

CHAPTER 22

LONG TERM CARE HICAP

NEED FOR LONG-TERM CARE (LTC)

Long-term care comprises a broad range of medical and personal services for persons who are in need of assistance with daily activities for an extended period. The need for such assistance can be due to either mental or physical impairment which frequently is brought on by the process of aging. Long-term care does not provide a cure for medical problems but rather helps a person live as he/she is now. Long-term care includes help with activities of daily living, home health care, respite care, adult day care, care in a nursing home, and care in an assisted living facility. It should be understood that neither Medicare nor Medicare supplement insurance covers long-term care. Medicare only covers 100 days of skilled nursing in a benefit period. It does not cover homemaker services.

The New England Journal of Medicine published a national study which stated that of persons who turned 65 in 1990 more than 43% are expected to enter a nursing home at least once in their life. The study further stated that among people who live to age 65, only one out of three will spend three months or more in a nursing home. About one out of four will spend one year or more in a nursing home; about one out of eleven will spend five years or more in a nursing home. Women are more likely to need nursing home care than men. The study stated that 13% of women will spend five years or more in a nursing home whereas only 4% of men will be in a nursing home that amount of time.

Another label that has evolved is the “Sandwich generation”. This essentially refers to the baby boomers—those born between 1946 and 1964. These people may feel the squeeze between caring for children and for aging parents. An average 45 year-old woman may spend 17 years raising children and another 18 years helping aged parents.

After looking at these statistics it becomes apparent that people need to make plans to receive the necessary assistance and to prevent their families from being burdened with the cost of such care.

PAYING FOR LONG-TERM CARE

Long-term care costs will be paid out of a person’s personal resources, by Medi-Cal, or through long-term care insurance. Paying out of personal resources means paying from one’s savings and also might involve liquidating other assets. According to the *Business and Health Magazine* of January 1997, 70% of single people and 50% of couples with one partner requiring long-term care become

impoverished within one year. This is understandable as according to a major insurer that did a market survey in 2004 of nursing home and home care costs, the average cost of a semi-private room in a nursing home was \$61,685 annually. This survey also stated that the average cost of a home health aide was \$18.12 an hour. At four hours a day, that amounts to about \$500 a week or \$2,000 a month.

Medicaid (called Medi-Cal in California) pays nearly half of all nursing home care in the United States. However, a person must meet federal and state guidelines for income and assets. This means the person is essentially destitute. Many people start paying nursing home care out of their own resources and when they spend down to the Medi-Cal guidelines, Medi-Cal will pay a portion or all of the nursing home costs.

The California Partnership for Long-Term Care is a project of the State of California and the Robert Wood Johnson Foundation. The concept of this program is to allow a person who purchases a LTC partnership policy to be able to shelter some assets that would not have to be spent down in order to qualify for Medi-Cal. An example would be a person having \$125,000 in assets who purchases a \$100,000 LTC policy. This person would be able to keep \$100,000 in assets and still qualify for Medi-Cal after spending down the remaining \$25,000. This is to create an incentive to purchase LTC coverage. Companies, products, and agents must meet certain state specifications before companies are allowed to sell these policies.

The last method for providing for long-term care is by purchasing a long-term care insurance policy that will pay for some or all of the necessary care. This is a relatively new form of insurance having been introduced in the 1980s. Insurance companies have medical underwriting standards for long-term care insurance. The person must be insurable according to company guidelines and premiums will be determined by age, sex, health, and a number of other factors.

The NAIC established the following guideline for someone to consider in deciding whether or not to purchase long-term care insurance.

You should NOT buy long-term care insurance if:

- You can't afford the premiums.
- You have limited assets.
- Your only source of income is a Social Security benefit or Supplemental Security Income (SSI).
- You often have trouble paying for utilities, food, medicine, and other important needs.

You should CONSIDER buying long-term care insurance if:

- You have significant assets and income.
- You want to protect some of your assets and income.

- You want to pay for your own care.
- You want to stay independent of the support of others.

Today most long-term care insurance policies are individual contracts. However, group policies are also available. Long-term care can be added as a rider to a life policy. Long-term care policies can be issued by insurers, fraternal benefit societies, non-profit hospital service plans, and other similar organizations regulated by the insurance commissioner.

Some individual contracts might have pooled benefits. This covers more than one person, usually husband and wife, and has a total benefit that applies to all of the individuals covered by the policy. Another type of pooled benefit contract provides a total dollar amount that can be used for various long-term care services. This type of contract pays a daily, weekly, or monthly dollar limit for one or more covered services.

HOW BENEFITS ARE PAID

Long-term care benefits normally are paid in one of two methods. These are the expense-incurred method and the indemnity method. Under an expense-incurred policy, the insurer will decide if the insured is eligible for benefits and if the claim is for eligible services. Benefits are paid either to the insured or to the provider. Today most long-term care contracts use the expense-incurred method.

With an indemnity policy, the benefit is a set dollar amount. The insurer will decide if the insured is eligible for benefits. Benefits are paid directly to the insured up to the limit of the policy.

SERVICES COVERED

Long-term care policies may cover the following services:

- Nursing home care
- Home health care
- Personal care in the home
- Services in assisted living facilities
- Services in adult day care centers
- Services in other community facilities

EXCLUSIONS AND LIMITATIONS

Most long-term care contracts do not pay benefits for the following:

- Alcohol and drug addiction
- Mental or nervous disorder or disease, other than Alzheimer's disease or other dementia

- Illness or injury caused by an act of war or participation in a felony, riot, or insurrection
- Attempted suicide or intentionally self-inflicted injuries
- Treatment in a government facility
- Most policies do not pay benefits to family members who give care in the home

TYPES OF LONG-TERM CARE INSURANCE SOLD IN CALIFORNIA

1. **Nursing Facility and Residential Care Only:** These contracts cover skilled, intermediate, or custodial care in a nursing home or similar facility. The insurance code states that any policy or certificate in which benefits are limited to the provision of institutional care shall be called a “nursing facility and residential care only” policy or certificate and the words “Nursing Facility and Residential Care Only” shall be prominently displayed on page one of the form and the outline of coverage.
2. **Home Care Only.** These contracts must include home health care, adult day care, personal care, homemaker services, hospice services, and respite care. The code states that any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a “home care only” policy or certificate and the words “Home Care Only” shall be prominently displayed on page one of the form and the outline of coverage.
3. **Comprehensive Long-Term Care.** These contracts must include a nursing home benefit as well as the six home care benefits. The six home care benefits will be discussed on the next page. According to the code, only those policies or certificates providing benefits for both institutional care and home care may be called “comprehensive long-term care” insurance. (CIC 10232.1)

Facility coverage includes skilled, intermediate, and custodial care received in a nursing home. Some policies will cover stays in licensed RCFE’s. These are not nursing homes but are homes where a person can live and receive personal care and supervision. Some policies also will pay for room and board in an assisted living facility or hospice facility.

Skilled nursing care is daily nursing that is ordered by a doctor and is required for certain medical conditions. It can be performed only by a skilled medical professional or under the supervision of a medical professional and is available 24 hours a day. Normally this is provided in a nursing home.

Intermediate nursing care is occasional or rehabilitative care ordered by a doctor. This type of care is provided by medical personnel and generally is provided in nursing homes. Intermediate care is needed by someone who requires daily supervision, but not 24-hour care.

Personal or custodial care helps a person with activities of daily living (ADL's). ADLs include bathing, eating, dressing, toileting, continence, and transferring. Custodial care must be given under a doctor's orders but often is provided by unskilled workers. This type of care can be provided in nursing homes, adult day care centers, respite centers, or in the home.

Home care only and comprehensive long-term care policies must provide at least six mandated home care benefits. These are home health care, adult day care, personal care, homemaker services, hospice services, and respite care. (10232.8)

Home health care is skilled nursing care or other professional services in the insured's residence.

Community based care includes programs such as adult day care. This is medical or social care in a daytime program in a licensed facility that provides personal care, supervision, protection, and assistance with ADLs.

Personal care is assistance in the insured's residence with any of the Activities of Daily Living (eating, dressing, bathing, ambulating, transferring, toileting, and continence) and Instrumental Activities of Daily Living (using the telephone, shopping for essentials, preparing meals, doing laundry, light housekeeping, moving about outside, and managing medications). Personal care services require a plan of care developed by a doctor. However, the services may be performed by either skilled or unskilled persons.

Homemaker services provide for assistance with activities and chores that are needed for the insured to remain in the home. These services require a plan of care developed by a doctor. Such services can be provided by skilled and unskilled persons.

Hospice services are services provided when a terminal illness has been diagnosed. It is meant to provide physical, emotional, and spiritual support for the insured, the caregiver, and the insured's family. Hospice services must be required in a plan of care developed by a doctor, and the services can be provided by skilled or unskilled persons.

Respite care is meant to provide the family caregiver with a short rest period or break. The insured can be moved to a nursing facility or a substitute caregiver can move into the insured's home for a short period.

BENEFIT TRIGGERS

Benefit triggers are standards that must be met before benefits will be paid under the LTC policy. The standards concern the mental or physical condition of the insured. The three normal benefit triggers are: (CIC 10232.8)

1. Impairment in certain Activities of Daily Living (ADLs)
2. Impairment in Cognitive Ability
3. Medical Necessity

Most policies will pay benefits when a doctor certifies that the patient needs assistance with two or three ADLs. A doctor must diagnose impairment in cognitive ability. This means the patient needs supervision to protect himself/herself or others due to mental deterioration caused by Alzheimer's disease or other organic mental disease.

Medical necessity means the doctor has certified that the patient's medical condition will worsen if nursing home care or home care is not received. In California, insurers are not allowed to require an insured to prove medical necessity in order to trigger home care benefits.

Some older long-term care policies required the insured to be hospitalized before benefits would be paid. This is no longer the case. In California any long-term care policy issued on or after January 1, 1990 cannot require prior hospitalization or institutionalization as a condition for payment of benefits.

LIMITS OF COVERAGE

Maximum benefit limit is the total benefit amount the insurer will pay over the term of the policy. Some contracts state the maximum benefit limit in years (i.e. one year, two years, etc., or even lifetime) called a benefit period. Policies that have longer maximum benefits periods cost more. Other contracts might state the maximum benefit limit in terms of total dollar amount.

Daily/monthly benefit limit is the amount the policy will pay on a daily or monthly basis. An example of a benefit amount is \$50 to \$250 per day or \$1,500 to \$7,500 a month for care in a nursing home. If the contract also covers home care, the benefit amount normally is expressed as a percentage of the nursing home benefit.

An **elimination period** is the number of days for which an insurer will not pay benefits after the insured starts receiving long-term care. It can be regarded as a deductible in time. Although an insured might choose a zero-day elimination period, more commonly elimination periods are 30 days, 60 days, or 90 days. The longer the elimination period, the lower the premium. Some policies count a second stay in a nursing home as part of the first stay as long as the insured returns to the nursing home within 30, 90, or 180 days thus avoiding another elimination period.

POLICY FEATURES

Renewability

All individual long-term care policies are issued as either guaranteed renewable or non-cancelable. On a guaranteed renewable policy, the insurer cannot cancel except for non-payment of premium. Coverage cannot be canceled due to either age or health. However, the insurer does have the right to increase premiums for an entire class of insureds.

If a policy is issued as non-cancelable, the insurer cannot cancel the policy except for non-payment and the insurer cannot change the premiums. If a LTC policy is purchased through a group, the individual has the right of continuation or conversion if the group policy is canceled or terminates. Continuation means the same coverage is maintained as long as the premium is paid on time. Conversion means an individual policy with identical or equivalent coverage will be issued. When conversion is chosen, the premium will be calculated on the insured's age at the time the group certificate was issued.

Free Look

All persons (except those purchasing LTC through a group) have the right to a 30-day free look. The policy must have a notice prominently printed on the first page of the policy to this effect. The insured has the right to review the policy for 30 days and, if not satisfied, may return the policy to the insurer or agent without explanation to receive a full refund of premium. The return of the policy shall void the policy from the beginning. All premiums paid and any policy fee paid for the policy must be fully refunded directly to the applicant by the insurer within 30 days after the policy or certificate is returned. (CIC 10232.7)

Third Party Notice

This benefit allows the insured to name someone who the insurance company can contact if a premium is not paid. This gives the third party time to arrange for premium payment to be made to keep the policy from lapsing.

Inflation Protection

A person purchasing LTC insurance must be offered the option of purchasing inflation protection. As the cost of care constantly is escalating, inflation protection increases the benefit payment. Inflation protection also increases the premium.

Policies that increase benefits yearly may use simple or compound rates. The daily benefit increases by a fixed percentage (usually 5%) each year for the life of the policy or for a specified number of years (usually 10 or 20 years). If

simple interest is used, the benefit increases by the same dollar amount each year. If compound interest is used, the benefit amount increases every year as the increase is a percentage of the previous year's benefit amount.

Another way of buying inflation protection allows the insured to increase benefits periodically (i.e. every three years). The premium will increase if benefits are increased. The amount of increase depends on the age at the time the increased benefit is purchased. If the insured does not increase the benefit at each interval, the ability to purchase more insurance in the future may be lost.

If the purchaser of a long-term care policy rejects inflation protection, he/she must sign a statement to that effect. The rejection is to be included in the application or on a separate form and states that the purchaser has reviewed the outline of coverage and specifically rejects the inflation protection. (CIC 10237.1; 10237.5)

Pre-existing Conditions

Long-term care policies (other than group) cannot exclude coverage for a loss due to a pre-existing condition unless the loss begins within six months following the effective date of coverage. Long-term care policies cannot define pre-existing more restrictively than a condition for which medical advice or treatment was received within six months prior to the effective date of the policy.

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. Unless otherwise provided in the policy or certificate a pre-existing condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period expires. Unless such waiver or rider has been specifically approved by the commissioner, no long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period. (CIC 10232.4)

Extension of Benefits Beyond Termination of Policy

Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits may be limited to the duration of the benefit period or to payment of the maximum benefits.

OTHER OPTIONS

Waiver of Premium

This rider allows the insured to stop paying premium when the insured is in a nursing home and the insurer has started paying benefits. Some companies waive the premium soon as benefits are paid and others wait for 60 to 90 days. This waiver may not apply if the insured is receiving home health care.

Restoration of Benefits

The restoration of benefits option allows the insured a method of keeping the maximum amount of the original benefit after the policy has paid some benefits. This option provides the ability to restore benefit amounts if the insured goes for a period of time without having further benefits paid under the LTC policy. For instance, the insured's policy paid \$7,000 in benefits under a policy that had a \$100,000 maximum benefit amount. There would be \$93,000 of benefits left. The benefit could revert back to \$100,000 if no further benefits are paid in a specified amount of time.

Premium Refund at Death

The premium refund at death option pays the insured's estate any premiums paid minus any benefit amount paid by the insurer. In order to exercise this option the insured must have had the policy for a specific length of time. Under some contracts this option applies only if death occurs before 65 or 70.

Nonforfeiture Options

With the nonforfeiture option the insured can receive some value for the money paid into the contract if coverage is dropped. The return of premium nonforfeiture benefit will pay the insured all or a portion of premium paid for the LTC policy after a given number of years from the policy issue date (usually ten years). The reduced paid-up nonforfeiture option allows the insured to have a paid-up policy with a shorter benefit period.

OUTLINE OF COVERAGE

The outline of coverage is a brief description of the important features of the policy. Buyers of LTC insurance should compare this outline of coverage to outlines of coverage of other available policies. The outline of coverage shall be a freestanding document using no smaller than 10-point type. The outline of coverage simply is a summary of coverage; the insurance policy sets forth in detail the rights and obligations of both the insured and the insurer.

The outline must be delivered to the prospective buyer at the insurance agent's first presentation. If the policy is purchased through the mail, the outline must be delivered with the application or enrollment form. A prospective buyer does not need to fill out an application in order to receive an outline of coverage. (CIC 10233.5)

PROHIBITED PROVISIONS

Long-term care policies may not: (CIC 10233.2)

- Be canceled, non-renewed, or otherwise terminated on the grounds of age or the deterioration of the insured's mental or physical health.
- Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new form within the same insurer, unless there is an increase in benefits voluntarily selected by the insured.
- Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Limit or deny benefits to a policyholder diagnosed as having a progressive, degenerative, and dementing illness, including but not limited to Alzheimer's disease.
- Provide for payment of benefits based on a standard described as "usual and customary" or "reasonable and customary" or other such similar wording.

REPLACEMENT OF LONG-TERM CARE POLICIES

No insurer, broker, agent or other person may cause a policyholder to replace a LTC policy unnecessarily. No insurer, agent, or other person may replace a LTC policy that will result in a decrease in benefits and an increase in premiums. It will be presumed that any third or greater policy sold to a policyholder in any 12-month period is unnecessary. (CIC 10234.85)

In recommending the replacement of a LTC policy, an agent must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. (CIC 10234.95) LTC care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance is intended to replace any other accident and sickness or LTC insurance presently in force. Upon determining that replacement will be involved, an insurer or its agent shall furnish the applicant a notice regarding replacement of coverage. One copy of this notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The replacement notice must include a statement signed by the agent documenting that the replacement policy materially improves coverage to the best of the

agent's knowledge. The notice must include the specific reasons the agent is making in recommending the replacement.

If a LTC policy replaces another LTC policy, the replacing insurer must waive any time periods applicable to pre-existing conditions and probationary periods to the extent that similar exclusions have been satisfied under the original policy. (CIC 10233.3)

Any time an individual long-term care policy is replaced, the sales commission that is paid and that represents the percentage of the sale normally paid for first year sales of LTC policies must be calculated based on the difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the replaced policy, the sales commission will be limited to the percentage of sale normally paid for renewal of LTC policies. No other type of remuneration is allowed. The insurer must make a declaration stating that the replacement policy materially improves the position of the insured. (CIC 10234.97[a] and [b])

UNDERWRITING AND COST

Underwriting guidelines will vary from one company to another. The applicant will need to fill out an application and answer questions regarding health. There are some health conditions such as Parkinson's disease that probably will preclude the applicant from being issued a long-term care policy.

According to statistics from the National Association of Insurance Commissioners (NAIC), it is not unusual for a couple age 65 to spend about \$7,500 a year for all of their health insurance coverage. The annual premium for a LTC policy with inflation protection can cost as much as \$2,000 or more for a person aged 65. If a person waits until age 75 to purchase a LTC policy, it might be more than double than having purchased the policy at age 65. Inflation protection can add anywhere from 25% to 40% to the premium. Nonforfeiture benefits can add 10% to 100% to the premium. Policies with large daily benefit amounts and long benefit periods will cost more. Short elimination periods also will result in a higher premium.

GROUP LONG-TERM CARE POLICIES

Most long-term care policies are sold to individuals. However, an employer may offer a group LTC policy. An advantage of an employer group plan is that employees may not have to meet any medical requirements. Some employers allow retirees, spouses, parents, and parents-in-law to apply for this coverage. However, relatives usually must pass the insurer's medical screening to qualify for coverage.

In group LTC policies, the individuals covered under the contract must be issued a certificate. This certificate will provide a description of the principal benefits and coverage provided by the policy. It also should contain a statement of the exclusions and limitations of the policy as well as an explanation of the insured's rights of continuation, conversion, and replacement.

All certificates must provide for continuation or conversion for the individual insured under the group contract in the event the group coverage is terminated. Continuation refers to the maintenance of coverage under an existing group plan subject to continued premium payments. Conversion means coverage under an individual LTC policy that is issued without the individual proving insurability and containing benefits equivalent to those offered under the terminated group policy.

An individual whose eligibility is based on relationship to an employee (e.g. spouse of an employee) is entitled to continuation coverage under the group policy if the qualifying relationship terminates due to divorce or death. As regards conversion, this relative must have been covered under the group contract for at least six months and will be required to submit an application and premium to the insurer within a reasonable amount of time. Conversion policies may have reduced benefits if the individual has an existing LTC policy payable on an expense basis and the combined benefit of the two policies would pay more than 100% of incurred expense. In such cases, if the policy has reduced benefits, there must be a corresponding reduction in premium.

QUALIFIED AND NON-QUALIFIED POLICIES

A tax-qualified policy can be eligible for a tax deduction of policy premiums and benefits. In order to qualify for the tax deduction, the insured must be certified by a health professional as having a chronic illness that will last for a minimum of 90 days, or must have a severe cognitive impairment, or must not be able to perform 2 activities of daily living. If deductions are claimed, medical expenses must be itemized and to deduct medical expenses they must exceed 7.5% of adjusted gross income. Refunds of premiums at death or cancellation are taxable income if the premiums were deducted from income.

A non-qualified policy's premiums are not deductible for income tax purposes. Benefits received on or after January 1, 1997 will not be taxed. Benefit triggers are more liberal, including a "medical necessity" benefit and patients whose period of care last for less than 90 days still receive benefit payments.

MARKETING PROCEDURES (CIC 10234.93)

Every insurer of long-term care in California shall:

- Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
- Establish marketing procedures to assure excessive insurance is not sold or issued.
- Submit to the commissioner a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semi-annually.
- Require that each agent or other insurer representative selling long-term care insurance shall satisfactorily complete the required continuing education requirements. Accident/health licensees will need to complete eight hours of LTC education in each of the first four 12-month periods beginning from the date of original license issuance and thereafter eight hours of long-term care education prior to each license renewal.
- Display prominently on page one of the policy or certificate and the outline of coverage: "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."
- Inquire whether a prospective applicant already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.
- Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with the California code.
- Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program. Where this is impractical, the prospective applicant shall be given the department's hotline telephone number (1-800-927-HELP) through which the consumer can get information about HICAP.
- In addition to other unfair trade practices, the following acts and practices are prohibited: twisting, high-pressure tactics, and cold lead advertising. Twisting is knowingly making misleading representations for the purpose of inducing any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or take out a policy of insurance with another insurer. High-pressure tactics is employing any method of marketing to induce the purchase of insurance through force, fright, threat, or undue pressure. Cold lead advertising is a marketing method which fails to disclose in a conspicuous manner that the purpose is to solicit insurance and that contact will be made by an insurance agent or insurance company. An agent or broker who contacts a consumer as the result of information gathered through a cold lead device must immediately disclose that fact to the consumer. (CIC 10234.9{c})

All insurers, agent, brokers, and others engaged in selling long-term care policies owe policyholders and prospective buyers a duty of honesty and a duty of good faith and fair dealing. (CIC 10234.8)

HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM (HICAP)

The Health Insurance Counseling and Advocacy Program (HICAP) was created by the California legislature in 1984 and is administered by the California Department of Aging. By 1988 HICAP was operating in all counties in California. Residents of the state who are 60 years of age or older may receive individual counseling and assistance free of charge from this agency.

HICAP's mission is "to provide accurate and objective counseling, advocacy, and assistance with Medicare, health insurance, and related health coverage plans for Medicare beneficiaries, their representatives, or persons imminent of Medicare eligibility, and, to educate the public on Medicare and health insurance issues." HICAP provides one-on-one counseling, home visits, attorney services, and community education presentations.

HICAP trains volunteer counselors to assist seniors with questions regarding Medicare, Medicare supplement insurance, and long-term care insurance. The volunteer counselors receive 30 hours of initial training plus receiving continuing education each year. HICAP counselors may not be licensed to sell insurance or work for any insurance company or agency. HICAP counselors do not sell, endorse, or recommend any type of health insurance product, agent, insurance company, or HMO.

HICAP will help individuals to:

- Receive the health care benefits to which a person is entitled
- Understand Medicare benefits
- Compare Medicare Supplement Insurance Plans
- Review HMO options
- Explore long-term care financing options
- File health insurance claims
- Develop a system to organize an individual's doctor and hospital bills
- Prepare Medicare and HMO appeals or challenge claim denials
- Clarify a person's rights as a health care consumer

A local program may be found on the internet (www.calmedicare.org) or by calling the statewide toll free number 800-434-0222.

REVIEW QUESTIONS

1. Who pays for long-term care?
 - A. An individual from savings or assets
 - B. Medi-Cal
 - C. A long-term care policy
 - D. All the above

2. In California insurers may require hospitalization of an insured before receiving any long-term care benefits.
 - A. True
 - B. False

3. Which of the following is a true statement about HICAP?
 - A. HICAP volunteers are representatives of insurance companies.
 - B. HICAP counselor may recommend specific insurance companies, products, and agents.
 - C. HICAP is a free service.
 - D. HICAP counselors provide information only on life insurance.

4. Who should consider buying a long-term care policy?
 - A. Persons with few assets.
 - B. Persons whose only income is Social Security.
 - C. Persons who have difficulty paying monthly bills.
 - D. Persons who wish to stay independent of the support of others.

5. Long-term care policies do **not** cover which of the following?
 - A. Adult day care
 - B. Nursing home care
 - C. Hospital care
 - D. Home health care

6. Which of the following long-term care policies will cover nursing home and home health care?
 - A. Institutional plans
 - B. Community facility plans
 - C. Comprehensive plans
 - D. Personal care plans

7. Which of the following **cannot** be excluded from a long-term care policy?
- A. Alcohol and drug addiction
 - B. Injury caused by an act of war
 - C. Alzheimer's disease
 - D. Treatment in a government facility
8. Triggers to receive long-term care benefits include:
- 1. Inability to do ADLs
 - 2. Hospitalization
 - 3. Medical necessity
 - 4. Impairment in cognitive ability
- A. 1, 2, & 3
 - B. 1, 2, & 4
 - C. 1, 3, & 4
 - D. All the above
9. An insurer selling long-term care in California must offer the applicant the ability to purchase inflation protection.
- A. True
 - B. False
10. The outline of coverage:
- A. May be delivered after issuance of the policy.
 - B. Is not necessary in long-term care insurance.
 - C. Is the responsibility of the agent to deliver.
 - D. Is the actual policy.
11. When is replacement of a long-term care policy considered unnecessary?
- A. If done 2 times or more in a 12-month period.
 - B. If done 3 times or more in a 12-month period.
 - C. If done 4 times or more in a 12-month period.
 - D. It cannot be replaced in a 12-month period.
12. If a LTC policy is replaced, the replacing insurer has to waive any time period regarding pre-existing conditions.
- A. True
 - B. False

13. Which of the following statements are true about HICAP?

1. It provides one-on-one counseling for seniors.
2. It does not endorse or sell any form of insurance product.
3. It requires a fee based on a sliding scale according to ability to pay.
4. The counselors help seniors compare and understand Medicare supplement insurance policies.

- A. 1, 2, & 3
- B. 2, 3, & 4
- C. 1, 2, & 4
- D. All of the above