the spectrum of LTC policies and prepared a Long-Term Care Insurance and Model Act and Regulation for adoption by the states. The Model Act became effective in Kentucky on July 15, 1992; it does not require that policies sold before then be amended to include its provisions.

While some Kentucky requirements have been discussed throughout this text, all agents should know that the Department of Insurance will provide free to anyone upon request, *The Consumer's Guide to Long-Term Care Insurance in Kentucky*.

The guide contains the following information:

- > Definition of long-term services, cost of services, sources of payment and eligibility for assistance programs;
- > Factors that affect premium rates, such as age, deductibles, duration of benefits and daily benefits;
- > Explanation of benefit limits;
- > Checklist that covers items that should be considered when buying a policy;
- > Comparison of all policies available in Kentucky with respect to:
  - Premiums at ages 55, 65 and 75,
  - Services covered,
  - Length of coverage,
  - Limitations on coverage,
  - Prior institutionalization requirements,
  - Elimination period, (*KRS 304.14-560*)

## **E KENTUCKY STATUTES AND REGULATIONS**

The Department of Insurance regulates the sale of Long-Term care policies through regulations and statutes. The following are some of the highlights of Kentucky Insurance Law as it applied to LTC insurance.

### **304.14-615 Required standards and disclosures; right to return policy; "pre-existing condition" defined**

- (2) A long-term care (LTC) policy shall not:
  - (a) Be canceled, non-renewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;
  - (b) Contain a provision establishing a new waiting period in the event existing coverage

is covered to or with respect to an increase in benefits voluntarily selected by the insured individual or group policy holder;

- (c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled nursing care than coverage for lower levels of care.
- (3) A LTC policy shall not:
- (a) Use a definition of "pre-existing condition" that is more restrictive than: Was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person."
  - (b) A LTC policy shall not exclude coverage for loss or confinement that results from a pre-existing condition unless that loss or confinement begins within 6 months following the effective date of coverage.
  - (c) The commissioner may extend the limitation periods of subsections (3) (a) and (b) of this section as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.
  - (d) The definition of "pre-existing condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of answers to that application, form underwriting in accordance with that insurer's established underwriting standards.

Unless otherwise provided in the policy, a pre-existing condition, regardless of whether it is the waiting period described in period (b) of this subsection expires.

A LTC policy shall not exclude or use waivers or riders to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in Paragraph (b) of this subsection.

- (4) (a) A LTC policy shall not be delivered or issued in the Commonwealth if it:
    - 1. Conditions eligibility for any benefits on a prior hospitalization requirement;
    - 2. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
    - 3. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.
  - (b)
    - 1. A LTC policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy entitled "limitations on conditions for eligibility for benefits" the limitations or conditions, including any required number of days of confinement.
    - 2. A LTC policy that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.
- (6) LTC applicants have the right to return the policy within 30 days after its delivery and to have the premium refunded if, after examination of the policy, the applicant is not satisfied for any reason. LTC policies shall have a notice prominently printed on the first page or attached thereto stating this.
- (7) (a) An outline of coverage shall be delivered to a prospective applicant for LTC insurance at the prominently direct the applicant's attention to the document and its purpose.
- 1. The commissioner shall prescribe a standard format, including style,

arrangement and overall appearance, and the content of an outline of coverage.

2. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.  
(The outline of coverage follows in Section 19 of 806 KAR 17:081, "Standard Format Outline of Coverage").
  
- (8) A certificate issued pursuant to a group LTC policy that is delivered or issued in Kentucky shall include:
  - (a) A description of the principal benefits and coverage provided in the policy;
  - (b) A statement of the principal exclusions, reductions and limitations contained in the policy;
  - (c) A statement that the group master policy determines governing contract provisions.
  
- 9) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides LTC benefits within the policy or by rider. In addition to complying with all applicable requirements, the summary shall also include:
  - (a) An explanation of how the LTC benefit interacts with other components of the policy, including deductions from health benefits;
  - (b) An illustration of the amount of benefits, the length of benefit and the guaranteed lifetime benefits, if any, for each covered person;
  - (c) Any exclusions, reductions, and limitations on benefits of LTC insurance; and
  - (d) If applicable to the policy type, the summary shall also include:
    1. A disclosure of the effects of exercising other rights under the policy;
    2. A disclosure of guarantees related to LTC of insurance charges; and
    3. Current and projected maximum lifetime benefits.

To assist in the enforcement of these statutes passed by the Kentucky General Assembly, the Commissioner of Insurance promulgated **806 KAE 17:081, Minimum Standards for Long-Term Care Insurance Policies**, a rule effective as of February 8, 1993.

### SECTION 3. POLICY PRACTICES AND PROVISIONS.

- (1) Renewability. The terms "guaranteed renewable" and "non-cancelable" shall not be used in any individual LTC insurance policy without further explanatory language in accordance with the disclosure requirements of Section 5 of this regulation.
  - (a) LTC policies issued to individuals shall not contain renewal provisions other than "guaranteed renewable" or "non-cancelable."
  - (b) The term "guaranteed renewable" may be used only when the insured has the right to continue the LTC and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
  - (c) The term "non-cancelable" may be used only when the insured has the right to continue the LTC insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
  
- (2) Limitations and exclusions. A policy shall not be delivered or issued for delivery in

Kentucky as LTC insurance if it limits or excludes coverage by type of illness, treatment, medical condition or accident except as follows:

- (a) Pre-existing conditions or diseases;
  - (b) Mental or nervous disorders, but this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease;
  - (c) Alcoholism and drug addiction
  - (d) Illness, treatment, or medical condition arising out of:
    - 1. War or act of war (whether declared or undeclared);
    - 2. Participation in a felony, riot, or insurrection;
    - 3. Service in the armed forces or auxiliary units;
    - 4. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
    - 5. Aviation (this exclusion applies only to nonfare-paying passengers).
  - (e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other government program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.
  - (f) The requirements of this subsection are not intended to prohibit exclusions and limitations by type of provider or territorial limitations.
- (3) Extension of benefits.
- (a) Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination.
  - (b) The extension of benefits beyond the period of long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any policy waiting period, and all other applicable provisions of the policy.
- (4) Continuation of conversion. Group long-term care insurance policies shall provide for continuation and conversion as required by KRS 304.18-110 and 304.18-120.
- (5) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination in accordance with KRS 304.18-127.
- (6) The premiums charged to an insured for long-term care insurance shall not increase due to either:
- (a) The increasing age of the insured at ages beyond 65; or
  - (b) The duration the insured has been covered under the policy.

#### SECTION 4. REQUIRED DISCLOSURE PROVISIONS.

- (1) Renewability.
  - (a) Individual long-term care insurance policies shall contain a Renewability provision.
  - (b) The provision shall:
    - 1. Be appropriately captioned;
    - 2. Appear on the first page of the policy;
    - 3. State the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

- (1) (c) This subsection shall not apply to policies that do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.
- (2) Riders and endorsements
  - (a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured,
  - (b) After the date of policy issue, a rider or endorsement that increases benefits or coverage with an increase in premium during the policy term shall be agreed to in writing signed by the insured, except if increased benefits or coverage are required by law.
  - (c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.
- (3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of these terms and an explanation of these terms in its accompanying outline of coverage.
- (4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-existing Condition Limitations."
- (5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in KRS 304.14-615(4) (b) shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."
- (6) Disclosure of tax consequences.
  - (a) A disclosure statement shall be required as specified in Paragraphs (b), (c) and (d) of this subsection, for life insurance policies that provide an accelerated benefit for long-term care.
  - (b)
    1. Of application for the policy or rider; and
    2. The accelerated benefit payment request is submitted.
  - (c) The statement shall disclose that:
    1. Receipt of the accelerated benefits may be taxable; and
    2. Assistance should be sought from a personal tax advisor.
  - (d) The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

## SECTION 5. PROHIBITION AGAINST POSTCLAIMS UNDERWRITING

- (1) Applications for long-term care insurance policies or certificates except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

- (2) (a) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.
- (b) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.
- (3) Except for policies or certificates that are guaranteed issue:
  - (a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:
 

"Caution: If your answers on this application are incorrect or untrue, (insurer's name) has the right to deny benefits or rescind your policy."
  - (b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at time of delivery:
 

"Caution: The issuance of this long-term care insurance (policy or certificate) is based upon your responses to the questions on your application. A copy of your (applicant or enrollment form) (is enclosed or was retained by you when you applied.) If your answers are incorrect or untrue, the insurer has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address)."
  - (c) Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:
    1. A report of a physical examination;
    2. An assessment of functional capacity;
    3. An attending physician's statement; or
    4. Copies of medical records.
- (4) A copy of the complete application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.
- (5) Every insurer issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both Kentucky and country-wide, except those that the insured voluntarily effectuated, and shall annually furnish this information to the Commissioner in the format prescribed by the National Association of Insurance Commissioners.

## SECTION 6. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS.

- (1) If a LTC policy provides benefits for home health care or community care services, it shall not limit or exclude benefits by:
  - (a) Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
  - (b) Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home, community, or institutional setting before home health care services are covered;
  - (c) Limiting eligible services to services provided by registered nurses or licensed

- practical nurses;
  - (d) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting with the scope of his licensure or certification;
  - (e) Excluding coverage or personal care services provided by a home health aid;
  - (f) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
  - (g) Requiring that the insured or claimant have an acute condition before home health care services are covered;
  - (h) Limiting benefits to services provided by Medicare-certified agencies or providers; or
  - (i) Excluding coverage for adult day care services.
- (2) If a LTC policy provides for home health or community care services, it shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of the year's coverage available for nursing home benefits under the policy, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

## SECTION 7. REQUIREMENT TO OFFER INFLATION PROTECTION

- (1) An insurer shall not offer a LTC policy unless it also offers, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or a policy that provides for an increase in the period of coverage that shall meet anticipated increases in the costs of LTC services covered by the increases in the costs of LTC services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than any one of the following:
- (a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%;
  - (1) (b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined.
- The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
- (c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.
- (2) Where the policy is issued to a group, the required offer in subsection (1) of this section shall be made to the group policyholder.
- (3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accumulated LTC benefits.
- (4) Insurers shall include the following information in or with the outline of coverage. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

- (a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period; and
  - (b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.
- (5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status, or claim history, or the length of time the person has been insured under the policy.
- (6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium is guaranteed to remain constant.
- (7) (a) Inflation protection as provided in Subsection (1) (a) of this section shall be included in a LTC insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.
- (b) The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans \_\_\_\_\_, and I reject inflation protection."

## SECTION 8. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE

- (1) Application forms shall include the following questions designed to elicit information as to whether:
- (a) The application has another LTC insurance policy or certificate in force as of the date of application; or
  - (b) A LTC policy or certificate is intended to replace:
    - 1. Any other accident and sickness policy or certificate presently in force or
    - 2. Any other LTC policy or certificate presently in force.
  - (c) Except where coverage is sold without an agent, a supplementary application or other form, containing the questions required by this section, may be used if signed by the:
    - 1. Applicant; and
    - 2. Agent.
  - (d) If a replacement policy is issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or LTC policies other than the group policy being replaced if the certificate holder has been notified of the replacement.
    - 1. Do you have another LTC policy in force (including health care service contract or HMO contract)?
    - 2. Did you have another LTC policy in force during the past 12 months?
      - a. If so, which company?
      - b. If that policy lapsed, when did it lapse?
    - 3. Are you covered by Medicaid?
    - 4. Do you intend to replace any of your medical or health insurance coverage with this policy?
- (2) Agents shall list other health insurance policies they have sold to the applicant which:
- (a) Are still in force; and

- (b) Were sold in the past 5 years, but are no longer in force.
- (3) Solicitations other than direct response.
  - (a) Upon determining that a sale will involve replacement, an insurer or its agent shall furnish the applicant, prior to issuance or delivery of the individual LTC policy, a notice regarding replacement of accident and sickness or LTC coverage.
  - (b) One of the notices shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.
  - (c) The notice shall be provided as follows:

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL  
ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE  
(INSURER'S NAME AND ADDRESS)  
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to (Your application or information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (insurer's name). Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

**STATEMENT TO APPLICANT BY AGENT:**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

- (a) Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (b) State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing condition or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- (c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (d) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for

the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Agent \_\_\_\_\_

Type Name of Agent \_\_\_\_\_

Type Address of Agent \_\_\_\_\_

The above "Notice of Applicant" was delivered to me:

Date: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

- (4) This subsection deals with direct response solicitors. For reference, consult the Kentucky insurance code.

**SECTION 9. REPORTING REQUIREMENTS**

- (1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of LTC policies sold by the agent as a percent of the agent's total annual sales.
- (2) Each insurer shall report annually by June 30 the 10% of its agents with the greatest percentages of lapses and replacements as measured by Subsection (1) of this section.
- (3) Reported replacement and lapse rates shall not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of LTC insurance.
- (4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding year.
- (5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding year.
- (6) For purposes of this section, "policy" shall mean only LTC insurance and "report" means on a state-wide basis.

**SECTION 11. DISCRETIONARY POWERS OF THE COMMISSIONER.**

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision(s) of this administrative regulation with respect to a specific LTC policy upon written finding that:

- (1) The modification or suspension would be in the best interest of the insureds;
- (2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

- (3) (a) The modification or suspension is necessary to development of an innovative and reasonable approach for insuring LTC; or
- (b) The policy is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of the community; or
- (c) The modification or suspension is necessary to permit LTC insurance to be sold as part of, or in conjunction with, another insurance product.

### SECTION 13. LOSS RATIOS *(Ed note: this is abbreviated to one sentence.)*

Benefits under LTC policies shall be deemed reasonable in relation to premiums if the expected loss ratio is at least 60%.

### SECTION 15. FILING REQUIREMENTS FOR ADVERTISING

- (1) (a) Every insurer providing LTC insurance or benefits in Kentucky shall provide a copy of any LTC insurance or benefits in Kentucky shall provide a copy of any LTC insurance advertisement intended for use in Kentucky whether through written, radio, or television medium to the commissioner for review to the extent it may be required under state law.
- (b) In addition, all advertisements shall be retained by the insurer for at least 3 years from the date the advertisement was first used.
- (2) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

### SECTION 16. STANDARDS FOR MARKETING.

- (1) Every insurer marketing LTC insurance in Kentucky directly or through its agents shall:
  - (a) Established marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
  - (b) Establish marketing procedures to assure excessive insurance is not sold or issued.
  - (c) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
  - (d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for LTC insurance already has accident and sickness or LTC insurance and the types and amounts of this insurance.
  - (e) Every insurer marketing LTC insurance shall establish auditable procedures for verifying compliance with the requirements of this subsection.
  - (f) If the state in which the policy is to be delivered or issued has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospect that such a program is available and the name, address and telephone number of the program.

- (2) In addition to the practices prohibited in KRS Chapter 304.12, the following acts and practices are prohibited:
  - (a) "Twisting" Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
  - (b) "High pressure tactics" Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
  - (c) "Cold lead advertising" Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

#### **SECTION 17. APPROPRIATENESS OF RECOMMENDED PURCHASE.**

In recommending the purchase or replacement of any LTC policy, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

#### **SECTION 18. PROHIBITION AGAINST PRE-EXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.**

If a LTC policy replaces another LTC policy, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new LTC policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

#### **SECTION 19. STANDARD FORMAT OUTLINE OF COVERAGE.**

This section is per KRS 304.14-615(7)

- (1) The outline of coverage shall be a freestanding document using no smaller than 10-point type.
- (2) The outline of coverage shall contain no material of an advertising nature.
- (3) Text that is emphasized in the standard format outline of coverage may be emphasized by any means that provide prominence to the text.
- (4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- (5) Format for outline of coverage:
  - (INSURER NAME)
  - (ADDRESS -- CITY & STATE)
  - (TELEPHONE NUMBER)
  - (LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE)
  - (Policy number or group master policy number)( Except for policies that are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your (application or enrollment form (is enclosed or was retained by you when you applied). If your answers are incorrect or untrue, the insurer has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If,

for any reason, any of your answers are incorrect, contact the insurer at this address:  
(insert address:

- (a) This policy is (individual or group) that was issued in the (jurisdiction in which policy was issued.)
- (b) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!
- (c) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.
  - 1. (Provide a brief description of the right to return -- "free look" provision of the policy.)
  - 2. (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon death of insured or surrender of the policy. If the policy contains either provision, include a description.)
- (d) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurer.
  - 1. (For agents) Neither (insert insurer name) nor its agents represent Medicare, the federal government, or any state government.
  - 2. (Deals with direct response writers.)
- (e) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

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

- (f) BENEFITS PROVIDED BY THIS POLICY.
  - 1. (Covered services, related deductible[s], waiting periods, elimination periods, and benefit maximums.)
  - 2. (Institutional benefit, by skill level.)
  - 3. (Non-institutional benefits, by skill level.)(Any benefit screens shall be explained in this section. If these screens differ for different benefits, explanation of the screen shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this shall be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens shall be

explained.)

(g) LIMITATIONS AND EXCLUSIONS. Describe:

1. Pre-existing conditions;
2. Non-eligible facilities or providers;
3. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by family member, etc.);
4. Exclusions and exceptions; and
5. Limitations.

This section shall provide a brief description of any policy provisions that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Paragraph (f) of this subsection.

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

(h) RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the costs of long-term services will likely increase over time, you should consider whether and how the benefits of this plan will be adjusted. (As applicable, indicate the following:

1. That the benefit level will not increase over time;
2. Any automatic benefit adjustment provisions;
3. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount of percentage;
4. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and
5. Describe whether there will be any additional premium charge imposed, and how that is to be calculated.

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

1. Describe the policy renewability provisions
2. For group coverage, specifically describe continuation and conversion provisions applicable to the certificate and group policy;
3. Describe waiver of premium provisions or state that there are no waiver of premium provisions; and
4. State whether or not the company has a right to change premium, and if this right exists, describe clearly and concisely each circumstance under which premium may change.

(j) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

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

(k) PREMIUM

1. State the total annual premium of the policy; and
2. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.

(l) ADDITIONAL FEATURES

1. Indicate if medical underwriting is used.
2. Describe other important features.

#### **SECTION 20. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.**

- (1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioner, or a guide developed or approved by the commissioner (commonly, "Kentucky Consumer's Guide to Long-Term Care Insurance"), shall be provided to all prospective applicants of a long-term care insurance policy or certificate.
  - (a) In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an applicant or enrollment form.
  - (b) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with any application or enrollment form.
- (2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but shall furnish the policy summary required under KRS 304.14-615.

#### **SECTION 21. PERMITTED COMPENSATION ARRANGEMENTS.**

- (1) Upon replacement, the replacing insurer shall not provide compensation to its agents or other producers greater than 200% of the renewal compensation payable by the replacing insurer or renewal policies. The commission or other compensation provided in subsequent (renewal) years by the replacing insurer shall be the same as the provided in the second year or period and shall be provided for a reasonable number of renewal years.
- (2) If long-term care insurance is provided under annuities or life insurance policies or riders, the requirements of this section shall apply only to the commissions or other compensation attributable to the long-term care insurance provided by these policies or riders.

## LONG-TERM CARE GLOSSARY

ACUTE CARE	Immediate, short-term care; usually medical in nature.
CHRONIC CARE	Long-term care; may or may not be medical in nature.
CONSUMER'S GUIDE TO LONG-TERM CARE INSURANCE POLICIES	Published by the Kentucky Department of Insurance and offered free of charge, the guide compares all LTC policies available in Kentucky.
CUSTODIAL CARE	Non-medical in nature and does not require trained nurses; term normally used when a patient requires assistance in activities of daily living.
ELIMINATION PERIOD	Similar to a deductible in other forms of insurance, the period of time that must elapse before benefits of LTC policy take effect (AKA, waiting period).
GUARANTEED RENEWABLE BASIS	Basis of offering LTC insurance (to a stated policyholder age) wherein only policyholder can cancel; carrier can adjust premium for all members of a class.
HOME CARE	Provided by visiting nurse or visiting homemaker when such services as cleaning, cooking and laundry are required.
HOSPICE CARE	Care provided for terminally ill patients.
INTERMEDIATE CARE	Care ordered by a physician and provided by an RN, LPN or professional in the areas of speech, physical, occupational and respiratory therapy. Not necessarily on a 24-hour basis.
KAR	(Kentucky Administrative Regulations) – Laws effecting all aspects of insurance in the State promulgated by the Kentucky Department of Insurance.
KRS	(Kentucky Revised Statutes) -- Laws effecting all aspects of insurance in the State passed by the Kentucky General Assembly and signed by the Governor.
LONG-TERM CARE	(LTC) -- Insurance designed to cover cost of long-term nursing home care; also provides benefits for hospice care, home health care and adult day care.
LOOK-BACK PERIOD	Period wherein carrier can determine received (or should have received) medical advice or treatment for a pre-existing condition.
MEDICAID	Federal government program of medical care for the indigent.

MEDICARE	Federal government program of medical care for persons over age 65, disabled persons, and their dependents.
MEDIGAP INSURANCE	Private health insurance designed to fill in the holes left by Medicare coverage (AKA, "Medicare Supplement Insurance").
ORGANIC CAUSE	In mental illness or nervous disorders, caused by a deficiency in the normal functioning of the human body.
PROHIBITED TRANSFER OF ASSETS	In Medicare, a transfer of assets (within 30 months of application for coverage) to make the applicant indigent and thus eligible for coverage.
SKILLED NURSING CARE	24-hour care ordered by a physician and provided by an RN, LPN or professional in the areas of speech, physical, occupational and respiratory therapy. Often hospitalization is the only alternative.
SKILLED NURSING FACILITY	(SNF) -- Facility that meets state and local licensing requirements and additional stringent federal mandates; only 30% of all U.S. nursing homes qualify as SNFs.
SPELL OF ILLNESS	In Medicare, benefits period that last from the day the patient is admitted until discharge.
WAITING PERIOD	See elimination period.