# A Guide for Your Long-Term Care Insurance Policy

Things to Know and Steps to Take
When you are Ready to Submit a Claim

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## About the Authors

**The Certification for Long-Term Care (CLTC®)** designation was created in 1999 and focuses on the discipline of extended care planning. It provides professionals the critical tools necessary to discuss the subject of longevity and its consequences on their client's family and finances. Students learn how to mitigate these consequences by developing a plan to protect their clients and their families.

This guide was developed in collaboration with **Linda Thalheimer**,CLTC, RICP **Board of Advisors** member for CLTC and a national expert in long-term care planning. Her academic training in Occupational Therapy and Health Care Administration give her a unique perspective into the world of long-term care insurance. Over the years, she has come to work closely with clients as they navigate the claims process and has generously shared her insights and expertise for the development of this guide.

# Introduction

You made an important decision when you decided to plan for the possibility of needing long-term care. Hopefully, if you need to access your coverage, it will be many years in the future. If so, it is likely you (or a family member or friend on your behalf) will need a refresher on the important definitions and terms of your policy and how they will influence your ability to submit a claim. This guide was designed to help you understand and prepare for the claim submission process.

Please note this is not a contract of insurance or any guarantee of how benefits will be determined. It is instead a general guide for how LTC insurance works and how that could impact your application for benefits. You or an authorized representative should also request a copy of the policy if you do not have it at hand.

# Section I:

## Long-Term Care Insurance is Catastrophic Coverage

The definition of long-term care is commonly defined as:

1. Requiring stand-by at arm's length or hands on assistance with two of six **Activities of Daily Living (ADLs)** (Older policies may be 5/6 excluding bathing).
    - Bathing
    - Dressing
    - Toileting
    - Continence
    - Transferring (getting on/off a bed or a chair)
    - Eating (getting food from your plate to your mouth)

    -Or-

2. Suffering from a **cognitive impairment** that requires substantial supervision for safety. The deterioration or loss of intellectual capacity will need to be certified by a licensed health care practitioner and measured by clinical evidence and standardized tests. Common causes of cognitive impairment include Alzheimer's disease, late-stage Parkinson's disease and other forms of dementia.

**Having appropriate expectations:**

It is important to understand that the definitions for long-term care insurance are specific. Declining health and function, the inability to perform Instrumental Activities of Daily Living (IADLs) like, driving, shopping, or managing finances are not at the level for long-term care insurance claim eligibility. In fact, it is likely you will need to hire caregivers prior to being eligible to submit a claim for long-term care benefits. Long-term care insurance is catastrophic coverage, designed for when the insured needs assistance with two activities of daily living or suffers from a cognitive impairment that threatens their safety. This typically means someone cannot be comfortably left alone for more than a couple of hours.

# Section II:

## Understanding Your Benefits

### Determine the Types of Long-Term Care Services that are Covered

**Nursing Home (NH**): Some policies may be a "nursing home only" plan and will not cover any care received at home or in an assisted living facility. Others may be home care only policies and will not cover any facility settings. It maybe possible to have a NH only policy cover a secure memory care unit in an assisted living facility or a memory care facility that is not licensed as a nursing home.

**Home Care (HC):** Care covered by these types of policies may be identified as a Skilled Home Care Agency, Home Care Services, or home care services (the capitalization does make a difference). The distinction is critical prior to using services. Independent care providers need to be identified specifically in the policy to be a covered service. (Note: Even when the policy may be open to independent caregivers, make sure to identify if "The Plan of Care" needs to be written by a "Skilled Medical Professional.")

**Assisted Living Facility (ALF)**: Assisted living facilities will be specifically identified in policies written after 1990. However, older policies that do not specifically state ALF, but include home care and nursing home care may pay benefits for an ALF as well. It is crucial to identify the definition of a nursing facility in these types of policies.

**Alternative Plan of Care (APOC)**: The alternative plan of care provides additional flexibility in the policy to fund services that are both beneficial and cost-effective that may not be otherwise identified in the policy. Examples may be a social day care program in a policy that only identifies Adult Day Health, or an experimental dementia inpatient program instead of a secure dementia unit or possibly robots in the future. The APOC provision in some instances may be used to cover a private aide in policies that would not otherwise cover a private provider.

### Determine How Long Benefits will Last

**Pooled Benefits:** If you use less than the daily benefit, and benefits are pooled, then those unused, remaining benefits will extend the policy duration. As an example, if

you have a $200 a day benefit and a 3-year duration, the total value of your benefits is $219,000 ($200 x 365 x 3). If you use less than $200 a day, then your benefits will last longer than 3 years (until you exhaust the $219,000). If you use exactly $200/day, then benefits will end at the 3-year mark.

**Fixed Duration**: A specific number of years of benefits regardless of the percentage of benefits utilized.

**Inflation Protection:** Inflation Benefits may have been purchased at the time of issue. Inflation may be automatic or be a required annual purchase for additional premium. Inflation may be based on the CPI (consumer price index), 3% or 5% simple inflation or anywhere from 1% to 5% compound inflation. There are also inflation options that are modified by age or limited to 20 years.

## Understand How the Elimination Period is Satisfied:

The elimination period (sometimes referred to as a "waiting period") is the deductible period before claims are paid. It is the time that must elapse after a benefit triggering event has happened and before coverage starts. The elimination period can be an expensive and frustrating period, although typically will only need to be satisfied once.

**Calendar day elimination periods** are a countdown of days from the day you meet the criteria for claim.

If you have a "reimbursement policy" then you must receive covered services on day one to trigger the start of the elimination period count down. In other words, the trigger to start the calendar day countdown is when you start receiving covered services (as defined in the policy) whether that be at home, an assisted living facility or nursing home.

On the other hand, if you have a "cash" policy, the elimination period qualification may start as soon as you meet the definition of long-term care such as in an in-hospital rehabilitation unit.

**Service day elimination periods** are fulfilled by each day that a billed service is received and meets the definition of benefits paid by the policy. If the elimination period is 90 days, it would require 90 days of paid qualified services to fulfill the elimination period. If you used only 3 days a week of care, this would more than double the time before you would be eligible to receive benefits.

Some policies allow one qualified day of paid service during a week to satisfy one full week. In this instance, the elimination period could be satisfied sooner, with potentially less out of pocket expenses, than if you had had to receive a covered service each day to satisfy the elimination period. It does not reduce the duration of the 90 or 100 days.

For most policies, rehabilitation days funded by Medicare will help satisfy the fulfillment of the elimination period IF these days are in a nursing home unit.

The EP is one of the most misunderstood provisions in long-term care insurance policies. Even if you have a 90 day EP, do not wait to call to initiate the claim process. You must be approved for benefits for any days to be counted towards the EP and your providers must also be covered under your policy.

**Waiver of the Home care elimination period** allows for services to start typically on day one of receipt of qualifying care when provided in the home. Some policies allow that this paid home care period count against satisfaction of the facility elimination period as well.

Important…for policies in which the waiver of the home care elimination period was built into the policy (rather than being an additional feature carrying additional cost), the elimination period may require use of the insurance companies' care coordination services. While you don't need to follow the plan of care provided, if you do not use this service, the waiver of the elimination period for home care will not apply.

**Hospice:** Most policies require that the elimination period be fulfilled first to receive benefits for hospice services. However, a few carriers will fund hospice on day one of qualifying for benefits. (Note: If you have a life insurance policy, in most states, you can accelerate the death benefit during this period of time.)

**The use of medical equipment:** Medical equipment is often included in the benefits of a LTC insurance policy. Before you purchase any equipment, call your carrier to initiate a claim. If the claim is approved, eligible expenses will qualify if purchased and approved after the initiation of the claim.

Be aware of how this benefit is calculated. Most often this benefit will be applied at the end of policy benefits; in other instances, it can be an extra month of benefits.

## Benefit Amount (or Benefit Level)

This provision defines how the daily or monthly benefit will be paid when you qualify for benefits. Policies pay benefits in one of three ways:

- Reimbursement
- Indemnity
- Cash

**Reimbursement policies** are the most common and pay based on covered, compensable expenses for long-term care up to a daily or monthly maximum. The key word here is “compensable” and requires you to fully understand the types of services the carrier will reimburse. For example, one carrier may pay for an independent aide while another will require that services be provided through a professional agency.

**An indemnity policy** pays the full daily benefit if one hour of service is required. Monthly indemnity policies typically pay based on the number of days in which services are utilized each month regardless of the actual expenses incurred.

**Cash indemnity** policies pay a monthly benefit regardless of services utilized or actual expenses.

# Section III:

## Making a Claim

When you feel you are qualified to submit a claim to your insurer, you or your Power of Attorney must call the insurer to initiate the claim. A family member or representative can only handle your claim if you have a valid Power of Attorney (POA) in place. They will then send you claims forms for you and your caregivers to complete. They will also request medical records from your primary care physician and if additional information is required, they may request documents from any of your other specialty providers.

An on-site assessment may also be required in your home or facility. When you call to initiate the claim, the claims specialist should provide you with a summary of your benefits. It is always good to confirm your benefits at the time of claim and get clarification on any items or question described earlier in this brochure.

**Claims Documentation**

There are typically three claims forms to complete.

- Client Form
- Provider Form
- Primary Care Provider Form

These forms may have check boxes or open-ended questions.

To help ensure this process is as quick and smooth as possible, it will be critically important that all of these forms are fully completed, accurate and consistent. If possible, you may want to meet with your primary care provider to ensure their records are accurate and clearly identify the level of care required for your safety. Medical records are often inaccurate or lacking critical information, complicating the claims department's decision-making process. Claims can be denied due to inaccurate or incomplete medical records.

Processing times for claims can be 30 days from the receipt of the last piece of information. This means the overall process can take up to several months if information

is not received in a timely manner. An appeal can add another 60 days or more. It is important to make sure claims documentation is accurate with the first application.

There are specialists who can be hired to help you through the claims process, which are significantly less expensive than attorneys.

Finally, you and your representative should be proactive in following up on your claim during the decision process. Ask what is still outstanding and contact your doctor's office or provider if they are not sending the information needed. Also, even when all of the information has been received by your insurer or their administrator, keep following up until the decision has been made. Stay on top of the process.

## Claims Redetermination

Claims redetermination typically takes place annually, but could occur at 30 days. The shorter redetermination typically occurs when the claims department believes the level of care could improve, when the cause of care is related to a post-surgical or post-accident medical condition that may resolve. The redetermination is an abbreviated claims process where a request for recertification that care is still required is sent to the primary care doctor and caregiver.