LTC Insurance Glossary

Words in ALL CAPS are defined elsewhere in the Glossary.

ACCUMULATION PERIOD:

A period of time within which the ELIMINATION PERIOD must be satisfied. If the ELIMINATION PERIOD is not satisfied within the Accumulation Period, the ELIMINATION PERIOD starts over. Not all policies impose this limit.

ACTIVITIES OF DAILY LIVING (ADLs):

The physical activities that policies use to measure your ability - or inability - to safely take care of yourself. The most common six ADLs used in LTC insurance are:

- TRANSFERRING
- TOILEITNG
- BATHING
- DRESSING
- EATING
- CONTINENCE

The loss of an ADL is measured either by HANDS-ON ASSISTANCE or STAND-BY ASSISTANCE.

"Mobility" or "Ambulation" are NOT typically used in determining LTCI eligibility.

ALTERNATIVE PLAN OF CARE (APOC):

Specific contract language offered in many policies. The policyholder has the right to negotiate with the carrier to pay for services not explicitly covered by the policy. The policyholder, the policyholder's doctor, and the carrier must all agree on the alternative. An alternative is not guaranteed as the carrier has the right to refuse the request. An alternative is typically only approved if it costs less than covered services or if a covered provider is not geographically available. It is not a substitute for benefits that were available at time of application but not chosen.
For example, a facility-only policy will only provide for an alternative facility, not for home care services as an alternative to a facility.

ASSIGNMENT OF BENEFITS (AOB):

The policyholder (or power of attorney) can assign the payment of benefits directly to an approved care provider. AOB does not give the provider any other rights in the policy.

BATHING:

An ACTIVITY OF DAILY LIVING. Bathing is the ability to wash yourself, either in the tub or shower - including safely getting into and out of the tub or shower; or with a sponge.

BENEFIT AMOUNT:

Also called the benefit level. May be expressed as a daily, weekly, or monthly amount. This is the maximum amount a policy will pay for a day (or week, or month) of care. The Benefit Amount may be higher for nursing home care than for assisted living and/or home care.

BENEFIT ELIGIBLE:

Disabled or “impaired” according to the policy's BENEFIT TRIGGERS and eligible for the ELIMINATION PERIOD and other policy benefits to begin.

BENEFIT PERIOD:

Starts on the first day of benefit payments and ends when you no longer require care or have reached the maximum benefits allowed by your policy. The Benefit Period may be measured by a total number of days, years, or more commonly by calculating a total POOL OF MONEY which may last longer than the stated time period. Some older policies have separate Benefit Periods for facility and home care that cannot be combined if one or the other is used up first.

BENEFIT TRIGGERS:

The condition(s) or impairments you must have to be BENEFIT ELIGIBLE before the policy’s ELIMINATION PERIOD starts or other benefits begin. Think of these as the policy's "definition of disability". The three possible triggers are:

- Physical assistance as measured by a loss of ACTIVITIES OF DAILY LIVING (ADLs); or
- Supervision due to a COGNITIVE IMPAIRMENT; or
- MEDICAL NECESSITY (not common)

Most policies pay when any one condition is met. Policies requiring ADL limitations along with a COGNITIVE IMPAIRMENT are less likely to pay claims. Most policies, including TAX-QUALIFIED policies written since 1997 do not include the “medical necessity” trigger.

CARE COORDINATION:

Also called "case management" or “care management. A benefit included in many policies that helps policyholders and their families make informed choices about care needs and services once BENEFIT ELIGIBLE. Benefits are usually limited to a one-time or yearly maximum. Some policies only offer a toll-free number for phone consultation.

CASH BENEFIT:

A type of INDEMNITY (or PER DIEM) policy that pays the full contract benefit in cash, regardless of who provides the care, where or how often, and regardless of expenses incurred (or not). Receipts are not required. Some policies may pay facility benefits on an INDEMNITY basis, while paying home care as a REIMBURSEMENT. Cash Benefit may also be called "total home care".

CRITICAL ILLNESS:

An alternative definition used to describe benefits that are similar to, but not legally allowed to be called LTC insurance benefits. Sometimes referred to as a 101(g) benefit, Critical Illness benefits may be part of a life insurance policy allowing part of the death benefit to be paid before death if “critically ill”. A Critical Illness benefit defines an ADL loss as having to be “permanent” to trigger benefits - a limitation that could deny or substantially delay benefits that would otherwise be paid by a true LTC insurance policy. The “permanent” determination also opens the door for disagreements between medical professionals and the insurance company.

CHRONICALLY ILL:

Generally means BENEFIT ELIGIBLE. TAX-QUALIFIED LTC policies written since 1997 require that an insured be certified as "Chronically Ill" by a LICENSED HEALTH CARE PRACTITIONER to be considered BENEFIT ELIGIBLE:

- A "severe" COGNITIVE IMPAIRMENT requiring SUBSTANTIAL SUPERVISION; or
- Unable to perform without SUSTANTIAL ASSISTANCE at least 2 ADL's for a period of at least 90 days.

COGNITIVE IMPAIRMENT:

A deterioration or loss in mental capacity which requires supervision to protect yourself or others. It is measured by impairment in the following areas:

- Your short term or long term memory,
- Your orientation as to
  - person (who you are),
  - place (where you are),
  - time (day, date, and year), and
- Your deductive or abstract reasoning.

CONTINENCE:

An ACTIVITY OF DAILY LIVING. The ability to control urinary and/or bowel function. *(If incontinent, the ADL includes the ability to manage it with a reasonable degree of hygiene (or not).)*

COORDINATION OF BENEFITS:

The practice paying benefits only after other insurance or government agency has made payment. Sometimes called “benefit offset”. Most policies will coordinate with Medicare and workers’ compensation to avoid double-payment for the same service. Most policies do not coordinate with other LTCI policies unless written by the same carrier and specifically noted in the policy. Many policies will count Medicare-paid days toward satisfying the ELIMINATION PERIOD. (Under Medicaid, LTCI benefits are considered a form of income that pays first to offset Medicaid’s responsibility.)

COINSURANCE:

Also called co-payment, is a percentage of the cost of care that the policyholder must pay on every covered expense. A typical COINSURANCE is 20% meaning for every dollar spent on care, the policy will only reimburse $0.80. *This is not common.*

CUSTODIAL CARE:

Help with ADLs or supervision for COGNITIVE IMPAIRMENT. Non-skilled care. Custodial care may also involve HOMEMAKER SERVICES including preparation of meals, housekeeping, laundry, transportation, help with managing medicines, and other routine activities. Custodial care can be received at home, in adult day care, assisted living facilities, or nursing homes.

DAILY BENEFIT AMOUNT:

The maximum amount that will be paid for any one day of covered services. See BENEFIT AMOUNT.

DRESSING:

An ACTIVITY OF DAILY LIVING. Putting on and taking off clothing and any necessary braces, fasteners, or artificial limbs.

EATING

An ACTIVITY OF DAILY LIVING. Feeding oneself by getting food into the body, or by a feeding tube or intravenously. *(Meal preparation is not part of the Eating ADL. Choking risk could constitute a STAND-BY loss of the Eating ADL. If a feeding tube is required and the policyholder can manage it herself she can perform the Eating ADL. If assistance is needed to attach and properly clean a feeding tube, that would constitute a loss of the Eating ADL.)*

ELIMINATION PERIOD:

This is the policy's "deductible." Often abbreviated EP. Usually expressed as a number of days. You must be disabled based on one of the BENEFIT TRIGGERS for the EP to start. An EP is not simply a waiting period, rather it counts the number of days you are BENEFIT ELIGIBLE and receiving and paying for a covered service. For home care, one-hour of a covered, paid service will count for one day.

The EP may be different for nursing home care and home care. Newer policies only require the EP be satisfied once; older policies may require a new EP for separate periods of care. A policy may set a total dollar amount that must be spent before benefits begin, but this is not common.

EXCLUSIONS:

All policies specify certain situations in which they will not pay benefits. Common Exclusions are for care:

- Caused by war or act of war;
- From intentionally self-inflicted injury or attempted suicide;
- Paid by the government (other than Medicaid);
- For which no charge is made in the absence of insurance;
- Due to alcoholism or drug addiction;
- Received outside the United States; or
- Provided by a family member.

GRACE PERIOD:

How long you have to pay your premium after the due date before the policy lapses. The standard Grace Period is 31 days. This means that you have 31 days after your premium due date to make the payment without losing coverage. Some companies may extend this to 60 or more days.

If a policy lapses after the grace period, but it can be proven that the policyholder was suffering from a COGNITIVE IMPAIRMENT at the time of lapse there is an extended 180-day "Unintentional Lapse" reinstatement period.

GUARANTEED RENEWABLE:

The insurance company cannot cancel your policy for any reason except for not paying premiums. The policy benefits also cannot be changed by the company. If a policy is Guaranteed Renewable, it states this on the cover page. Most LTC insurance is Guaranteed Renewable.

Guaranteed Renewable does not mean that premiums are guaranteed. Premiums can increase. It is the coverage that is guaranteed as long as premiums are paid on time.

HANDS-ON ASSISTANCE:

Direct, physical assistance of another person, without which the disabled individual would be unable to perform an ADL.

HIPAA:

The Health Insurance Portability and Accountability Act of 1996 went into effect on January 1, 1997. In addition to strict medical information privacy rules, HIPAA established specific federal requirements that a LTC insurance policy must meet to be "TAX QUALIFIED". HIPAA grandfathered all policies issued before 1/1/1997 and are considered TAX QUALIFIED as long as the policy's schedule of benefits are not "materially changed". Policies issued after 1/1/1997 must state on the cover page if it is TAX QUALIFIED or not.[1]

HOME CARE:

CUSTODIAL CARE, private-duty services. Most policies do not use this term to identify CUSTODIAL CARE services as distinguished from skilled "home health care" services. See HOME HEALTH CARE below.

HOME HEALTH AIDE:

A person employed by a Home Health (or HOME CARE) Agency or working as an individual, who provides help at home with ADLs, cognitive impairment, and in some cases additionally HOMEMAKER SERVICES. A Home Health Aide may have additional training or certification to provide higher levels or care or service than a HOME CARE aide. A policy may use this as an all-encompassing term to cover a person who provides skilled and/or CUSTODIAL CARE services.

HOME HEALTH CARE:

In most policies this is an all-encompassing term. It is care provided by an agency or individual (if allowed by the policy) and includes services provided by a nurse, home health aide, nutritionist, or occupational, speech, respiratory, or physical therapist. It does not cover services provided by members of your family, or only companion care.

HOME HEALTH CARE generally includes custodial care services; it does not exclude private-duty home care and in most policies includes HOMEMAKER SERVICES.

HOME HEALTH CARE is not covered by all policies. When offered, the services may be covered as part of the policy, as an option or rider attached to a facility policy, or as a separate policy.

HOMEMAKER SERVICES:

Activities such as meal preparation, housekeeping, laundry, using a telephone, shopping, and driving/traveling outside the home are considered Homemaker Services. Help with HOMEMAKER SERVICES alone does not qualify a person for benefits to begin, but once BENEFIT ELIGIBLE most policies will pay for HOMEMAKER SERVICES.

Also called: INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

[1] IRC 7702B

INDEMNITY:

Also called PER DIEM. An indemnity benefit is a fixed amount paid when any care is received, regardless of the cost of care. A policy with a daily (or "Professional") indemnity benefit will pay the full contract benefit for each day any covered care is received and paid for regardless of the actual charges - receipts are still required. CASH BENEFIT indemnity pays the full benefit with or without professional care – receipts are not required.

See also CASH BENEFIT.

INFLATION PROTECTION:

An optional benefit that increases the BENEFIT AMOUNT (and the POOL OF MONEY) over time to keep up with the rising cost of care. Inflation increases can be "automatic" or "pay-as-you-go" purchase options. If a policy schedule shows an inflation benefit, the actual coverage available will likely be higher than shown

INFORMAL CARE:

Unpaid care. Care provided by family or friends. Most policies do not pay for informal care. A few policies provide limited benefits for informal care.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING: (IADLs):

Meal preparation, housekeeping, laundry, using a telephone, shopping, traveling outside the home, taking medications, managing money, preparing meals, doing housekeeping and laundry. Clients unable to perform one or more of these without assistance are said to have an IADL limitation.

These limitations may be early warnings of disability requiring long-term care, and evidence of IADL limitations may be used in the underwriting process to deny insurance to an applicant. IADL assistance does not qualify a person for benefits to begin, but once BENEFIT ELIGIBLE most policies will pay for IADL services that are considered HOMEMAKER SERVICES.

LICENSED HEALTH CARE PRACTITIONER:

A doctor, nurse (R.N. or L.P.N.), or licensed social worker.

LIFETIME BENEFIT LIMIT:

Most insurance companies set a limit on the maximum amount of benefits that a policy will pay, unless it is an “unlimited” or "lifetime" policy. These limits are set in terms of days, years or dollars. Most policies have a maximum POOL OF MONEY.

See BENEFIT PERIOD.

MEDICAL NECESSITY:

A BENEFIT TRIGGER on some older policies. Usually defined as care needed according to "accepted standards of medical practice" required by the patient's condition, specified by a "plan of care" written by a doctor, and not just for the convenience of the policyholder or family. *Some carriers have refused to pay benefits for CUSTODIAL CARE arguing it is not “medical” care.*

Medical necessity is not allowed in TAX QUALIFIED policies.

MENTAL/NERVOUS DISORDER:

Refers to a mental or emotional disease or disorder that does not have an "organic" origin.

Both Alzheimer's disease and other dementias are considered organic in origin; most policies cover these and should clearly say, "Alzheimer's Disease, senile dementia and other organic brain disorders" are covered by the policy.

Some policies exclude coverage for "nonorganic" mental and nervous disorders (generally psychiatric conditions) and disorders due to alcohol or drug-related problems.

MONTHLY BENEFIT AMOUNT:

If the home care BENEFIT AMOUNT is expressed as a Monthly Benefit, the policy will reimburse any covered amount per day until it reaches the Monthly Benefit maximum.

For example, a policy with a $100 DAILY BENEFIT AMOUNT will never reimburse more than $100 in any one day. An equivalent MONTHLY BENEFIT of $3000 ($100/day x 30 days) allows for higher reimbursements on high-usage days offset by days where little or no professional care is used. A MONTHLY BENEFIT policy of $3000 could therefore reimburse $200/day every other day.

OUTLINE OF COVERAGE:

A marketing outline with basic, legally-mandated disclosures about the policy. An Outline of Coverage is not detailed enough to be an acceptable policy evaluation tool for use at time of claim.

PER DIEM:

See INDEMNITY benefit.

PHYSICAL IMPAIRMENT:

Loss of (or need for help with) ACTIVITIES OF DAILY LIVING (ADLs).

PLAN OF CARE (POC):

A written POC is required by TAX QUALIFIED policies, but all insurance companies now make a POC part of their standard claim process even for older polcies. TAX QUALIFIED policies say the POC can be written by a LICENSED HEALTH CARE PRACTITIONER (LHP). In most cases the client can choose the LHP who writes the POC, or it may be a LHP on an agency's staff. A few policies require the POC be written by a company-appointed care coordinator. The POC must be updated whenever care services or schedules change. A carrier can request a POC monthly. Many agencies send a copy of the most recent POC with every claim submission, even if it has not changed.

POOL OF MONEY:

The maximum BENEFIT AMOUNT payable in dollars. Calculated by multiplying the daily (or weekly, or monthly) benefit by the BENEFIT PERIOD. A Pool of Money policy can pay benefits long than the stated BENEFIT PERIOD if not all the benefits are used each day (or week or month). Most policies have a single Pool of Money for all services - home or facility care, though there could be separate pools for each type.

PRE-EXISTING CONDITION:

An illness or disorder for which you received treatment during a specified period of time before the policy took effect - typically 6 to 12 months. A pre-ex condition is then not covered for a defined period of time after the effective date - typically also 6 to 12 months. Carriers do consider Pre-Existing Conditions during underwriting, and a pre-ex could cause an application to be declined. Once approved, most policies do not impose a pre-ex limit. Usually only seen in "guaranteed-issue" employer group policies where there was no underwriting.

PRIOR HOSPITALIZATION:

A STEP-DOWN provision that only pays for care if you are hospitalized immediately before needing long-term care services. A similar STEP-DOWN only pays for home care following a nursing home stay. Not allowed in new policies since 1993. Older policies may still be in-force with these limitations.

REIMBURSEMENT:

Benefits are paid up to the maximum BENEFIT AMOUNT based on what the policyholder actually spends on covered care. Reimbursement policies will only pay for charges and providers explicitly named and covered in the contract. This is the most common way policies pay for professional care services.

While rare, some older policies only reimburse for "Usual and Customary" charges rather than actual charges; reimbursement is likely to be lower than actual charges incurred.

REINSTATEMENT:

If the policy lapses by not paying premiums, and you later decide you want to reactivate it, the insurer may allow you to do so, but you will likely have to pass a new health underwriting review. See also: UNINTENTIONAL LAPSE.

RESPITE CARE:

Care provided by a paid caregiver as a replacement to care usually received at home from a family member or friend. Respite care is an additional benefit provided to give relief to a person who provides INFORMAL CARE. Respite care may be covered at home, in adult day care, or a residential facility.

RESTORATION OF BENEFITS:

A policy may reinstate - or restore - the full BENEFIT PERIOD/POOL OF MONEY if you fully recover (no ADL limitation) have not needed care for a period of time, usually 180 days. *Example: you have a 3-year policy, receive benefits for 1 year, and then recover and need no care for at least 6 months. The policy restores the year you used, and you have three full years of coverage available for a new disability in the future.*

Restoration of benefits may be included in the base policy, or may be an optional rider. In some cases only a percentage of the benefit amount you have used is restored.

SHARED BENEFITS:

Combines the BENEFIT PERIODS/POOLS OF MONEY of a couple into one larger shared benefit. If one spouse (or partner) uses up all of her maximum benefit, she can draw from her spouse's (or partner's) POOL OF MONEY to continue receiving benefits. If a spouse (or partner) dies without using all of his benefits, the unused POOL OF

MONEY rolls over to the surviving spouse/partner. Shared Benefits is an optional rider, or a single joint policy covering both spouses.

SHARED BENEFITS are available to unmarried "domestic partners", as well as gay and lesbian couples. Depending on the insurer, siblings or other family members who live together may also be able to share benefits.

STAND-BY ASSISTANCE:

The presence of another person within arm's reach that is necessary to prevent injury while the individual is performing an ADL. It is sometimes referred to as Supervisory Assistance. *An example is being ready to catch or steady an individual who may fall getting into or out of a bath or shower.*

STEP-DOWN PROVISIONS:

"Step-Down" provisions require a higher level of care before a lower level is covered. Examples include:

- PRIOR HOSPITALIZATION immediately before needing care services;
- Nursing home say before home care is paid;
- Skilled care must be received before CUSTODIAL CARE is paid.

Step-Down restrictions have been illegal to write into new policies since 1993. Older policies may still be in-force that contain these types of benefit limitations.

SUBSTANTIAL ASSISTANCE:

TAX QUALIFIED policies written since 1997 require that an ADL loss require "Substantial Assistance". Most polices will separately define Substantial Assistance, and most include either HANDS-ON or STAND-BY ASSISTANCE as being "substantial".

If a TAX-QUALIFED policy does not explicitly define Substantial Assistance, the US Treasury Department states that "substantial" includes either HANDS-ON or STAND-BY ASSISTANCE.[2] Policies can explicitly limit the definition of ADL assistance to only HANDS-ON which is more restrictive.

SUBSTANTIAL SUPERVISION:

TAX QUALIFIED policies written since 1997 require that a severe COGNITIVE IMPAIRMENT require "Substantial Supervision" as part of the COGNITIVE IMPAIRMENT BENEFIT TRIGGER.

Substantial Supervision is interpreted as meaning 24/7 supervision. This does not mean round-the-clock, paid professional care, but simply that someone, anyone needs to be present at all times for the client's care and safety. This can include a spouse, family or friends. The PLAN OF CARE for LTC insurance benefits should always describe all caregivers, professional and INFORMAL.

Policies issued before 1997 generally do not include the word "substantial" to gauge a COGNITIVE IMPAIRMENT claim. However some companies wrongly apply the "substantial", 24/7 standard to COGNITIVE IMPAIRMENT claims on these older, pre-HIPAA policies. Policies issued before 1997 that do not include the "substantial"

[2] IRS Notice 97-31, 1997-1 C.B. 417

language do not require that the supervision be 24/7 even though they are grandfathered as TAX QUALIFIED policies.

TAX QUALIFIED (TQ):

Policies that meet HIPAA's requirements for policy language and consumer protection standards. TQ policies are generally considered "health insurance" for tax purposes. They have guaranteed tax-free benefits (with limitations for INDEMNITY benefits), and the premiums may be deductible as a medical expense depending on the taxpayer's circumstances.[3]

TOILETING:

An ACTIVITY OF DAILY LIVING. Using a toilet to relieve bowels or bladder, including getting to and from as well as on and off the toilet with a reasonable degree of hygiene.

Note that if assistance is needed just to get on and/or off the toilet that would qualify the client for the TOILETING ADL. This is essentially the same as TRANSFERRING into/out of a chair. These two ADLs are commonly lost at the same time.

TRANSFERRING:

An ACTIVITY OF DAILY LIVING. The ability to get into or out of bed or a chair.

WAIVER OF PREMIUM:

When a policyholder is on claim, her premiums are "waived", not payable. Typically premiums are waived once benefit payments begin after the ELIMINATION PERIOD, though the premium waiver can start sooner or later depending on the policy. Future premiums are waived, and "unearned premiums" - premiums paid previously in advance that cover the time after the waiver starts - are refunded.

A policy may have different waiver of premium rules for nursing home and home care, or may waive the premium only for nursing home care. A "joint waiver of premium" waives both spouses' (or partners') premiums if only one needs care. Future premiums are waived

WEEKLY BENEFIT AMOUNT:

If the home care BENEFIT AMOUNT is expressed as a Weekly Benefit, the policy will reimburse any covered amount per day until it reaches the Weekly Benefit maximum.

For example, a policy with a $100 DAILY BENEFIT AMOUNT will never reimburse more than $100 in any one day. An equivalent WEEKLY BENEFIT of $700 ($100/day x 7 days) allows for higher reimbursements on high-usage days offset by days where little or no professional care is received. A WEEKLY BENEFIT policy of $700 could therefore reimburse around $175/day every other day.

WRITTEN PLAN OF CARE:

See PLAN OF CARE

[3] IRC 7702B