

LTC ALERT!

What you should know about Long-Term Care

GLOSSARY OF LONG-TERM CARE INSURANCE TERMS

*It's Important
We All Speak The
Same Language!*

Long-term care definitions can be confusing. There are many long-term care consumer guides with glossaries, each with a slightly different definition for the same term. The definitions in this LTC Alert apply to Partnership policies. They were drawn from a variety of consumer guides, including some from the California

Department of Aging's "Taking Care of Tomorrow: A Consumer's Guide to Long-Term Care." Many of these terms are also defined in the California Insurance Code (CIC). However, we have not used the CIC definitions in this glossary, choosing instead to use definitions that your clients would more easily understand.

ADL

An abbreviation for the phrase "Activities of Daily Living" that is limited to eating, bathing, dressing, continence (inability to control one's bowel or bladder), transferring (getting in and out of a bed or chair) and toileting. ADLs are used to determine if and when a policyholder can draw benefits under his/her policy. Typically, a policyholder must be "deficient" (unable to do) in two ADLs before he/she can begin to draw home benefits under his/her Long-Term Care policy. An individual must be "deficient" in two or, in some policies, three ADLs before he/she can draw Nursing Home benefits under his/her policy.

Adult Day Care*

These are services for people in a community setting which are provided in a licensed day care program that usually provides Personal Care, supervision, protection or assistance in eating, bathing, dressing, toileting, moving about and taking medications.

Adult Day Health Care

Services in an Adult Day Care Center that includes a level of day care including medical, Skilled Nursing and therapy services in addition to those services listed under Adult Day Care above.

Assisted Living Facility

Often incorrectly used interchangeably with Residential Care Facility. A license is required to operate a Residential Care Facility (RCF) or Residential Care Facility for the Elderly (RCFE), while there is no specific licensure requirement for an Assisted Living Facility. Facilities that are advertised as Assisted Living Facilities often offer Independent Living with on-site services such as meals, supervision, and assistance with ADLs. Many of these facilities have multiple buildings on the same property. People who need no or relatively little assistance with ADLs can live in the Independent Living units (unlicensed) while others that need assistance with ADLs live in a building that is licensed as a RCF or RCFE. Partnership policies will only pay benefits in a facility licensed as a RCF or an RCFE. There are special conditions for when Partnership policies will pay for services outside of California in unlicensed facilities.

Care Management

Care Management is also known as Care Coordination. It is a process of assessing and reassessing an insured's need for Long-Term Care (not specifically limited to policy benefits alone), developing a Plan of Care, coordinating services, and monitoring the adequacy of the care

received. Care Management takes an all-inclusive look at an individual's total needs or resources, and links the individual to a full range of appropriate services, using all available funding sources. For Partnership policies, the Care Management must be completed by an organization independent from the insurance company and approved by the State Department of Health Services. The costs of the assessment and development of a Plan of Care are counted as administrative expenses and are not deducted from the policies' daily or lifetime maximums. Some Partnership companies also pay the costs of coordinating services and monitoring the adequacy of the care received as an administrative expense.



**CALIFORNIA DEPARTMENT
OF HEALTH SERVICES**

Co-Insurance

An amount that a policyholder must be willing to pay out-of-pocket to make up for any difference between his/her policy's Daily Benefit and the care provider's daily charges.

Daily Benefit

The value of benefits a policy will pay each day until the total value of the policy is exhausted.

Elimination Period

Also known as a deductible or a waiting period. This is the number of days in which formal paid care must be received *after* the insured is determined to have become chronically ill *before* the policy begins paying for care. While some policies have no deductible periods and pay benefits from the first day, the most common waiting periods are 30 days, 60 days, or 90 days. For Partnership policies, an insurer must allow at least a nine month period in which to satisfy the Elimination Period. The Elimination Period need only be met once during a lifetime. Any day when covered services are reimbursed by other insurance or Medicare must be counted toward meeting the Elimination Period. An insured need not meet the Elimination Period requirement to receive Respite Care.

Guaranteed Renewable

Every Long-Term Care policy sold to an individual must be either Guaranteed Renewable or Non-Cancelable. Guaranteed Renewable means that the company cannot cancel a policy or change any of the benefits, unless a policyholder fails to pay the premiums. Insurance companies are allowed to increase premiums for a "class" of policies, but not for a person individually. Non-Cancelable means that a policy cannot be canceled, except for non-payment of premium, and that premiums can never be increased after a policy is issued to an individual.

Hands-On Assistance

The physical assistance of another person without which the insured would be unable to perform the Activities of Daily Living.

Home Care Aide Organization

An entity that provides a wide range of non-medical assistive services to adults and children, including: environmental management such as housekeeping, chores and shopping; companionship and respite care; transportation and escort services; assistance with Activities of Daily Living such as grooming, bathing, ambulating, toilet and elimination assistance, meal planning and preparation, medication reminders.

Home Health Agency

A licensed organization which is primarily engaged in providing Skilled Nursing services and other therapeutic services to persons in the home on a part-time or intermittent basis under a plan of treatment prescribed by the attending physician. Most Home Health Agencies are certified by Medicare, but some choose not to be.

Home Health Care*

Skilled Nursing or other professional services in the residence, including, but not limited to, part-time and intermittent Skilled Nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Homemaker Services*

These services provide assistance with chores or activities that are necessary for an individual to be able to remain in his/her residence and include house-keeping, cooking and grocery shopping. Services may be provided by a skilled or unskilled person when they are required in a Plan of Care developed by a doctor or a care team under medical direction.

Hospice Services*

Hospice Services are provided in an individual's residence and offer physical, emotional, social and spiritual support for an individual and his/her caregiver and family when a terminal illness has been diagnosed. Hospice Services may be provided by a skilled or unskilled person when they are required in a Plan of Care developed by a doctor or a care team under medical direction.

Independent Living

Place in which residents are expected to function independent of any assistance with their Activities of Daily Living. Independent Living includes senior retirement communities, retirement apartment buildings, mobile home parks and independent single family dwellings with no services.

Instrumental Activities of Daily Living*

IADLs are the activities of using the telephone, managing medication, moving about outside, shopping for essentials, preparing meals, laundry and light housekeeping.

Lapse

Termination of a policy due to the policyholder's failure to pay the premium.

Lapse Protection

Companies are required to allow a policyholder to reinstate his/her policy after a Lapse if the policyholder can show that his/her failure to pay premiums was because of an impairment in cognitive or functional abilities. Reinstatement of the policy shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premiums.

Long-Term Care

Services and assistance to an individual who has severe limitations in his/her ability to function independently and require care over an extended period of time. The inability to function independently can result from either physical or mental limitations and is defined in terms of the inability to perform essential Activities of Daily Living and/or Instrumental Activities of Daily Living. Long-Term Care can be received in a Skilled Nursing or a Residential Care Facility.

Look-Back Period for Medi-Cal

The time (currently 30 months) during which a person may not transfer property to others, or set up certain types of trusts, in order to qualify for Medi-Cal. When a person applies for Medi-Cal, any transfers made during -

this Look-Back Period could be counted as part of the applicant's assets for purposes of Medi-Cal qualification. This may result in a period of ineligibility during which an individual will have to pay for his/her Long-Term Care costs, even though they are receiving other Medi-Cal benefits.

Medi-Cal

This is California's version of Medicaid, a joint federal and state program for people with low incomes and few assets. Medi-Cal provides health care services to people on public assistance and to others who cannot afford to pay for these services themselves.

Medi-Cal Asset Protection

A unique feature that is only available in a Partnership-Certified policy. It is an exemption to Medi-Cal eligibility rules that allows people to keep more money than they would otherwise be able to keep, and still qualify for Medi-Cal. Every dollar paid out in benefits by a Partnership-Certified policy will protect an equal amount of an individual's assets in the event that he/she ever needs Medi-Cal benefits. This benefit is most valuable to an individual who can only afford a policy that will provide services for one or two years. If the policy benefits are used up, the individual can qualify for Medi-Cal to pay for their Long-Term Care needs without becoming impoverished.

Medigap Coverage

A private insurance that supplements Medicare. While Medigap (Medicare supplement) policies typically cover Medicare's deductibles and Co-Insurance amounts, they do not provide benefits for Long-Term Care. Like Medicare, Medigap policies primarily cover hospital and doctor bills and limited skilled care in a nursing home.

Monthly Benefit

All Partnership policies (and some, but not all traditional policies) allow greater flexibility in the use of home and community care services by combining Daily Benefits to create a Monthly Benefit cap. For example: A traditional policy may pay \$100 a day nursing home benefit and \$50 a day home and community based benefit. If the policyholder, however, needs \$200 of home-based care one day and no services the next day he/she

would have to pay \$150 out of his/her own pocket to supplement the one day of home-based care. With a Partnership policy, the policyholder accrues a "bucket of money" ($\$50 \times 30 = \$1,500$) that he/she can spend as a Monthly Benefit when home-based services are actually needed.

Nonforfeiture Benefits

Nonforfeiture Benefits allow the policyholder to retain some benefit of a Long-Term Care insurance policy if he/she Lapses his/her policy. The amount of that remaining benefit will be specified in the policy.

Nursing Facility

Nursing Facilities are licensed by the California Department of Health Services to provide both Skilled Nursing and Personal Care. Residents receiving Skilled Nursing care usually are convalescing from serious illness or surgery and require continuous observation and rehabilitation. The most common type of non-medical care given in Nursing Facilities is Personal Care services such as assistance with ADLs like bathing, grooming and toileting. Most residents are only receiving Personal Care services in a Nursing Facility and have cognitive impairments such as Alzheimer's disease, or they are extremely elderly and can no longer live independently at home.

Outline of Coverage

A summary of the terms of a policy or certificate. Agents are required to provide an Outline of Coverage to prospective applicants at the time of initial solicitation. If a person is purchasing insurance through the mail, companies must give him/her the Outline of Coverage with the application or enrollment form.

Partnership-Certified

A Long-Term Care insurance policy approved by the California Partnership for Long-Term Care containing key features that meet the special regulations of the California Department of Health Services. These key features assure that meaningful services will be provided in the event an individual needs Long-Term Care services. Partnership-Certified policies are especially designed to meet the Long-Term Care needs of people with modest to middle income.

Personal Care*

Personal care provides "Stand By" or "Hands-On" help in order for an individual to be able to perform his/her ADLs and IADLs. It also includes help with self-administration of medications. A person with cognitive impairment (i.e., Alzheimer's disease) often does not need assistance with ADLs, but often needs Personal Care in the form of verbal cues, or "Stand By" assistance to be certain he/she does not hurt himself/herself in activities such as cooking. The Partnership policies cannot require that the provider of the Personal Care service be at a level of licensure or certification greater than that required by law to perform that service or require that the service be provided by Medicare-certified agencies or providers.

Plan of Care

Means a written individualized plan of services prescribed by a Licensed Health Care Practitioner (LHCP). For Partnership policies, the LHCP must be an employee or a designee of a Care Management Organization approved by the State Department of Health Services. The Partnership requires the Plan of Care to include the type and frequency of all formal (provider is paid) and informal (provider receives no reimbursement) Long-Term Care services required for the insured, and the cost to the insured, if any, of any formal Long-Term Care services prescribed. The Plan of Care must also include a non-inclusive list of potential providers available in the community that can provide the services listed.

Pre-existing Conditions

Medical conditions that existed, were diagnosed, or were under treatment before the policy was issued. Long-Term Care insurance policies may refuse to pay the benefits payable for such conditions during the first six months after the policy was issued. Some companies will pay for any pre-existing conditions revealed at the time of application.

Residential Care Facility

These facilities provide room and board, assistance with personal care and any necessary supervision. They range in size from small, two- to six-bed “mom and pop” operations to facilities with over 200 living units. They are licensed by the California Department of Social Services.

Respite Care*

Means the supervision and care of the insured in the home or out of home while the family or other individuals who normally provide care take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving. Eligible providers for Respite Care include: a Nursing Facility, a Residential Care Facility, community-based programs such as an Adult Day Health/Social Care provider, persons employed by a Home Health Agency, and a person who is qualified by training and/or experience to provide the care.

Severe Cognitive Impairment

Means that an individual needs supervision or assistance to protect himself/herself or others because of mental deterioration caused by Alzheimer’s disease or other organic mental diseases. In policies that use the Federally Tax Qualified eligibility standard, an individual must require substantial supervision because of Severe Cognitive Impairment. “Cognitive Impairment” (a definition used for non-Federally Qualified policies) and “Severe Cognitive Impairment” (a definition limited to Federally

Qualified policies), are measured by clinical evidence and the same standardized mental health tests.

Skilled Nursing

Nursing and supportive care provided by licensed nurses to patients who need nursing service on an extended basis. This care is usually provided 24 hours a day, is ordered by a physician, and involves a treatment plan. Skilled Nursing care is generally provided in a nursing facility, but may also be provided in other settings such as the patient’s home with help from visiting nurses or therapists.

Skilled Nursing Facility

A health facility or a distinct part of a hospital or other institution that:

- provides room and board;
- provides 24 hour a day nursing care and related services on a continuing inpatient basis;
- has a registered professional nurse on duty or on call at all times;
- has a duly licensed physician available in case of emergency;
- has a planned program of policies and procedures developed with the advice of, and periodically reviewed by, at least one physician; and
- maintains a clinical record for each patient.

Residents receiving Skilled Nursing care usually are convalescing from serious illness or surgery and require continuous observation and rehabilitative services.

Stand-By Assistance

The presence of another person within arm’s reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing an ADL, such as being ready to catch an individual if he/she falls while getting into or out of the bathtub.

Step-Down

A policy feature which allows a policyholder to reduce coverage in exchange for a lower premium. There are primarily three ways this can be done. A policyholder can reduce the Daily Benefit, or the total number of years the policy will pay, or he/she can change his/her coverage from a Comprehensive policy to a Nursing Home Only policy if the company sells one. This right to reduce coverage can be exercised anytime after the first year or whenever the premium increases. Companies must also offer this option to a policyholder if he/she stops paying premiums as an alternative to lapsing coverage.

Waiver of Premium

Policies certified by the Partnership must waive the premiums upon a policyholder’s receipt of the policy’s Residential Care Facility or Nursing Facility benefit. Some Partnership policies waive the premium upon receipt of Home Care services.

* Also defined in the California Insurance Code Section 10232.9