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CHAPTER ONE - LONG TERM CARE POLICIES

THE NEED FOR LONG TERM CARE

We have had many opportunities to stand before large audiences and present our long term care policy course. Probably the most disheartening survey we have ever conducted in front of an audience was to ascertain the following:

- How many in the audience have had a loved one in a long term care facility?
- How many in the audience currently have a loved one in a long term care facility?
- How many in the audience contemplate having a loved one in a long term care facility in the very near future?

To our amazement, an average of better than 70% of those in the audience raised their hands. Many of them were kind enough to take the time to share their sorrows with us concerning their loved ones and long term care. We have seen many teary-eyed audience members tell of the heartache and the financial devastation that long term care brought to their families. We hope this guide will give you a better understanding of long term care and perhaps convince you or someone you know of the need for this very important coverage.

I recall one story in particular where an elderly lady named Alice had recently lost her husband of 45 years. She got along relatively well for 8 or 10 years following his death. Her grown children, Mark and Helen, soon began to notice changes in her behavior. Alice used to pride herself on the fact that she could always balance her checkbook to "the exact penny". This was increasingly becoming a simple accounting principal she could no conquer.

One day, while at the doctor's office, Alice became lost and was more than an hour and a half late getting home. Needless to say, her children were frantic. Upon arriving home, Alice had her story all prepared. Although she knew that she had become lost

she convinced her children that she was window-shopping and time had just "got away from her".

Soon, her grandchildren began noticing drastic changes in her behavior. At family get-togethers, she would go off into a corner and withdraw and isolate herself. She had been having trouble with her arthritis and her eyes and everyone wrote it off to the medication she was taking.

One day, the reality of it all finally came to a head when her son, Mark, received a call from his mother. It was obvious she was upset and crying. She asked Mark if there was any money at home for her to take a cab? Mark inquired as to the whereabouts of her car. Alice went on to tell him that she had gone to the Division of Motor Vehicles to take her driving test in order to renew her license and that she had failed and the licensing officer would not permit her to drive her car home. Mark immediately left work and drove to the Division of Motor Vehicles to meet with the licensing officer.

The officer told Mark that not only did his mother incorrectly answer 80 percent of the questions, but also many were not answered at all. He went on to say that during the driving test, his mother was disoriented and lost her way.

Mark and Helen had a family meeting that evening and decided that it would be best to have their mother take a physical exam to determine what was going on. Following the exam the next week, the doctor told them that their mother had the beginning stages of Alzheimer's disease and that this situation was going to get progressively worse.

A couple of months later, Alice suffered a stroke, was unable to speak and could no longer care for herself. In a tearful moment at the hospital emergency room, Mark and Helen finally admitted to each other the real reason they were pretending nothing was wrong. It was because they had checked into the cost of a long term care facility and were amazed to find that it ran from $25,000 to $52,000 per year. They also admitted that neither of them would be able to put this additional financial burden on their families.

While preparing their mother for the nursing home, Mark found a policy neatly tucked away under some linen in his mother's closet. To his amazement, he found that his father, prior to his death, had purchased a long term care policy that included Alice. The policy paid up to $100 per day for life and was still in full force and effect since their father had paid for it in full at the time of purchase. Surely this is a case of a long term care policy being a lifesaver.

Let's see how they work.

SOME STARTLING FACTS

We had the privilege of having a Registered Nurse in one of our audiences. She asked if she could share some disheartening facts with us and we invited her to do so. She

told us that there were 120 folks in her long term care facility. Of those 120, she told us that 405 (or 48 people) were under the age of 65. Imagine 4 out of 10 people in this nursing home were under the age of 65. Our first question to her was for what reason were these 48 people admitted to a long term care facility? Three were teenagers who were brain-dead due to a serious automobile accident. The other 45? To our amazement, each and every one was there as a result of STROKES!

She went on to tell us that of the 120 patients, NOT ONE was paying for their care with a long term care policy benefit. Who was paying for the care? 29 of the 120 were paying with personal checks from their lifetime savings. 89 were receiving Medicaid benefits and 2 were receiving Medicare benefits that only pays for skilled nursing care.

Another misconception is the length of time a person stays in a long term care facility. They say it's 456 days. However, when we survey our audiences and ask them to shout out how long their loved one has been in a long term care facility, we get an average of OVER 9 YEARS! Where does the 456 days come from? It comes from the fact that over 50% spend less than 90 days in a nursing home and this distorts the real numbers that affect most people and do the most financial damage.

One factor that is rarely considered is the emotional damage that is done to an elderly person that is removed from loved ones and familiar surroundings to be placed in a long term care facility. Statistics show that the mental and physical health of a person improves dramatically if they could only stay at home.

WHO NEEDS LONG TERM CARE?

For the most part we feel that long term care is only for the elderly. Quite the contrary. In 1990, there were approximately 6.9 million Americans, 65 or older, who required long term care. And by the year 2030, that 6.9 million figure will be 19 million plus!

The 21st century will see a dramatic increase in the size of the older population as the larger baby boomer population retires. Studies show that, eventually, one out of every two of us may need some form of long-term care. Increasingly people will be turning towards private long-term care insurance to ensure access to quality affordable long-term health care.

A BRIEF HISTORY OF LONG TERM CARE

Long term care is not a new concept or idea. They first appeared on the scene in the early 1980s, but were very primitive in nature and had numerous stipulations, requirements and exclusions that put them into the "hit by a cow on the third of the month providing there was a full moon" category.

Insurance companies were reluctant to get into this market simply because there was no previous claims experience that they could follow. Actuarial science could not be applied and there were not records on who went into long term care facilities, when, for what, and how long. Needless to say, this posed major obstacles in the pricing of the product.

LONG TERM CARE AND STANDARD PROVISIONS

If you will recall the Medicare fiasco where elderly people were found to own four or five different Medicare supplement policies, when only one was necessary, you can appreciate the fact that the National Association of Insurance Commissioners are in the process of designing "standard long term care policies". The insurance companies will be required to sell the same type of policies with the same coverage and the same restrictions. This will eliminate confusing policy language and misunderstandings of exactly what is, and is not, covered. In all likelihood, some of the major standard provisions will probably be as follows.

- No prior hospitalization confinement necessary.
- All levels of care will be fully covered.
- Standardization of waiting and benefit periods.

WHAT TO LOOK FOR IN LONG TERM CARE

The most important feature to consider is what type of benefits the policy provides. The four most common long term care benefits are as follows:

1. Skilled nursing care.
2. Intermediate care.
3. Custodial care.
4. Home health care.

Let's review each of these so that you completely understand the differences.

SKILLED NURSING CARE

Skilled nursing care is the most expensive. It requires a prescription from a qualified licensed physician. The care must be continuous on a 24 hour a day basis and you are to be cared for by a Registered Nurse.

INTERMEDIATE CARE

Although a doctor's prescription is not necessary for this level of care, it does require medical care under the supervision of medical personnel. A Registered Nurse, Licensed Practical Nurse, or a Physical Therapist must administer it.

CUSTODIAL CARE

Custodial care assists the patient in meeting "Activities of daily living", also referred to as "ADLs". ADLs are as follow:

- Mobility.
- Dressing.
- Personal Hygiene.
- Eating.

HOME HEALTH CARE

Under this care, the patient is not confined to a nursing home and is usually able to care for him or herself. Usually a non-medical type person assists in shopping, meal preparation, and some physical therapy.

OPTIONAL BENEFITS

Some of the more common optional benefits are:

- Hospice.
- Adult Day care.
- Inflation Protection.
- Waiver of premium.

HOSPICE

This provides the terminally ill with comfort in their last days and does not prolong treatment of employ life saving devices. Typically a hospital bed is set up in the patient's home to keep them in familiar surroundings with family members their last days. Depending on the severity of pain or medical needs, home visits are made by Registered Nurses as well as Social Workers. This is a wonderful organization that provides care to the rich and poor and truly does make the last days as comfortable as possible.

ADULT DAY CARE

This care is usually given at a center that caters to those that are mentally or physically impaired. A typical day at the center provides social activity, medical care, meals and transportation to and from their home.

INFLATION PROTECTION

An important option is inflation protection. It provides for future increases in the daily benefit. Most policies offer a 5 percent increase in the daily benefit each year. Long term care is not immune to inflation and it is a safe assumption that nursing home care is going to do nothing but go up.

WAIVER OF PREMIUM

While optional, most companies include waiver of premium as a standard provision. Typically, once you have been confined and receiving benefits for more than 90 days, the policy premiums will be paid by the company.

HOW LONG WILL BENEFITS BE PAID

This depends entirely on the type of policy the insured purchased. The cost factor enters into this question also. Most companies offer benefits of from one to five years, some even for a lifetime.

PRE-EXISTING CONDITIONS

Most policies make provisions for pre-existing conditions. Most pre-existing conditions are measured by excluding any condition for which you were treated or given medical advice for the period of six months prior to the effective date of coverage. Additionally, the pre-existing clause continues for six months following the effective date of the policy. So in reality, you are looking at a year.

EXCLUSIONS

You must be aware of the exclusions that long term care policies contain. Claim time is not when you want to find out. In the early long term care policies, they would exclude Alzheimer's disease by saying that "the policy excludes diseases of an organic nature" which was their way of excluding Alzheimer's without mentioning the disease by name. This has since been rectified because Alzheimer's disease and other organic diseases are not covered in most policies that we have seen.

Here are some of the more common exclusions:

- Care given in a Veteran's Hospital.
- Losses that Workers' Compensation provides for.
- Mental psychoneurotic, or personality disorders that are not the result of organic or physical disease.
- War.
- Self inflicted injuries that are intentional.

LONG TERM CARE POLICY RIDERS

It is now possible to purchase a life insurance policy or a disability income policy and add long term care as a rider. The rider is very much like the standard long term care policy in that it affords you the same elimination periods, benefit periods and levels of care.

LIVING BENEFIT LONG TERM CARE RIDER

This rider permits terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness. Typically, this option will make available to the insured 70 to 80% of the death benefit they are entitled to cover the cost of nursing home care. Another option in this category is receiving 90 to 95% of the death benefit they are entitled to because they are terminally ill.

CHAPTER TWO - WHAT ROLE DO HOSPITALS PLAY?

NURSING HOME ALTERNATIVES

Contrary to popular belief, nursing homes are not places that families choose as their first option; they are a last resort. Families will struggle for years to keep their parents or relatives out of a nursing home.

With the exception of a stroke or accident, most conditions that incapacitate people start slowly and run their downhill course over a period of years. At the beginning, it is easy for a family to overlook the financial impact of providing care at some future date when the sick person's health has deteriorated. Family members tend to hope that they will somehow be able to manage at home.

Unfortunately, best intentions notwithstanding, people underestimate the physical, emotional, and logistical burdens created by trying to cope with a person who is seriously ill. If they do recognize these problems, the family often assumes that a hospital will be a resource when the time comes that they cannot handle the burdens. This is no longer the case. Here's why:

THE ROLE HOSPITALS PLAY

Hospitals have historically been paid through one of four sources:

1. Cash.
2. Medicare.
3. Medicaid.
4. Private insurance (such as HMOs and Blue Cross/Blue Shield).

CASH

A hospital stay in most metropolitan areas can cost up to a $1,000 or more a day depending on type of care.

MEDICARE

Medicare should not be confused with Medicaid. Medicare is the primary insurance plan that covers people on Social security. It pays for hospital and medical expenses. Medicare covers the vast majority of older people in hospitals.

Prior to 1984, Medicare paid whatever bills were submitted by the hospital for a person's care. The expense to the federal government was so enormous that in 1984 the system was drastically reformed.

The federal government established a reimbursement system called Diagnostic Related Groupings (DRGs). Under this system, Medicare pays the hospital a flat rate for a person's illness. If the hospital can stabilize the patient for a cost that is less than what Medicare pays, they keep the change. On the other hand, if the patient cannot be stabilized for the designated amount, the hospital usually pays the additional costs out of pocket. Therefore, there is a strong economic incentive for a hospital to move a patient out as soon as he is stabilized.

As a result, the word "stabilized" has a much different meaning today than it did prior to 1984. In the old days, a person could stay in the hospital almost indefinitely, until he either got significantly better or died. Today, stabilized does not mean that the patient has gotten better at all. It means that the hospital has determined that the illness won't get any worse.

A man was shocked at the treatment his mother received from a hospital. His mother had suffered a stroke and it was apparent to her son that she was still gravely ill. He felt that the hospital should keep her until she was "stabilized" and ready to go home. The hospital said she had to go. It was the hospital's opinion that she would not have another stroke and by their definition, she was "stabilized" and ready to be discharged.

Under the law, the hospital had the right to discharge his mother. She was discharged in a semi-conscious state, on a catheter, and with a feed tube going into her stomach.

The remaining two possible methods of payment are Medicaid and private insurance.

MEDICAID

Both the state and federal government fund this health care system. It is only available to the financially needy. Unlike Medicare, there are not deductible. It pays when nothing else will.

PRIVATE INSURANCE

There are numerous health care plans, which people can buy or which are provided by employers to pay for hospital care. Most private insurers now have a form of DRGs that they use to limit costs.

TAKING YOUR LOVED ONE HOME

Regardless of who pays for the hospital, one thing is certain; hospitals are no longer places to get better. Once the patient is stabilized, the family must quickly find another place to care for him. At that point, there are usually only two options left. Take the sick person home or put him into a nursing home.

When the sick person's illness or disability takes a mild form, home care may be a viable option for a while. But what happens when he cannot feed or clothe himself or take care of bodily functions without assistance? What if he is incontinent, in pain, depressed, unruly, or hostile? What happens when he cannot be left alone during waking hours? When he must be lifted from a bed to a wheelchair to the toilet and back?

What about the daughter who can't leave the house for twenty minutes because her mother might fall or set the house on fire? There is a saying about dealing with chronically ill people at home: Dealing with someone who is chronically ill eventually makes healthy people chronically ill. The caregiver becomes a virtual prisoner in the house. The world closes down. Life as it was before the illness is gone completely.

And who is the caregiver? The burdens of caring for our aging population fall disproportionately on women. It is usually the wife, daughter, or daughter-in-law who sacrifices her way of life to take care of the chronically ill family member. Often she has sole responsibility in this difficult task. Her life takes a back seat to the needs of the sick person who requires care twenty-four hours a day. She may quit a job and give up all her other activities outside the home. The stress on her is enormous.

The situation affects members of the family not directly responsible for giving care. Families have been known to fall apart over taking care of mother or father. Some marriages are driven to the brink of divorce by the tremendous pressure of coping with the problem.

While the ideal of caring for an incapacitated family member at home is what every loving family aspires to, the realities of the situation are often so difficult that no amount of love, sacrifice, or denial can make it work.

What is left is the last viable, though often least desired alternative: placement in a nursing home.

HOW THE NURSING HOME WORKS

Nursing homes provide three types of care as follows:

- Medically necessary care (which in many ways approximates hospital care), for which Medicare will pay.
- Skilled nursing care which provides patients with continuous care and assistance by nurses and other professionals.
- Intermediate care for those who need help with everyday routine activities.

Medicare or other types of medical insurance plans will not pay for skilled nursing care or intermediate care since they are considered custodial care. The yearly cost for this kind of care can run as high as $60,000 in the northeast and west coast to $25,000 in the south, southwest and Midwest. Many people have the mistaken idea that there exists some system or institution, which will pay these bills.

People sometimes assume that the Veterans' Administration will pay for veterans who need custodial care. They rarely pay unless care is required because of a service-related illness or injury.

SO WHERE DOES THE MONEY COME FROM?

Few people want to escape reasonable financial responsibility for unfortunate circumstances in their own lives. Most people are more than willing to pay their fair share. But in every situation, there comes a point when enough is enough. The central issue in preserving a family's wellbeing is the ability to have a measure of control when a catastrophic hits.

Make no mistake about it; if families do not take steps early on to protect their assets from the consequences of a long-term illness, they *will* lose control. When that

happens, there may be little or nothing left to provide for the surviving spouse and their offspring.

So we go back again to the question: Who pays for long term nursing home care? The answer will shock you.

- Private health insurance companies will not pay for custodial care.
- The Veterans' Administration, in most cases, will not pay.
- Health Maintenance Organizations (HMOs) or related insurance plans will not pay.
- Medicare will not pay.

In fact, there are *only three sources to pay for long-term nursing home care.*

- Cash
- Medicaid
- Nursing home insurance.

CASH:

At a national average cost of $25,000 a year for nursing home care, a recent American Association of Retired Persons (AARP) poll found that an average family's life savings would be wiped out within nine months.

MEDICAID:

No one likes to apply for public assistance. It is one of the great ironies that the very system that older Americans struggled for years to avoid, for many will be the only means to pay for nursing home care.

NURSING HOME INSURANCE:

Insurance companies are beginning to offer plans what will pay certain amounts towards daily custodial care for a period of years. These policies may be the right answer for those who fear the financial consequences of nursing home confinement but want to maintain control for as long as possible.

If you understand how these systems work, your life savings need not be wiped out. It *is* possible to protect your savings for a surviving spouse or to take care of your children should they need assistance in the future.

It's time to get educated. Let's look at the law and see how the law looks at your assets. The earlier you begin to plan, the better!

The following information, by nature must state only general principles because the federal government allows each state a certain amount of flexibility in applying the law. Be sure to determine how your state interprets the regulations. Also, regulations change constantly. Call your local Department of Public Welfare to see if the rules have changed.

CHAPTER THREE - THE UNKNOWNS OF MEDICAID

Under the current system, there are two factors that determine eligibility for public assistance: assets and income.

ASSETS:

Definition: Everything that you own that has value.

This definition seems simple enough. Medicaid, however, divides assets into three categories. Don't try to make sense out of why a particular asset falls into one category and not another. No one ever said that the Medicaid program was rational. In fact, it sometimes appears that Medicaid is as confused as we are in trying to figure out what they will take and what they will let us keep.

The three groups of assets are countable, non-countable and inaccessible.

ASSETS THAT APPLY:

These are also known as ***non-exempt assets***. There are things that Medicaid wants you to spend to zero before financial assistance is available to include:

- Cash over $2,000 (in most states)
- Stocks
- Bonds
- IRAs
- Keoghs
- Certificates of deposit
- Single premium deferred annuities
- Treasury notes and treasury bills
- Savings bonds
- Investment property
- Whole life insurance above a certain amount

- Vacation homes
- Second vehicles

Every other asset that is not specifically listed as non-countable is included in this list.

These are things that are in jeopardy when catastrophic illness strikes. In order to qualify for Medicaid, the applicant must in effect be BANKRUPT!

ASSETS THAT DO NOT APPLY:

These are also known as *exempt assets.* Believe it or not, these things can be worth hundreds of thousands of dollars but Medicaid has chosen not to count them in determining eligibility. The following assets are not in jeopardy.

- A house used as a primary residence (in most states, this can include two and three-family homes)
- An amount of cash (usually $2,000)
- A car
- Personal jewelry
- Household effects
- a pre-paid funeral
- A burial account (not to exceed $2,500 in most states)
- Term life insurance policies (as opposed to whole life) which have not cash surrender value

Life insurance is generally divided into two groups: whole life and term. Whole life has cash value which increases the longer you hold the policy. Although the insurance lapses when you stop paying, you receive cash value back. This is called the policy's surrender value.

Term insurance never builds up a cash value, but is worth only the face amount on the policy and then only when you die. Coverage stops when you stop paying. Most states allow you to keep unlimited term insurance when applying for Medicaid but only a limited amount of whole life insurance.

ASSETS THAT CANNOT BE TOUCHED:

These are countable assets, which have been made unavailable to Medicaid. To put it bluntly, *If you can't get them, they can't get them!* Assets are made inaccessible by:

- Giving them away
- Holding them in Medicaid trusts
- Holding them in certain types of joint accounts

- An involuntary situation where the person who owns the assets is too incapacitated to get access to them.

MEDICAID TRUSTS:

There are two kinds of trusts to consider: revocable and irrevocable. The difference between the two is that the first can be changed after it is set up, the second cannot.

A REVOCABLE TRUST:

A legal instrument that you set up to hold assets. There must be at least one trustee and one or more beneficiaries. A trustee is simply the person who makes the decisions for the trust. The beneficiary is the person who gets the benefit of the assets in the trust. Since you make the trust, you make the rules that the trustee must follow. If you don't like the trust, you can change it or do away with it. That's why it is called revocable. A revocable trust also acts as a will. The rules you make can include who gets your money and under what conditions after you die. While you are alive you receive the benefits. This kind of trust is useful in protecting your house, but it will not protect countable assets.

IRREVOCABLE TRUST:

Like a revocable trust, is a legal instrument that you set up to hold assets. Like a revocable trust, there must be one or more trustees and one or more beneficiaries. The definition of a trustee and beneficiary are the same as above. You can make the same rules. The difference is that once you've made the rules you cannot change them. By making it irrevocable you give up the power to modify or do away with the trust. Simply put, you lose control.

The only trust that will protect countable assets is an irrevocable trust but ONLY one that limits the amount of discretion a trustee has. These are called Medicaid trusts.

Congress passed a law that took effect in 1986 restricting the use of irrevocable trusts. It says that if you set up an irrevocable trust, name yourself as a beneficiary, and give the power to your trustee to give you all, some or none of the income and assets, Medicaid will assume your trustee will make all the income and principal available to you and thus the nursing home. It doesn't matter that your trustee can say, "I have the power to refuse to give the nursing home any money." Medicaid won't buy it.

The trust has to be set up in such a way as to limit the power of the trustee. If, for example, the trustee has no power to give you the assets, but only to hold them, Medicaid can't get them. It's the old principal, "If I can't get them, you can't get them."

Example:
An irrevocable trust that DOESN'T protect assets.

A husband and wife set up the Smith Family Trust. They name their son as the trustee and themselves as beneficiaries. They give the trustee the power to give them all, some or none of the principal and income. The day a parent/beneficiary goes into the nursing home is the day the "snapshot" is taken of the couple's assets. Since they gave discretion over the assets and income to the trustee, Medicaid assumes that the trustee will use his full discretion and make the assets and income available to the parent. In other words, the assets are considered countable, available, and therefore subject to division just as if they were not in trust.

Example:
An irrevocable trust that DOES protect assets.

A husband and wife set up the Smith Family Trust with the same trustee and beneficiaries. This time they don't give any power to the trustee to give them the assets, only the power to hold them in a trust while they generate income. The day a parent goes into the nursing home is the day the "snapshot" is taken of their assets. However, this time the assets in the trust are not in the snapshot because the trustee cannot make them available to the parent.

WHAT IS THE SPOUSAL IMPOVERISHMENT ACT?

The Spousal Impoverishment Act (SIA) supposedly protects a stay-at-home spouse (the person not going into the nursing home) by allowing him or her to keep certain amount of assets and income.

As of October 1, 1989, Medicaid treats marital assets this way:

- Medicaid determines the day a spouse goes into a nursing home or medical institution.
- Medicaid requires that the couple list all their countable assets regardless of whose name they are in, who earned them or how long they've been in either spouse's name.

- Medicaid takes a snapshot, a picture of the combined assets on the day the spouse goes into the nursing home or medical institution.

- The stay-at-home spouse is then allowed to keep one-half of the total amount of the assets in the snapshot, but **not less than $12,000 or more than $60,000.** This figure increases annually.

  Example:
  Glen is going into a nursing home on January 1st. He and his wife, Angie, have total assets of $20,000, $15,000 of which is in his IRA. Medicaid will take a snapshot of the couple's combined assets on January 1st. Angie will be allowed to keep one-half of $20,000. Since half of $20,000 is $10,000, she will be allowed to keep $12,000, the minimum.

To make matters a little more confusing, although the principles here are consistent across the board, the dollar amounts may vary from state to state. The law allows each state to set the amount the stay-at-home spouse may keep between a minimum of $12,000 and a maximum of $60,000.

For example, your state decides to raise the floor on the amount a stay-at-home spouse may keep of their joint assets. Rather than a floor of $12,000, you state may allow $40,000. What happens in your example when the floor is raised to $40,000? Angie would be allowed to keep the entire $20,000 because their state raised the floor from $12,000 to $40,000.

An application for Medicaid is usually not made on the day the spouse goes into the nursing home. Whether he or she will be able to qualify is determined by using the method described previously.

IF ASSETS HAVE TO BE SPENT DOWN BY THE INSTITUTIONALIZED SPOUSE IN ORDER TO QUALIFY, THE APPLICANT FOR MEDICAID MAY NOT TAKE PLACE FOR MONTHS. REGARDLESS OF WHAT THE TOTAL ASSETS ARE ON the day he applies, the stay-at-home spouse's share will always be determined on the day of the snapshot.

Example:
Joe and Martha have combined countable assets of $100,000 at the time Martha goes into a nursing home on January 1st. The snapshot is taken on January 1st. Joe's spousal share (the amount he is allowed to keep) is $50,000. Unless Martha buys non-countable assets or otherwise protects her money, she will have to spend $48,000 on her care. ($50,000 minus $2,000, the maximum assets she can keep.)

Let's say that Joe applies for Medicaid for his wife when there is $70,000 left of countable assets. All Martha would have to spend is $18,000. Why? Because Medicaid goes back to January 1st to determine what Joe's

share is ($50,000.) This amount deducted from $70,000 leaves $20,000 that Martha will have to spend. She is allowed to keep $2,000 of that amount.

INCOME

Definition:
Income is all the money you receive from any source. Like countable assets, it is in jeopardy.

This income may derive from one or a combination of the following:

- Social Security
- Interest and investments
- Trusts
- Rental Units
- Help from family members
- Pensions
- Annuities

In short, you name it, if you get it, Medicaid wants it.

Income eligibility is quite simple. In most states, if the person who is going into the nursing home has monthly income that exceeds the nursing home bill, he pays the nursing home directly.

If that person's monthly income is less than the nursing home bill, Medicaid has him give it to the nursing home and Medicaid makes up the difference. Most, if not all, of your income, regardless of where it comes from, for whatever reason you get it, will have to go to the nursing home.

Most states allow single people to hold back:

- A personal needs allowance
- A home maintenance allowance if they are planning to return home
- A monthly premium to pay for medical insurance

Income rules do not apply to the stay-at-home spouse. She is free to continue working and keep her salary and other monthly income such as Social Security. In addition the state usually allows the spouse to keep her half of the assets that generate income such as dividends, rent, etc.

The law requires states to set a specified amount the stay-at-home spouse make keep from total joint income. As of October 1989, the minimum is $815.00 per month, the maximum is $1,500 per month. The states have discretion in setting the amount within

those limits. The well spouse has the opportunity to increase the state-set amount if she can show that her housing expenses are unusually high.

Example:

Don and Gina's only income is $1,200 a month in social security. Of this amount, $1,000 is the husband's, $200 is the wife's. If Don goes into a nursing home he will be allowed to make the following deductions from his $1,000:

- A personal needs account (approximately $50 a month in most states.
- The premium for his Medicare supplement policy
- $615 monthly to supplement his wife's $200 a month since the minimum she is provided from the spousal income is $815.

Remember that Gina's income is unaffected. If she is working, all her salary remains hers. She does not have to make a contribution to Don's nursing home expense.

CHAPTER FOUR - SHIELDING INCOME

Most of an unmarried person's income cannot be protected from a nursing home or other long-term care institution. There are three exceptions.

He may keep:

1. A small personal needs accounts
2. Premiums for health care coverage
3. A home allowance in most states if he can show he will be coming home.

However, Medicaid makes a provision for married couples that allows the stay-at-home spouse to keep a minimum of combined income.

Under the Spousal Impoverishment Act, a non-institutionalized spouse may be allowed to keep a certain amount of his or her spouse's earned income. Income is defined as any money received from investments, pensions, social security, trusts, royalties, etc. received by either party. The minimum amount the states allow the stay-at-home spouse to keep is $815 per month; the maximum is $1,500 monthly plus certain additional allowances. As mentioned before, these amounts increase automatically each year.

The stay-at-home spouse may be entitled to additional monies if she can show that housing and utility expenses exceed 30% of the amount the state allows her to keep.

> **Example:**
> Lou and Cindy hare married with a total income of $2,200 a month, broken down as follows:
>
> Lou has $800 in social security and a pension of $1,200. Cindy has $200 in social security. If their state allowed Cindy to keep only the minimum of $815, she would be able to keep 4515 of her husband's income in addition to her $200.
>
> The rest would go to the nursing home with the exception of a small personal needs account for him and a deduction for his Medicare supplement payment. If their state allowed Cindy to keep $1,300 a

month she would then be allowed to keep $1,100 of his income in addition to her $200.

Note: The state allows a stay-at-home spouse to keep all her income including that earned from working and income from the assets she is allowed to keep. If Cindy has monthly income from a part-time job of $1,500, she does not have to give money to her husband; she just would not be able to get any of his income. In addition, Medicaid usually divides investment income in half. Our example uses the wife as the stay-at-home spouse, but the rules apply just the same if the husband is at home.

OTHER WAYS TO SECURE INCOME

Spouses who cannot survive financially on the allowance given to them by Medicaid can appeal directly to the state's welfare office. You must show that the income available is not sufficient to cover your needs because of extraordinary expenses or unusual circumstances. Be prepared to document your request.

Finally, SIA does allow the stay-at-home spouse to file a petition in the family or probate court that handles domestic relations to secure more income than Medicaid would allow.

The stay-at-home spouse may be entitled to additional monies (a shelter allowance) if she can show that the monthly maintenance allowance ($815 is insufficient to keep up her house. There is a formula that Medicaid uses to figure out the maximum additional allowance.

The figuring is complicated and best explained by an example:

Bob is in a nursing home and has qualified for Medicaid. His monthly income is $1,2000. His wife, Laura, continues to live at home. Her income is $450 from Social Security. The mortgage on the house is $600 per month and the utilities are $100 monthly.

Here are the steps that Laura should take to determine if she can get more than $815 a month.

- Add the monthly amount that Laura pays for her mortgage ($600) and utilities ($100) for a total of $700.
- Take 30% of $815, Laura's standard monthly maintenance allowance. That amount is $244.
- Deduct $244 from the total amount Laura pays for her mortgage and utilities ($700). $700 minus $244 equals $456, called her excess shelter allowance.

- Add $815 and $456 = $1,271.

- Deduct Laura's monthly income ($450) from $1,271.

- The figure arrived at in step 5 ($821.00) is Laura's new monthly maintenance allowance.

The question the stay-at-home spouse must ask is: Does she think that her monthly housing expenses eat up too much of her monthly maintenance allowance? Always assume that they do and use the above formula to see if you may be entitled to more than the minimum. In Laura's case, she can only get $6.00 more under this formula.

Remember, the only unquestioned increase that Medicaid allows in the monthly maintenance amount is to cover mortgage, rent, and utilities.

CHAPTER FIVE - PROTECTING YOUR HOMESTEAD

TRANSFERING YOUR HOME

Does owning your house jointly avoid a Medicaid lien?

Prior to July 1988, states had different interpretations of Medicaid regulations. Since Medicaid is funded 50% by the states and 50% by the federal government, each state felt free to adopt rules that suited its particular circumstances. As a result, there was little uniformity.

Although the states agree on little, everyone seems to support the notion that a person's home is a very special asset that should be given certain protections that ordinary assets don't have. Most states allow the primary residence to remain a non-countable asset even if no one lives there. Many states even allow the house to be transferred to family members or anyone else, not only within 30 months of requesting Medicaid, but even if the person making the transfer is on Medicaid.

But wait for a moment. Is it fair to allow a Medicaid recipient to transfer the house solely for the purpose of avoiding repayment for money paid on their behalf? Put another way, should the taxpayer be subsidizing inheritances? Most of us would answer no, with one exception; if the house being transferred belongs to our family member or friend.

Congress realized that the states did not have the political backbone to prohibit these transfers. If any state representative voted to place alien on a voter's property he wouldn't have a prayer of getting re-elected.

As of July 1, 1988, Congress mandated that the states adopt, within approximately a year and a half, the following rules regarding the transfer of a house:

FOR SINGLE PERSONS

A transfer of the house to anyone within 30 months of institutionalization or applying for Medicaid triggers a disqualification for Medicaid until either 30 months passes or the nursing home bills accumulate to the value of the house.

> **Example:**
> Howard has a house worth $65,000. He transfers it to his sister for one dollar on January 1st, 1990. He goes into a nursing home on January 1st, 1991. The nursing home charges $30,000 a year or $75,000 for 30 months. Since he transferred the house within 30 months, he will not be eligible for Medicaid until either July 1, 1992 or if/when his nursing home bills reach the value of his home ($65,000).

In this example, Howard will qualify for Medicaid prior to July 1st, 1992 because the nursing home bill for 30 months exceeds the value of the house. He can request assistance once the bill reaches $65,000.

FOR MARRIED COUPLES

Either spouse is allowed to transfer without penalty his or her interest in their home to the other spouse at any time, even while on Medicaid. However, the spouse who becomes sole owner of the home MAY NOT be able to transfer it to another party. To do so might trigger the 30-month disqualification rule for the institutionalized spouse.

However, if the institutionalized spouse dies, the surviving spouse is free to transfer the property without penalty. In other words, even though Medicaid paid, the house cannot be used for reimbursement.

> **Example:**
> John and Beth are married and own a house jointly. Beth goes into a nursing home on June 1st 1991. She is allowed to sign over her interest to her husband even though she may request Medicaid within 30 months. John may not be able to transfer the property while his wife is alive. After she passes away, however, he is free to transfer the house without a lien.
>
> - If Beth dies having been on Medicaid, and John dies with the property in his name, Medicaid will put a lien on the property.
> - If John dies before Beth, and doesn't change his will (which like most husbands leaves everything to the wife), the property immediately goes to her and is subject to a lien at her death.

EXCEPTIONS TO THE RULE

Medicaid allows certain exceptions to the above prohibition against transferring houses. A single person or married couple can transfer a home to:

- A child who is blind, disabled, or under 21.

- A sibling who owns a share of the home and has resided there for at least one year before the co-holder goes into the nursing home.

- A child of any age who has resided in the home for at least two years before the parent's institutionalization and can show that he has cared for the parent at home.

- Anyone at any time as long as it is for fair market value.

- Anyone, providing the purpose of the transfer is not to qualify for Medicaid. For example, a person gives his house to his children while healthy for the purpose of avoiding probate or estate taxes. Later he is permanently disabled in an accident and is forced to go into a nursing home within 30 months of making the transfer. This transfer would probably not disqualify him for Medicaid.

One last possibility; Even though the transfer of a house would ordinarily disqualify a person for Medicaid, he may still receive benefits if he can show that he would suffer undue hardship by not being granted benefits. This alternative is very unusual and is rarely accepted by Medicaid.

PROTECTING YOUR HOUSE WHEN YOU HAVE TIME TO PLAN

There are four options for protecting your home if you have 30 months or more to plan. They are:

- ❑ Give away the house
- ❑ Give away the house with a life estate
- ❑ Put the house in trust
- ❑ Hold the house jointly

GIVING AWAY YOUR HOUSE

A person is free to give a house to whomever he chooses and later qualify for Medicaid providing the transfer takes place at least 30 months prior to institutionalization of application for Medicaid. There are three considerations before you do this.

- First, giving your home away leaves you with no control. There are more than a few cases of a daughter who has tried to have parents evicted from their home or a son who has lost the house through bad investments or a divorce.

- Second, while you may trust the person or persons to whom you give your house, you sacrifice the one-time $125,000 exemption from capital gains taxes (assuming you are over 55) if you later decide to sell the house.

- Third, by giving away your home, you pass on to the receiver a greater capital gains tax liability when the house is sold. Capital gains is the difference between the basis (what you paid for the house plus what you paid for major improvements) and the sale price. Most older Americans paid relatively little for their homes and have seen their homes appreciate greatly in value. They have a low basis relative to the value of the house, which means higher taxes. This basis is passed on to the recipient of the house. When she later sells the property at fair market value, she pays a substantial tax on the capital gains.

GIVING AWAY THE HOUSE WITH A LIFE ESTATE

When a person gives away his house he may make a provision that he keep an interest in the property for the remainder of his life. That interest may take the form of a life estate through which he has a lifelong right to live in the home as well as to receive any income or benefits that may accrue from the property.

A life estate does not mean that you *own* the property; it means that you have an *interest* in the property that ends when you die. Medicaid can only place a lien on your property to recoup nursing home expenses if you alone legally own the property when you die. Assuming that you absolutely, positively, are willing to stake your life on the integrity of the person you want to hold your house, a life estate is a very good way to protect your house from a Medicaid lien.

In addition, there are significant tax advantages. You may be able to claim a portion or all of the capital gains exemption if the property is sold during your life. The recipient also avoids the problems we discussed above when the house is eventually sold. See your accountant for a complete explanation of the tax savings.

SHOULD YOU PUT YOUR HOUSE IN TRUST?

For an explanation of different kinds of trusts, please refer back to the previous chapters. You will recall that revocable trusts can't be used to protect *countable* assets. But remember your house is a *non-countable* asset. Therefore, placing it in a revocable trust (even though it's an instrument you fully control) does not in most states jeopardize Medicaid eligibility.

In most states, liens are not placed on the Medicaid recipient's home until he dies and then only if the property is in his name only. A home placed in a revocable trust is owned by the trust, not the Medicaid recipient. It stands to reason that if there's nothing in the recipient's name no lien can be attached. (Be sure to check with an attorney to see how your state treats revocable trusts.)

THE ADVANTAGES OF A REVOCABLE TRUST:

- Gives the trustee absolute control over the property during his lifetime.
- Does away with the need for a co-owner of the property.
- Gives the person who set up the trust (if over age 55) the entire $125,000 capital gains exemption if the property is sold during his lifetime.
- Avoids probate.
- Minimizes capital gains.

Note: In some states legislators are considering placing liens on homes when the applicant first goes into a nursing home. Therefore, although the house can be transferred, the lien goes with it. When the house is sold, Medicaid would get reimbursed. Be sure to check with your Department of Public Welfare to find out what regulations apply in your state.

JOINT OWNERSHIP

A single or widowed person may consider holding his house jointly with the person who will eventually inherit it. However, joint ownership is both impractical and dangerous. Impractical, because you no longer have full control over the property. Dangerous, because the co-holder may go into a nursing home before you do.

For example, if Medicaid does not consider the house the primary residence of the institutionalized co-holder, it would have to be sold and one half the proceeds spent on his nursing home bills.

Another problem, you may decide to sell the house. Co-holding costs you at least one half of the capital gains exemption (assuming you are over age 55).

Other problems, what if your co-holder gets a divorce and the house is considered part of the couple's common property? Or your co-holder may get sued.

If you must hold property jointly, make sure you do so with a younger person such as your son or daughter, and insist that he or she enter into an agreement with the spouse that exempts the property from their joint marital assets.

AVOIDING A LIEN

In most states, joint ownership of real estate avoids a Medicaid lien since a lien attaches only to property that is owned individually. The two most common forms of co-ownership are joint tenancy (Steve Smith and Carl Jones) and tenants in common (Steve Smith or Carl Jones).

Joint tenancy means that if Steve dies, Carl automatically gets his share of the property and vice versa. Tenants in common means that if Steve dies, his heirs get his share automatically, not Carl, and vice versa.

Property held in joint tenancy in most states is protected from a lien because the share belonging to the deceased co-owner never goes through his estate. Instead, it goes automatically to the surviving co-owner. Not so with tenants in common. The share belonging to the deceased co-holder goes through his estate, which immediately makes it available for a lien.

If you are single, as a way of avoiding a Medicaid lien, you may choose to hold your home in a joint tenancy with someone else.

Warning:

States have varying regulations covering this issue. Your state may not agree with the above interpretation. They may hold that a lien attaches to the deceased's one hold share even though it doesn't go through probate. Be sure to check with an attorney or your local welfare office.

THE PITFALLS OF PROCRASTINATING

No time to plan means that a person will be going into a medical institution or nursing home or requesting Medicaid within 30 months of transferring his home.

MARRIED COUPLES

There's no problem here since the law allows the person going into the nursing home to transfer his interest to the spouse even while on Medicaid. Under present regulations, the spouse who now has the house in her name can give it away or sell it while her husband is alive or after his death without penalty.

SINGLE PEOPLE

Transferring your house within 30 months of going into a nursing home poses a difficult situation for single people. Your best option is to see if you fall into any of the exceptions mentioned earlier. If you don't, here is a grim option.

Don't try to transfer the house at all if it is worth a great deal of money, (say, over $200,000). Medicaid will place alien on it when you die. But since Medicaid usually pays only half of the private daily rate, the bite out of your estate will be less than if you pay privately for institutionalization.

For example, if a nursing home charge private pay patients a $100 a day, the rate that Medicaid pays for the same person is about $50. Upon your death, your family will have to pay the lien, but it's only half of what the private rate would have been.

The only problem is that your state may have adopted the federal regulation which mandates that a primary residence be sold after six months of institutionalization if the patient cannot show that he will be returning home.

Example:

George is divorced with three children. His only asset is his house, which is worth $200,000. On January 1, 1991, he will need nursing home care. Cost, $3,000 per month. He transfers his house to his children on June 1, 1990. George will be disqualified from receiving Medicaid benefits either for 24 months or until the cost of the nursing home equals the value of his house ($200,000).

Either way, George has to sell his home to come up with $72,000 (24 months x $3,000.) Add to this the capital gains tax, and his children will receive very little when they are forced to sell the house. However, this is the family's maximum exposure ($72,000 plus capital gains tax).

What if George keeps the property in his name? Sure, there's a lien on the house upon his death, but Medicaid is running up a bill at only one-half the rate that George would be running up as a private patient. As long as George does not stay in a nursing home for a long period of time, this option will save money.

However, if his stay extends for more than four years, this option becomes more costly than simply selling the house. Why? Because, four years of nursing home care at a Medicaid reimbursed rate of $50 a day ($18,250 a year) would equal $72,000, the maximum exposure (excluding taxes) in the first example. Therefore, after four years, this option provides no savings.

CHAPTER SIX - THE LEGAL SYSTEM

In this chapter, we will discuss how assets can be handled if you know that at some time in the future you will not be able to manage your own financial affairs. It is also for people who are making arrangements for friends or relatives who cannot presently handle their financial affairs.

POWER OF ATTORNEY

A power of attorney is a legal instrument that gives to another or others the right to handle financial affairs. Typically, a person will create a power of attorney to give another the right to have access to a bank account or to sell stock on his behalf. The person given this responsibility does not have to be an attorney.

A *regular power of attorney* usually gives specific and limited powers like the ones mentioned above. It usually does not have an expiration date but ceases the minute you become incapacitated.

A *durable power of attorney* is exactly the same except that it remains valid even if you become incapacitated. It can be very effective in planning to protect assets which otherwise would have to be spent on a nursing home.

> **Example:**
> Scott is a widower with two children. He has $50,000 in cash and $10,000 in stock in his name only. His wife recently died in a nursing home. He is concerned about protecting his assets if he needs long-term care but does not want to give up control while he is still healthy.
>
> Scott could simply put his children's names on his assets. However, if one of his children got divorced or got into financial trouble, his assets could be in jeopardy.
>
> Or he could make up a durable power of attorney giving authority to one or both offspring to get at his assets should he become incapacitated. If he became ill and couldn't get at his assets, let alone manage them, his

children could use the power of attorney to close out the accounts and transfer the assets to their names.

Warning: giving a power of attorney is giving away control. It is not advisable to do this unless absolutely necessary. It is best to give it to someone who is trustworthy to hold until it is needed. Instructions should be given about how and when it will be used.

If your state allows it, consider putting two people on the power of attorney so there are checks and balances.

Consider a "springing" durable power of attorney. This instrument is valid only when you become incapacitated unlike a regular or durable power of attorney, which becomes effective the moment you sign.

Make sure you update!!!

THE BIGGEST MISTAKE LAWYERS AND FINANCIAL ADVISORS MAKE WHEN RECOMMENDING POWERS OF ATTORNEY IS TO FORGET TO INFORM THEIR CLIENTS THAT MOST FINANCIAL INSTITUTIONS WILL NOT ACCEPT THEM AFTER A PERIOD OF TIME. THERE IS NO SET POLICY ON WHEN THE INSTRUMENT BECOMES "STALE." Remember, a power of attorney is only as good as a person's or institution's willingness to accept it. Update by rewriting it (if only by changing the effective date) at least every two years.

CONSERVATORSHIPS

A conservatorship usually means that a person has requested of an appropriate court permission to handle the assets and affairs of someone who is incapacitated (the ward). Anyone can be named a conservator. In some states the ward can participate in choosing a conservator.

Once the court appoints a person, she becomes responsible for handling the assets in approximately the same way the ward would. Conservatorships are almost useless in protecting assets unless the ward has at least 30 months to plan to protect countable assets.

A durable power of attorney would be just as effective as a conservatorship at a fraction of the cost and without having the court and the world know your business.

Conservatorships are most effective when a person becomes so ill that long-term management of his/her assets is necessary. Readers of this book who have acted on what they have learned should not find this alternative attractive or necessary.

Those with relatives who are already ill and who may need a nursing home down the road may think that a conservatorship is the answer. The problem is that Medicaid planning in practice means taking the assets out of the ward's name.

A conservatorship, by definition, means keeping the assets in the ward's name but under the legal control of the conservator. Therefore, a conservator never gets assets away from Medicaid, but rather, *preserves them for Medicaid.* Conservatorship therefore should not be considered unless you consult with an attorney who understands Medicaid.

GUARDIANSHIPS

A guardianship is the same as a conservatorship except that the court grants to the guardian control of the ward's body as well as his assets. The guardian requests that the court grant power to make decisions about such things as medication, treatment, and even matters of life and death.

On the subject of protecting assets, it is enough to say that a guardianship has the same advantages (not many) and disadvantages (many) as a conservatorship.

CHAPTER SEVEN - UNDERWRITING AND LONG TERM CARE POLICIES

SOURCES OF INFORMATION

The underwriting process employs four important sources of information.

- The application
- The agent
- Verification reports
- Medical records and history

THE APPLICATION

Obviously, the application provides the company with the basis upon which they will make the decision to issue a contract. Questions need to be answered in full with honesty and integrity.

THE AGENT

Years ago, you were permitted to take applications by mail or phone so long as they were signed by the applicant. Today, however, companies what to know that the agent actually sees the applicant and assists in the field underwriting. You will be able to make observations unavailable to the home office underwriter.

VERIFICATION REPORTS

The verification reports provide investigative information to verify statements made by the applicant. These reports also sometimes produce additional information or problems that may not have been listed on the application.

MEDICAL RECORDS AND HISTORY

Often, companies employ the Medical Information bureau (MIB) as well as Attending Physician's Reports, (APR's) in verifying medical records and history. Obviously, this information is extremely important in the underwriting process.

SUBSTANDARD UNDERWRITING

Not all applications are approved as submitted or issued standard. Often, the applicant is required to pay more than the standard premium in order for the company to absorb certain hazards or risks. Factors that directly affect whether the policy will be issued standard or substandard are:

- Pre-existing conditions
- Age
- Occupation (if applicable)
- Moral issues
- Current, past and possible future medical conditions

CHAPTER EIGHT - POLICY PROVISIONS

POLICY PROVISIONS

Years ago, the National Association of Insurance Commissioners developed a model Uniform Policy Provision Law. They established 23 policy provisions of two types. 12 that are required to appear in all policies and 11 that are options and may be used at the discretion of the insurance companies to better customize their policies. One rule that is strictly enforced is that no substitute language may be used in any provision unless the substitute language is in favor of the insured.

12 REQUIRED POLICY PROVISIONS

- Entire contract
- Time limit on certain defenses
- Reinstatement
- Claim forms
- Grace period
- Notice of claims
- Time payment of claims
- Proof of loss
- Claimant payment
- Autopsy or physical exam
- Change of beneficiary
- Legal action

ENTIRE CONTRACT

A policy including all attached papers constitutes the entire contract. Riders, endorsements and changes must be approved in writing and executed by an officer of the company. The agent does not have permission to change or waive any policy provision.

TIME LIMIT FOR CERTAIN DEFENSES

This provision is more commonly referred to as the "period of incontestability". It is usually two years in length. Should an application contain any fraudulent statements, the policy's period of contestability shall be extended to the life of the contract. The only exception is a "guaranteed renewable policy" in that once the period has expired, the policy cannot be contested even if fraudulent statements were made on the application.

RE-INSTATEMENT

A policy that has lapsed may be reinstated under certain conditions providing the proper procedure is followed. Some companies require an application for reinstatement, which may or may not be approved.

CLAIM FORMS

Companies are required to supply you with a claim form within 15 days after receiving a claim. Should they not meet this requirement, you may submit proof of loss on any form you choose.

GRACE PERIOD

Normally, 31 days this is the time the company gives you to make a delayed payment without penalty and with the policy remaining in force. Should payment not be made by the end of the grace period, the policy will lapse and/or terminate.

NOTICE OF CLAIMS

You are required to notify the company within 20 days or as soon thereafter as is reasonably possible.

TIME PAYMENT OF CLAIMS

This provision stipulates that "the company must pay the claim immediately". Usually payment of claim is made within 60 days.

PROOF OF LOSS

You are given 90 days in which to submit proof of loss. Should you be unable to meet this 90 days deadline, your claim will not be affected if it was reasonably possible for you to do so.

CLAIMANT PAYMENT

Payment for losses of life would be made to the designated beneficiary. Should a beneficiary not be designated, the payment will go to the insured's estate. Also the insured has a right to request a payment be made directly to the hospital or physician that rendered services.

AUTOPSY OR PHYSICAL EXAM

The company can request at its own expense, physical exams. So long as law does not forbid it, the company has a right to request an autopsy on the body of the insured.

CHANGE OF BENEFICIARY

The insured has a right to change the beneficiary at any time except if an irrevocable beneficiary has been designated.

LEGAL ACTIONS

Should you have a dispute with the company in regards to a claim, you must wait at least 60 days and no longer than 5 years to take legal action.

THE ELEVEN OPTIONAL POLICY PROVISIONS

1. Misstatement of age
2. Unpaid premiums
3. Insurance with other insurer
4. Cancellation
5. Change of occupation
6. Other insurance with this insurer
7. conformity with state statutes
8. Relation of earnings to insurance
9. Illegal occupation
10. Intoxicants and narcotics
11. Insurance with other insurers

MISSTATEMENT OF AGE

If an applicant misstates his/her age at the time they are applying for coverage, any benefit due them will be adjusted to reflect what would have been purchased had the correct age been stated in the first place.

UNPAID PREMIUM

Should a claim become due and payable while a premium remains unpaid, the premium due will be subtracted from the claim amount due and the difference will be sent to the insured or designated beneficiary.

INSURANCE WITH OTHER INSURER

So as to avoid over-insurance and if the company finds that there was other existing coverage for the same risk, the excess premiums will be refunded to the policyholder.

CANCELLATION

The company has the right to cancel the policy with 20 days written notice to the insured and the insured may cancel the policy following the expiration of the policy's original term.

CHANGE OF OCCUPATION

After a policy has been insured should the insured change to a more hazardous occupation that would require an increase in premium and the insurance company is not notified and a loss occurs, the benefit paid will be reduced. Should the opposite occur, and a loss occurs, a refund will be made to the insured for the excess premium.

OTHER INSURANCE WITH THIS INSURER

To avoid over-insurance and limit a company's risk, coverage written on one person is restricted to a maximum amount no matter how many separate policies the insured has. Premiums that have been applied to the excess coverage will be refunded to the insured or to their estate.

CONFORMITY WITH STATE STATUTES

Should any part of a policy conflict with state statutes in the state where the insured resides, the policy shall automatically amend itself to conform to statutory requirements.

RELATIONS OF EARNINGS TO INSURANCE

If at time of disability, monthly benefit amounts due exceed the insured's monthly earnings or the average of his earnings for the previous two years, the company is only liable for the amount that is proportionate to the insured'' earnings under all such coverage.

ILLEGAL OCCUPATION

Policy benefits are not payable if the insured has a loss while committing a felony or being connected with a felony or participation in any illegal occupation.

INTOXICANTS AND NARCOTICS

Should the insured be under the influence of narcotics or intoxicated, unless such were administered on the advice of a physician, the company is not liable for any losses.

CHAPTER NINE - NON-FORFEITURE OPTIONS FOR LONG TERM CARE

As the popularity of long term care policies grow, the insured is going to have to be afforded non-forfeiture options that protects their policy and benefits and protects t hem from forfeiting same.

Life insurance policies currently contain these three non-forfeiture options, but, the wording of these non-forfeiture options will be different for long term care policies.

THE THREE NON-FORFEITURE OPTIONS:

CASH VALUE

This would provide a guaranteed amount to be paid to the insured should the policy be surrendered or lapsed.

REDUCED PAID UP

This would provide that the daily benefit be reduced for the policy's benefit period and that the insured not be required to continue payment of premiums.

EXTENDED TERM

Extension of coverage for the full amounts that the policy would have ordinarily paid without any future payments of premiums for a limited extension of time.

Another type of non-forfeiture options that has come upon the long term care scene is a cash back feature. Under this provision and insured might typically receive 50, 60, 70,

or 80% of total premiums paid upon discontinuing the policy either by surrender or having the policy lapse. Of course, as is the case in most cash back features, claims paid are deducted from the amount of returned premiums.

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