

KRAUSE FINANCIAL

Helping Clients Navigate the Modern Long-Term Care Insurance Policy

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1

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30+
Years of Experience

40+
Professionals on Staff

400+
MCA Cases Monthly

About Krause

Krause Financial is an attorney-led firm that provides asset preservation solutions for estate planning and elder law attorneys and their clients. Using our specialized insurance products, resources, and support, we help attorneys streamline the process of advising clients planning for long-term care.

Our Mission:

> Empower legal professionals to navigate long-term care planning with confidence.

2

Today's Goals

INTRODUCE the standard structure of the long-term care insurance (LTCI) contract.

DEFINE policy terms, benefits, exclusions and coverages

DISCUSS how to advise clients who are considering purchasing a policy or preparing a claim.

3



The LTCI Policy Structure

4

Traditional LTCI Policy Structure

Most insurance companies use the same structure for a traditional LTCI policy.



Benefits schedule



Required acknowledgements and disclosures



Policy



Any riders purchased



Submitted application

5

Hybrid LTCI Policy Structure

- A hybrid policy is structured as a two policies - life insurance then long-term care insurance policy or a long-term care rider
  - **Life insurance policy:**
    - Policy Data Pages for Life Insurance and Long-Term Care Benefits
    - Life Insurance Policy
    - Any Riders Purchased
    - Submitted Application
  - **Long-Term Care Policy or Rider:** same as traditional policy in most cases

6



Benefit Schedule

7

7



Benefit Schedule

Key benefit terms:

- **Benefit periods**: long term care insurance policies provide coverage for at least 12 months and most are between two and five years at the maximum monthly benefit.
- **Policy Limit**: maximum amount of money the policy will pay out for covered services. This is the key number as it will determine maximum monthly benefit amounts and periods.

8

8



Benefit Schedule

Key benefit terms:

- **Maximum Monthly Benefit or MMB:** highest dollar amount paid for all expenses incurred for **covered services** in a month.
- **Benefits at each care location**: maximum monthly benefits are listed by types of care – home health care, assisted living, nursing home.
- **Additional policy benefits**: can include respite care, hospice care, international benefits and the associated maximum monthly benefit.

9

9



Benefit Schedule

Key benefit terms:

- **Covered services:** this section will define whether the policy is an indemnity (stated dollar amount per day) or reimbursement (actual charges incurred)

Covered services means services or supplies you receive for which a benefit may be payable under your policy. You must incur actual charges in order for services and supplies to be *covered services*. A service must also be a *qualified long-term care service* in order to be considered a *covered service*.

10

10

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Your Elimination Period: 90 calendar days
Your Policy Limit: $180,000*
Your Maximum Monthly Benefit or MMB: $5,000*

*If these benefit amounts increase due to any inflation protection that may be part of your coverage, we will send you an updated policy schedule showing the change. The amounts shown do not reflect any benefits we may have paid under your policy. Any benefits we pay are deducted from your Policy Limit unless otherwise stated.

BENEFITS PROVIDED BY YOUR POLICY		
HOME HEALTH CARE BENEFITS		
Home Health Care Maximum Monthly Benefit	100% of MMB = $5,000 per month	
ASSISTED LIVING FACILITY BENEFITS		
Assisted Living Facility Maximum Monthly Benefit	100% of MMB = $5,000 per month	
Assisted Living Facility Bed Reservation Benefit	100% of MMB = $167 per day, up to 30 days in a calendar year	
NURSING HOME BENEFITS		
Nursing Home Maximum Monthly Benefit	100% of MMB = $5,000 per month	
Nursing Home Bed Reservation Benefit	100% of MMB = $167 per day, up to 30 days in a calendar year	
BASIC POLICY BENEFITS PROVIDED BY RIDER		**Your Premium**
Cash Benefit = $1,250 per month	Included	Basic Policy

11

11

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OTHER POLICY BENEFITS	
Respite Care Benefit Limit	Pays up to 100% of MMB for one month in a calendar year = $5,000
Hospice Care Benefit	Pays Home Health Care Benefits, Assisted Living Facility Benefits, and Nursing Home Benefits for Hospice Care
International Benefit Limit	Pays 100% of MMB up to an International Benefit Limit of 12 months = $60,000
Waiver of Premium Benefit	Included
Contingent Nonforfeiture Benefit	Included
CARE COORDINATOR BENEFITS	
Care Coordinator Benefit	*THIS BENEFIT IS NOT DEDUCTED FROM YOUR POLICY LIMIT*
Alternate Care Benefit	As approved by your Care Coordinator; subject to your Policy Limit
STAY-AT-HOME BENEFITS (AVAILABLE WHEN YOU USE THE CARE COORDINATOR)	
Caregiver Training Benefit	These benefits combined are payable up to your Stay-At-Home Benefit Limit of 2 times the HHC MMB = $10,000
Durable Medical Equipment Benefit	
Home Modification Benefit	
Medical Alert System Benefit	

12

12



Policy Provisions

13

13



Traditional Policy - Premiums

- LTCI policies will reserve the right to change the premium. However, the increase is generally limited to a full class with proper notice.
- A class is defined as persons that have the same application date, policy form, sex, issue age, issue year, rate classification, coverage and state of policy issuance as listed on the policy schedule.

14

PREMIUMS CAN CHANGE

The premium for your policy can change. We will not increase premium due to a change in your age or health or your use of the long-term care coverage. However, we can change premiums if we make the same change for all persons of the same *class*, but never more than once per year. We will notify you at least 60 days before we change premiums for your *class*. Your premium rates will also increase when you purchase additional coverage after the *policy effective date*, such as an increased level of inflation protection.

15



Traditional Policy - Premiums

- In most states, prior to issuing the policy the insurance company must disclose all previous class premium increases of the type of policy being purchased.

16

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Traditional Policy - Premiums

Premium Increase History

Mutual of Omaha Insurance Company has sold long-term care insurance since 1987 and has sold this policy form since 2013. The company has not increased its premiums on this policy, but has on similar policies in the last ten (10) years. There was a 30% or greater premium increase in 2022. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

Policy Form*	Years Available for Purchase	National Rate History
LT50/NH50/NHA/LTA/HCA	1997 - 2004	18% overall rate increase 2015
LT50/NH50/NHA/LTA/HCA	1997 - 2004	10% overall rate increase 2016
LT50/NH50/NHA/LTA/HCA	1997 - 2004	30% overall rate increase 2022
LTC04I	2004 - 2015	19% overall rate increase 2013
LTC04I	2004 - 2015	2022 rate increase range: 0% - 38%
LTC04G	2004 - 2014	22% overall rate increase 2013 (for issues prior to 8/1/2007)
LTC04G	2004 - 2014	2022 rate increase range: 0% - 38%
LTC04I7	2006 - 2009	2022 rate increase range: 0% - 38%
LTC09M	2009 - Present	2022 rate increase range: 0% - 38%
ICC13-LTC13	2013 - Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally. The availability, rate increase amounts, and dates of approvals vary by state.

*Or state equivalent.

17

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Contingent Nonforfeiture Benefit

If there is a substantial premium benefit increase then the policyholder has two options:

Choose a Reduced Benefit Amount

This will continue the policy at the then current premium amount but reduce the level of coverage

Convert The Policy To Paid Up Status

No further premiums will be paid and the policy limit for benefits will be reduced to the amount of the monthly maximum at the time of the increase or the total amount of premiums paid to that date.

18

18

Contingent Nonforfeiture Benefit

- A substantial premium benefit is defined in the terms of the contract by an increase in premium that exceeds the percentage of the initial premium based on the issue age of the policy holder.
  - Generally, the younger the issue age the higher the percentage of increase over initial annual premium for this to be triggered.

TABLE OF TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

Issue Age	Percentage of Increase Over Initial Annual Premium	Issue Age	Percentage of Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 – 34	190%	73	34%
35 – 39	170%	74	32%
40 – 44	150%	75	30%

19

19



Contingent Nonforfeiture Benefit

- Mark, 43 years old at issue date, has an **annual premium of $2,000**.
- The policy defines the substantial premium increase for this age range as **150% increase** over initial annual premium.
- If Mark, at age 73, his premium is increased equal to or **over an additional $3,000 per year** then the benefit is triggered.
- His new rate must be **$5000 or more per year**.

  $2000 x 150%= $3000 then $2000 + $3000= $5000
- If that happens what are his options?

20

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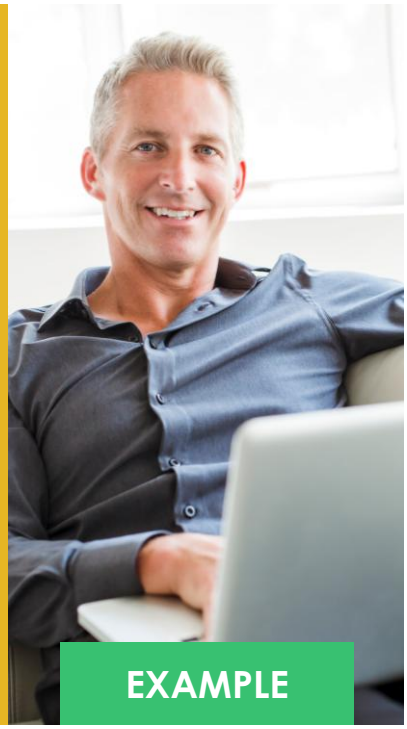

Contingent Nonforfeiture Benefit

- Mark has paid **$60,000 ($2,000 x 30) in premium** payments.
- If he chooses a reduced benefit amount his premium will **stay at $2,000** but the benefits will not be as robust as stated in the benefit statement.
- If he chooses to covert the policy to paid up status Mark will not pay any further premiums and **his policy limit will be capped at $60,000** at the maximum monthly benefit amount.
- In most cases, we recommend that they keep their coverage in force, even at a lower benefit amount. If he were to accept the paid up policy at $60,000 that will not cover very much in LTC costs.

21

21



Grace Period

- Policies allow a term of days prior to cancelling a policy. If the premium is paid within the grace period the policy remains in effect.
- If the premium is not paid during the grace period then the coverage will terminate as of the date the premium was due.

22

22

Grace Period

GRACE PERIOD

Your policy has a 65-day grace period. This means that if you do not pay the full amount of the renewal premium on or before the date it is due, you can pay it during the following 65 days. During the grace period, your policy will stay in force, as long as you pay the full amount of the premium due before the end of the grace period. The grace period operates as follows:

If you do not pay your premium within 30 days from the due date, we will send notice of lapse to you and the person you may have designated to receive notice of lapse due to non-payment of premium. We will send notice by United States first-class mail. You will have at least 35 days from the date of the notice of lapse to pay all premiums that are due. If you do not pay the premium during the grace period, coverage will terminate as of the date the premium was due, and we will not pay claims incurred on or after that date. The grace period does not apply if you cancel your policy.

23

23



Reinstatement

Once the grace period has passed and the premium has not been paid the insurance company has a few options:

- accept a late payment and continue the policy's effect
- if a request of reinstatement is made within a certain number of days from lapse (180 days) they may require a new application for reinstatement and require underwriting.

24

24

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Reinstatement Requirements

Submit application

Go through underwriting

Pay all past due premiums
(generally with interest)

25

25

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Reinstatement

If reinstated the policy will continue as originally purchased.

- Reinstatement protects the original policy premium rather than starting over at the reinstatement date with a new issue age.
- This is very important for hybrid policies, if not a single premium, to protect their cash value which is growing over time and if the policy is not reinstated as the original policy then cash value is lost.

26

26

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Reinstatement

REINSTATEMENT

Your policy will lapse if you do not pay your premium before the end of the grace period. If your policy lapses, you may request that we reinstate your policy. We must receive your request within 180 days from the date of lapse. We may or may not reinstate your policy at our option. If we accept a late premium without refunding it or requiring you to complete an application for reinstatement, your policy will be reinstated.

We may require you to complete an application for reinstatement and meet our underwriting guidelines. If we approve the application and receive payment of all past due premium, we will reinstate your policy as of the last premium due date. If we do not approve your application within 45 days of the date that we receive the application and all past due premium, we will reinstate your policy unless we have previously given you written notice of our disapproval of your request for reinstatement.

Your reinstated policy will only cover loss that results from cognitive impairment or loss of functional capacity that occurs after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the policy lapsed, subject to any provisions noted on or attached to the reinstated policy.

In the event of reinstatement, we may charge interest up to 6% on the overdue premium.

27

27

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Third Party Lapse Protection

A policyholder can designate a third party to receive notice that the premium on the policy is past due. The person can be changed at any time.

- Very important to keep up designation when policyholder and/or designee moves and mail may not be forwarded properly.
- If not paying monthly highly recommended as not being automatically withdrawn.

28

28

Third Party Lapse Protection



THIRD-PARTY NOTICE REQUEST FORM

This form is used to designate a person, in addition to yourself, to receive notice that the premium on your policy is past due and the policy is at risk of lapsing. If you wish to designate an additional person, complete the information below and return to the attention of Policyowner Services at the address above. You have the right to change this third-party designation at any time; however, you must submit the change in writing to Policyowner Services at the address below.

If you do not return this form to us within 30 days from the date of receipt, we will presume that you have elected not to change or designate a third party; however, you may change or designate a third party at any time in the future by submitting a request in writing to Policyowner Services at the address below.

29

29

Protection Against Unintended Lapse

If a policyholder has a lapse due to non-payment it can be reinstated if there is proof the non-payment was due to being chronically ill on or before the expiration date of the grace period.

- must give notice within the time stated in the policy (usually 180 days from the lapse)
- a health care provider must conduct an assessment
- all past due premiums will be due
- no additional underwriting needed if reinstated

30

30

Elimination Period

- An elimination period is the amount of time must pass after the benefits are triggered before the insurance company will pay.
- Most policies allow you to choose an elimination period of **30, 60 or 90 days** when you purchase the policy.
- During the elimination period, the insured is responsible for paying for their care. Medicare may pay during this time if coordinated properly.
- A rider may be added **Waiver of Elimination Period for Home Healthcare** to receive care at home during the elimination period.

31

Elimination Period

Sample Policy Language: Elimination period means the initial number of calendar days that you must be chronically ill before we will pay benefits under your policy. The elimination period begins on the first day you are chronically ill and receive a covered service. Subsequent days on which you are chronically ill will be used to satisfy the elimination period, even if you do not receive a covered service on those days. If you cease to be chronically ill during the elimination period, the elimination period will stop. The elimination period will resume on the next date that you are chronically ill and receive a covered service. The length of the elimination period is shown on the policy schedule. Your policy's elimination period must be satisfied only once in your lifetime. Any days for which Medicare pays benefits for qualified long-term care services can be used to satisfy the elimination period. The elimination period applies to all benefits unless otherwise stated in a specific benefit provision.

Service Days: Only counts the days in which a service was received

Calendar Days: Counts every day, following the calendar regardless if a service was performed that day

32

32



Making a Claim

33

Triggering Benefits

- Generally long-term care benefits are triggered when the policyholder is **chronically ill** and there is a plan of care written by a licensed health care practioner prescribing qualified long term care services.
- **Chronically ill** is a defined term but generally the policyholder must be either:
  - unable to perform **two activities of daily living** for a period that is expected to last at least 90 consecutive days due to loss of functional capacity; or
  - require substantial supervision to protect themselves from threats to health and safety due to **a severe cognitive impairment**.

34

34

Making a Claim – Chronically Ill

"Unable to perform at least two activities of daily living"

- **Bathing** – washing oneself by sponge bath or either a tub or shower including getting in and out of the tub or shower.
- **Continence** – ability to maintain control of bowel and bladder function and associated personal hygiene.
- **Dressing** – putting on and off all times of clogging and any necessary braces or fasteners, or artificial limbs.
- **Eating** – feeding oneself by getting food into the body from a receptacle or by a feeding tube.
- **Toileting** – getting to and from the toilet, on and off the toilet and performing associated personal hygiene.
- **Transferring** – moving into or out of a bed, chair or wheelchair but does not include mobility outside of the home or facility.

35

35

Making a Claim – Chronically Ill

- Activities of Daily Living (ADLs) vs. Instrumental Activities of Daily Living (IADLs)
- IADLs are insufficient to trigger LTC insurance coverage and are usually detected before ADLs as they involve problem solving skills and their deterioration can be early indicators of decline. That may require assistance from a family member or care provider even though they won't trigger insurance benefits.

IADL Examples:

- Meal preparation
- Home maintenance
- Medication and financial management
- Transportation

36

36

Making a Claim – Chronically Ill

- "*without* ***substantial assistance*** *from another person who is physically present with you*"
- Substantial assistance:
  - Hands on assistance means the physical assistance of another person without which you would be unable to perform the activities of daily living;
  - Standby assistance means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, injury while you are performing activities of daily living.

37

37



Making a Claim – Chronically Ill

- "*for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity*"
- Temporary loss of ability to perform ADLs must be expected to last at least 90 days (stroke with possibility of long term recovery)
- Loss of ability to perform ADLs does not have to be a permeant inability. Chronic illness riders do require the diagnosis be permanent.

38

38

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Making a Claim – Severe Cognitive Impairment

- **Severe Cognitive Impairment -** requires substantial supervision to protect themselves from threats to health and safety due to a severe cognitive impairment
- **Substantial assistance:**
  - Hands on assistance means the physical assistance of another person without which you would be unable to perform the activities of daily living;
  - Standby assistance means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, injury while you are performing activities of daily living.

39

39

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Making a Claim – Severe Cognitive Impairment

- **Severe Cognitive Impairment -** requires substantial supervision to protect themselves from threats to health and safety due to a severe cognitive impairment
- **Severe cognitive impairment:**
  - A loss or deterioration in intellectual capacity that is comparable to Alzheimer's disease and similar forms of irreversible dementia.
  - Requires measurement by evidence and standardized tests.

40

40

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Making a Claim - Process

Notice of Claim – generally a claim is started by calling the insurance company and follow the companies process for providing information. Generally, over the phone or through a written form.

Assessment – the insurance company will then request supporting medical records and also conduct an in-person interview.

Plan of Care – will describe the impairments, the type of care needed and who will be providing the care. It is written by a licensed health care practitioner and can be modified if conditions change.

41

41

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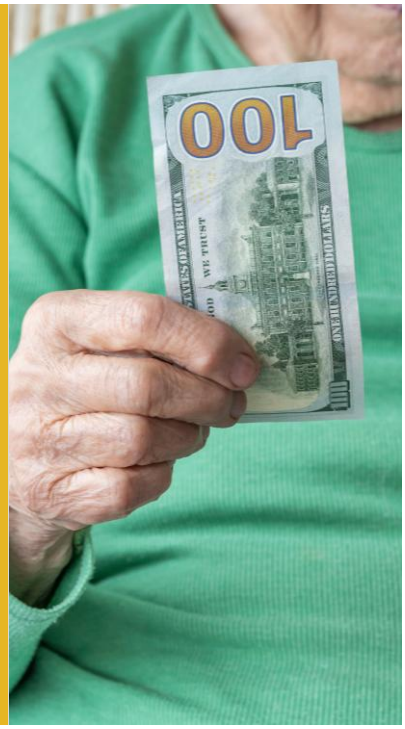
Care Coordination

- Many carriers offer care coordinator services to help clients navigate the claims process. You do ***not*** need to meet your elimination period to access these services.
  - A care coordinator can assist with the following:
  - Evaluating your specific needs for care and services
  - Developing your initial and subsequent plans of care
  - Helping you obtain the services and facilities outlined in the care plan
  - Monitoring your progress and the quality of care you receive on an ongoing basis
- Once your policy benefits are exhausted, the care coordinator will also assist with creating a transition plan.

42

42



Waiver of Premium

Once your claim has been approved, your premium is normally waived. Continue to pay your premium until your claim is approved. Failure to pay your premium could lapse your policy. If you have paid your premium, the carrier will reimburse any unearned premium on a prorated basis. If you recover and are no longer on claim, your premiums will start again.

43

43

Making a Claim - Appeals

- Appealing the Benefit Trigger Decision
  - A written notice will explain why it was determined that the benefit triggers were not met.
  - **Internal Appeal** – make request in writing within 120 days. Further information may be requested and a decision will be made within 30 days after information is received. If denied an independent review may be requested.
  - **Independent Review** – conducted by an organization from a list that the insurance company provides. The organization must be certified by the state to conduct reviews. The review is limited to benefit trigger decisions. The review is paid for by the insurance company and a decision is binding on them.

44

44



Common Riders

45

Common Riders

Inflation rider – allows policy benefits to grow over time to keep up with the rising cost of long-term care services. Benefits can grow at a simple or compound percentage. Standard inflation percentage is 3%.

Return of premium – provides for a refund of premiums paid, minus all benefits paid out, to a beneficiary if the policy is in effect when the policyholder passes away.

46



Questions

47



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Thank You!

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48