

Consumer Guide to Long-Term Care Insurance

Helping Montana seniors and their families make informed decisions about long-term care



COMMISSIONER OF SECURITIES & INSURANCE

MATT M. ROSENDALE
COMMISSIONER



OFFICE OF THE
MONTANA STATE AUDITOR

Dear Montana Senior:

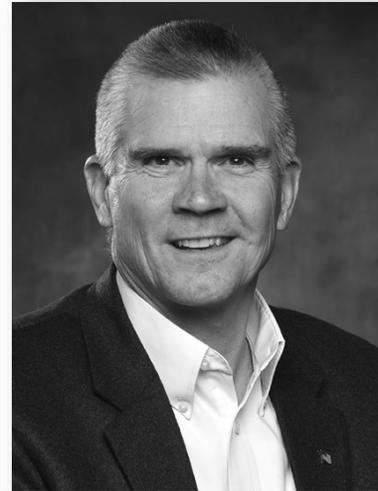
Long-term care is a variety of services that help you with health or personal needs over a period of time. Insurance policies may cover care in a nursing home, an adult day care facility or even your own home. Choosing long-term care is a very important decision. Planning for long-term care requires you to think about possible future health care needs.

Sorting through all the options can be very confusing. That's why my office is pleased to provide you with this *Consumer Guide to Long-term Care Insurance*. It defines the terms used, offers guidelines about who should buy long-term care insurance, includes shopping tips and useful worksheets, and provides specific information about the policies sold in Montana.

I encourage you to put this guide to work for you. Remember to take your time, shop carefully before you buy and contact my office if you have questions or need additional assistance. Our knowledgeable staff is here to help you with a range of insurance issues. Call the consumer assistance hotline at 1-800-332-6148 or visit our website at www.csimt.gov for more information.

Sincerely,

Commissioner of Securities & Insurance
Office of the Montana State Auditor



One of my goals as Commissioner of Securities and Insurance is to help you be an informed buyer.

CONSUMER GUIDE TO LONG-TERM CARE INSURANCE

CONTENTS

Introduction

 What is long-term care?1

Government Programs

 Medicare3

 Medicaid4

Long-Term Care Insurance Policies..... 5

What Services are Covered by the Policies..... 6

What Services are not Covered by the Policies 7

Designing a Long-Term Care Plan 8 -11

Policy Renewals and Cancellations 12

Assessing your Income 13

Long-Term Care Suitability Worksheet 14

Favorable Tax Treatment 15

Shopping Tips 16

Policy Evaluation Worksheet..... 17

Glossary of Terms 18

Consumer Resources 19

INTRODUCTION

What is long-term care?

Long-term care is the help you may need if you are unable to care for yourself because of a prolonged illness or disability. People often think of long-term care as nursing homes. In fact, the term now refers to a variety of private and semi-private care situations and services, including in-home care, assisted living, adult family homes, adult residential care and nursing homes.

Long-term care differs from traditional medical care. Medical care services rehabilitate or correct certain medical problems while long-term care services help a person maintain his or her lifestyle.

Will I need long-term care?

Before making a decision about buying a long-term care policy, you may want to consider your finances, your age, your family's health history and the average length of stay in a nursing facility. The possibility of needing nursing care increases with age. This is most often the result of chronic illness or disability. In some case, the illness or disability may include memory loss, confusion or disorientation, sometimes called cognitive impairment.

What percentage of individuals stays in nursing homes more than 90 days?

Age	Percentage
65-74 years	1.4 percent
75-84 years	6 percent
85 years +	25 percent

How long do people stay in long-term care facilities?

44.2%	<i>Less than 1 year</i>
30.3%	<i>From 1 to 3 years</i>
12%	<i>From 3 to 5 years</i>
12%	<i>5 years or longer</i>

If you decide to buy a policy, you should consider how many years you want to receive benefits. Policies are sold with benefit terms from one year to a lifetime. The average nursing home stay lasts 290 days, according to U.S. Census data, but increases with age.

How much does long-term care cost?

Nursing home care is the single largest out-of-pocket health care expense for older Americans. The cost of long-term care varies greatly in Montana depending on the kind of services provided. According to Genworth Financial, Inc., the median annual cost in 2016 for a private nursing home stay was \$92,376 nationally. The state annual private median rate was \$83,220. Costs also vary in Montana depending on whether you live in a rural or urban area.

Home-based health care also is expensive. In Montana, Medicare pays \$40 to \$100 for a home health care visit. A visit typically lasts 15 to 20 minutes and rarely is more than an hour. The cost depends upon the type of care and where you live.

According to a recent study, Montana's rate for home health aides is \$23 per hour (\$20 nationwide) and the hourly median rate for Medicare-certified home-health aides is \$27.

Who pays for long-term care?

Many people assume that Medicare will pay if they need long-term care. However, **Medicare only pays limited benefits**. Others assume that their private Medicare supplemental insurance policy will pay for long-term care expenses. It covers only the services authorized by Medicare. Since Medicare does not cover long-term care for the most part, neither does Medicare supplemental insurance.

In most cases the individual pays for long-term care, or Medicaid does after the individual or family qualifies for government assistance.

The following section will help you understand the differences between the public programs and private financing options (ie. long-term care insurance) for long-term care services.

DO YOU NEED LTC INSURANCE?

Whether you need long-term care insurance depends on your income, family situation and personal risk factors.

Use the LTC *Suitability Worksheet* on pg. 15 of this guide to help you assess your needs.



GOVERNMENT PROGRAMS

Medicare

Medicare pays approximately 7 percent of the nation's total nursing home bills, primarily because it *only covers skilled care*. Assistance from nonmedical personnel for individuals who need help with activities of daily living (ADL) is not covered by Medicare. ADL care applies to 95 percent of residents in a nursing home; fewer than 5 percent require skilled care.

Medicare and Nursing Homes

Medicare pays when the following conditions are met:

- You must have been in a hospital at least three consecutive days, not including the day of discharge, before entering a nursing facility.
- You must receive care in a skilled nursing facility and occupy a designated skilled bed.
- Your doctor must certify that the care you need and receive is skilled nursing or skilled rehabilitation care.
- Your admission must be for the same condition for which you were treated in the hospital.
- The nursing home care must be received within 30 days of discharge from the hospital.

If you meet these conditions, Medicare will pay for:

- The first 20 days - all covered expenses.
- The next 80 days - all covered expenses minus the individual's daily coinsurance contribution, which is \$164.50 in 2017.

Medicare and Home Health Care (*Patient must be home bound*)

When ordered by a doctor, home health care coverage includes:

- The services of a part-time skilled nurse.
- The services of physical and speech therapists furnished by a Medicare-certified home health agency.
- Services including home health aide services, occupational therapy, medical social services and medical supplies.
- Payment of 80 percent of the cost of durable medical equipment.

Medicare does not cover:

- Full-time nursing care.
- Drugs or meals delivered to your home.
- Home services that primarily assist you in meeting personal care or housekeeping needs.

Medicaid

Nationwide, Medicaid pays for 64 percent of all nursing home bills. Medicaid assists elderly, blind and disabled individuals who cannot afford medical expenses. For some, Medicaid can provide assistance with nursing home expenses when they become impoverished.

Medicaid and Nursing Care

A county welfare eligibility specialist will conduct a financial review when you apply for Medicaid and will consider your available assets at the time you or your spouse enters the nursing home.

If you are single, you may have to pay for your nursing home care until your assets are less than \$2,000 to qualify for Medicaid. You are allowed to keep your house, if you are expected to return to it, personal property and generally your car. You may keep \$71 a month for personal needs and the amount you need to pay for health insurance.

Under the spousal impoverishment program, when a person enters a long-term care facility, the spouse at home may retain a maximum of half of the couple's resources, not to exceed \$109,560 (as of 2011). Certain assets are exempt, including the home in which they live, household goods and one car. There also are regulations concerning the amount of income the spouse may retain on a monthly basis.

If you recently transferred assets, prior to seeking government assistance, the transfer may be considered in deciding your eligibility for nursing care benefits. If you have questions about Medicaid eligibility, you may wish to consult with the county eligibility office in your area or an attorney.

Medicaid and Home Health Care

If you qualify for Medicaid, you may be eligible for up to 75 nursing visits from a certified home health agency. Other services provided through Medicaid include personal care attendant services, physician visits, emergency ambulance service, and oxygen and prescription drugs.

MEDICAID

***For information on
Medicaid, contact:***

Montana Senior and Long
Term Care Division
P.O. Box 4210
Helena, MT 59604

1-800-332-2272

The guides "**Medicare and You**" and "**Can Medicaid Help Me with My Nursing Home Bills**" are available through your county Public Welfare Office, Office of Human Services, Area Agency on Aging and at the number listed above.

LONG-TERM CARE INSURANCE POLICIES

Indemnity Policies

Most policies are indemnity policies. These policies pay a fixed dollar amount for each day you receive care in a nursing facility or in your home.

Generally, the nursing care daily benefit ranges between \$40 to more than \$200. The daily benefit for home health care usually is about half the benefit for nursing care.

Before determining how much you want your policy to reimburse, you should check the cost of nursing homes in your community.

Montana requires insurance companies to offer policies containing an optional inflation adjustment. There is more information about that option on page 10.

Expense Policies

Expense policies are different from indemnity policies in that they pay the actual expenses incurred, a set percentage or up to a maximum dollar amount per day.

Life Insurance Policies

Some life insurance policies offer long-term care benefits. Under “living benefits” provisions or riders, a portion of the life insurance benefit is paid to the policyholder if he or she needs long-term care. The death benefit then is reduced by the amount paid for long-term care. Benefits for long-term care often are limited by the rider and policy to 50 percent or less of the total benefit.

Montana law requires that a quarterly report be provided to the policyholder any time that long-term care is funded through the acceleration of death benefits in a life insurance policy. The report notes if long-term care benefits were paid each month in that quarter, provides an explanation of any changes in the policy including death benefits or cash value and indicates the amount remaining in long-term care benefits.



Need Help?

Call the Commissioner of Securities
and Insurance, Office of the Montana
State Auditor

1-800-332-6148

WHAT SERVICES ARE COVERED BY THE POLICIES

Long-term care policies may offer coverage for three levels of care: skilled, intermediate and custodial. Many policies also offer home health care and adult day care. Montana law states that policies cannot pay for skilled care alone or pay more for skilled care than other types of care because most nursing home stays are for custodial care.

Prior Levels of Care

Montana law states that you do not need a prior hospital stay to become eligible for nursing home benefits from your long-term care policy, unless the policy was issued before 1989. (This is different from Medicare, which requires hospitalization prior to reimbursement for skilled nursing care.) Under Montana law, your policy can require prior confinement in a nursing home or a hospital before it pays for home health care. The company cannot require that you use adult day care or other community programs before you are eligible for home health care benefits.

Be sure to ask your agent what type of restrictions are in the policy and what conditions must be met for benefits to be paid.

OTHER RESOURCES

Montana Health Care Association has a nursing home brochure and check list with the names of licensed facilities in Montana. Contact the association at: 406.443.2876
www.mthealthcare.org
36 S. Last Chance Gulch
Helena, MT 59601

Location of Treatment

- **Your policy may provide a different level of benefits based on how the facility is licensed.** Most policies will provide benefits based on the type of care you receive and the licensure of the facility. *Your policy will offer the highest level of benefits if you are receiving skilled nursing care in a facility licensed as a nursing home and in a nursing home bed.* However, a facility may be licensed for nursing care but also licensed to provide assisted living care. Be sure to ask the facility or your physician which type of care you will need because the assisted living daily benefit will be less than for nursing care. If you require skilled nursing care but end up in an assisted living bed, your policy will only pay for the lesser benefit. Your policy may also provide a reduced daily benefit if you are required to receive home health care within the provisions of the policy of insurance.
- Before you purchase a policy, **check to make sure that the type of care you may need is available in your community.** If you have a particular facility in mind, check to see if its services would be covered by your policy. This is particularly important if you live in a rural area where licensed nursing facilities providing skilled care are not always available.
- Finally, when shopping for long-term care insurance, you should confirm with your agent that your policy allows you to receive nursing care in another state.

WHAT SERVICES ARE NOT COVERED BY THE POLICIES

Pre-existing Conditions

Insurance policies typically feature a pre-existing condition clause. In general, if you have a health problem at the time you become insured, the company will not pay benefits for a certain period of time.

In Montana, **companies may exclude coverage of pre-existing conditions for the first six months following the effective date of the policy.** The law states that a pre-existing condition can be defined only as a condition for which medical advice or treatment was recommended by or received from a provider of health care services in the six months preceding the effective date of your policy.

If you have health problems, ask the agent exactly how your medical history would be treated under the policy. Be sure you understand what will be covered. The law states that if you replace or convert your existing policy, a new waiting period for pre-existing conditions cannot be required. However, if you decide to increase your benefits, you may be subject to a new waiting period for the increased benefits of the policy.

Specific Exclusions

In Montana, all long-term care policies with limitations must list them in an area clearly labeled "Limitations or Conditions on Eligibility for Benefits." State law allows insurance companies to limit long-term care coverage or deny it for the following reasons:

1. Pre-existing conditions.
2. Mental or nervous disorders except those that are a result of a demonstrable organic disease or physical injury. Alzheimer's cannot be excluded.
3. Alcoholism or drug addiction.
4. Injury or illness as a result of war or service in the armed forces, commission of a felony, intentionally self-inflicted injury or injury resulting from a suicide attempt or an aviation accident, except when you are a paying passenger.
5. If the service is provided by your immediate family, through a state or federal workers' compensation program, or in a governmental facility (unless otherwise required by law, or if it is covered by Medicare or another government program, except Medicaid.)

DESIGNING A LONG-TERM CARE PLAN



For 2017, a healthy 55-year old man can expect to pay \$1,050 annually, while a married couple, both age 60, would pay \$2,200 annually, according to the American Association for Long-Term Care Insurance. A good option for Long-Term Care Insurance is a comprehensive policy with a daily nursing home benefit of \$150 and some form of automatic inflation protection.

Your premium cost will depend on factors including where you live, your age, the type of policy, the benefits it covers, the deductible period, whether it includes inflation protection and whether you can retain some value if you cancel your policy.

A long-term care policy has these basic features:

- An elimination period
- A maximum benefit period
- A daily benefit

Age

The average age of people who buy long-term care policies is 61. The cost of coverage depends on how old you are. Premiums are lower for younger individuals, but the younger you are when you buy coverage, the longer you will pay the premium. Some companies won't sell a policy to anyone younger than 50 or older than 80.

Your premium will remain the same each year unless the company increases the cost of the policy for all policyholders or you have a policy with an inflation adjustment.

Benefit Types

Nursing Care

Premium costs are directly tied to the size of the daily benefit and the length of time benefits will be paid. For instance, a policy that pays \$150 a day for nursing home care up to three years will cost less than a policy with lifetime benefits.

In Montana, all indemnity policies are required to pay the designated benefit regardless of the level of nursing care received.

Home Health Care

Home health care typically pays a different daily benefit amount from nursing home care because it is less expensive. In Montana, home health care coverage may be applied to the non-home health care benefits in your policy to determine the maximum coverage available.

Duration of Benefits

Policies generally limit benefits to a maximum dollar amount or a maximum number of days. Often, separate benefit amounts are applied to nursing care and home health care within the same policy.

There are two ways a company may define a maximum benefit period:

1. **One-time maximum benefit period:** If you buy a three-year policy and stay in a nursing home for three years, it will pay just once in your lifetime;
2. **“Period of Confinement”:** A three-year benefit period would cover more than one nursing home stay lasting up to three years if the stays were six months or more apart.

Waiting Period (also known as an Elimination Period)

A waiting period may be the length of time you have to wait for your policy to go into effect because of a pre-existing condition clause or because your policy requires hospitalization prior to paying for home health benefits.

You will have a choice in the length of the elimination period when structuring your policy. Most policies offer options for waiting periods from 0 to 100 days. If you buy a policy with a 20-day waiting period, your insurance benefits would begin on the 21st day. The longer the waiting period, the lower the premium.

When selecting your waiting period, keep in mind that although 20 percent of nursing home stays last three months or less, more than one-third last one year or more. It is the longer stay that can be financially devastating.

Premium Waivers

You have to continue paying premiums on some policies even if you are confined to a nursing home. It is common for some companies to require a 90-day nursing home stay before you can stop paying your premiums. Ask your insurance agent what restrictions your policy contains.

Inflation Protection

Inflation protection can be one of the most important additions you make to a long-term care insurance policy.

Montana law requires companies to offer inflation protection, in writing, as an option in all long-term care policies. Your response to the offer also must be in writing. Life insurance policies that contain accelerated long-term care benefits are not required to offer inflation protection. Adding inflation protection to your policy will make it more expensive, but potentially more valuable.

There are three inflation protection options:

Option 1

Benefit levels must increase at a compounded rate. Compound interest protects against inflation. Simple interest, while better than a daily benefit that remains constant, doesn't provide as much protection.

A common protection offered is 5 percent simple interest. This automatically raises your daily benefit limit by 5 percent each year. An \$80 per day benefit would increase \$4 a year. After 20 years, the \$80 per day benefit would increase to a \$160 daily benefit. Your benefits would increase faster and would more adequately keep pace with inflation if interest is compounded. At 5 percent interest compounded annually, the \$80 policy would rise to \$212 per day after 20 years.

Option 2

You must be **allowed to increase your benefit level** periodically without again going through underwriting or without providing evidence of insurability or health status.

Option 3

Your policy will cover a specified percentage of actual or reasonable charges for each day you receive care rather than giving you a maximum specified amount limit.

Nonforfeiture Benefits

Montana law requires this option be offered to consumers and requires agents to review criteria to ensure the sale is appropriate for your level of income. If you choose to discontinue your coverage or your coverage lapses because you forgot to pay the premium, this benefit returns part of what you have paid in premiums. The return likely will not be in cash, but will guarantee some portion of your benefits.

To receive a reduced benefit, you must have paid premiums for a specified number of years. The policy should define this and should state what portion of the benefit you will receive.

Premium Return

Some companies offer a premium return feature. At an additional cost, you can buy a policy that will return all or a portion of your premium depending on whether you have claims. Paid claims generally are deducted from the premium return.



For more information

Visit www.longtermcare.gov to learn more about planning for long-term care.

POLICY RENEWALS & CANCELLATIONS

Renewing your Policy

Montana law states that long-term care policies cannot be cancelled or non-renewed because of health, age or mental condition. Review the renewability provision of your policy, normally found on the first page. It will list the conditions under which the policy may be cancelled and when premiums may be increased.

Switching your Policy

Policies in Montana cannot impose requirements for a prior hospital stay or for prior levels of care. Montana law also states that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. If you have fully satisfied the waiting period under your present policy, your new policy cannot require another waiting period.

Remember:

- Never switch policies before making sure the new policy truly is better than the old one; and
- Never discontinue your old policy until you are certain that your new one is in effect.

Cancellations

A company can cancel your policy, even if you pay your premiums, if you misrepresent your health status on your application. The company also may be within its rights to deny coverage when you file a claim. It is very important to fill out your application completely and accurately.

Each policy sold in Montana must have a cautionary note regarding cancellation when you sign the application, as well as when you receive the policy or certificate.

Free-Look Period

Montana law requires that the insurance companies give you time to think over this important decision.

You have 30 days from the time you receive a policy to review it and decide whether you are happy with it. If, within 30 days of receiving the policy, you decide you are not satisfied for any reason, your entire premium must be refunded. It is a requirement that the notice informing you of the 30-day free-look period be printed prominently on your policy. *The Office of the Montana State Auditor, Commissioner of Securities and Insurance, urges you to use this time to review your policy and ask questions.*

Consumer Tip

It is very important to fill out the insurance application completely and accurately. The insurance company can deny coverage when you need it most if you did not fill out the medical history properly and honestly.

ASSESSING YOUR INCOME

Long-term care is expensive, but so are insurance premiums. If your savings are low or modest, insurance may not be a good buy. On average, it takes a person 13 weeks to deplete his or her savings on nursing care. At that point, many people become eligible for Medicaid.

You need to consider whether you can afford insurance, if you have a level of assets worth protecting and if your assets will be sufficient to pay an increase should premiums increase in the future.

If you are 65, it is possible that you may pay premiums for 20 years before you need long-term care. You should consider whether you can afford that.

Many people who decide to buy long-term care insurance have assets they want to protect for their children, or they want to preserve their independence and avoid depending on others.

Before shopping for a policy, list the *income and assets* you have available to pay for a nursing home stay.

Include the following <i>Income</i>:	Include the following <i>Assets</i>:
Social Security income	Savings accounts
Veterans' benefits	Real estate
Family contributions	Life insurance cash value
Private retirement or pension income	Stocks, bonds, and money market funds
Bank account stock and bond earnings	Personal property
Income from real estate rentals	Antiques and jewelry

In general, if your total assets do not exceed the Medicaid guidelines on page 4 of this publication, you may not need a long-term care policy. You shouldn't buy something you can't afford.

Also, individuals with normal cash flow and sufficient assets to pay for the cost of a nursing home stay may choose not to purchase a long-term care policy.

FAVORABLE TAX TREATMENT

The favorable tax treatment of long-term care insurance premiums and benefits will apply only if your policy is a qualified long-term care policy as defined by federal law. Long-term care policies issued before January 1, 1997, automatically qualify. Policies issued on or after that date must meet federal standards to be considered “tax qualified.”

If you have a tax-qualified plan:

- The benefits paid out by a qualified long-term care policy will generally not be taxable as income by the federal government.
- You *may* deduct all, part or none of the premium – to a certain level based on your age – for a long-term care insurance policy as medical expenses on your itemized federal tax return. The threshold is now 10% as determined by the 2010 Patient Protection and Affordable Care Act (ACA).

Federal law states that unreimbursed expenses for qualified long-term care services are treated as medical expenses for itemizing deductions, subject to the floor of 7.5 percent of adjusted gross income. Long-term care insurance premiums also are treated as medical expenses for itemized deductions. This variable deduction increases with the age of the taxpayer. The premium should be indexed to account for inflation.

Proceeds from a long-term care insurance contract are excluded from taxable income, subject to a cap of \$360 per day annually for 2017 on a per diem benefit. If the aggregate amount of periodic payments exceeds the cap, the excess payments are excluded from taxation to the extent that they represent actual costs for long-term care services during the period.

Full Deductions

Montana offers both a deduction for the entire amount of qualified LTC insurance premiums covering the taxpayer, taxpayer's parents, grandparents & dependents. A tax credit is now allowed for premiums paid for long-term care insurance coverage for a qualifying family member. The amount of the credit shall be based on the taxpayer's adjusted gross income and cannot exceed \$5,000 per qualifying family member in a taxable year or \$10,000 for two or more family members.

You should consult with an attorney, accountant or tax advisor regarding the tax implications of purchasing a tax-qualified policy.

Maximum Deductions for LTC Insurance for 2017

AGE	DEDUCTION LIMIT
40 and under	\$410
41-50	\$770
51-60	\$1,530
61-70	\$4,090
71 and older	\$5,110

SHOPPING TIPS

- If your income and assets qualify you for Medicaid, you do not need long-term care insurance.
- Your medical history is very important. Fill out the application truthfully and completely. If the health information is incomplete or inaccurate, the insurance company can refuse to pay your claims or cancel your policy.
- Carefully compare policies. They are not all the same. (Use the checklist on the following page.)
- Check with several companies and agents. Companies offer different services. Find a professional able to offer multiple policies from multiple insurance carriers.
- Do not buy more than one long-term care policy.
- Montana requires that an agent leave an Outline of Coverage at the time he or she initially contacts you. If an agent promises to provide the information later, we suggest that you do not deal with that person.
- Be wary of an agent who says a policy can be offered only once. Do not let anyone scare you or pressure you into making a quick decision.
- Ask the agent to come back a second time. If the individual is not willing to come back, do not purchase insurance from that agent.
- If the agent gives you answers that are vague or different from the information in the policy or brochure, do not buy the insurance.
- Never buy a policy or sign something you do not understand. Ask questions. Discuss the policy with a trusted friend or adviser before you buy.
- Never pay the agent in cash. Always write a check payable to the insurance company and get a receipt.
- Be sure to get the name, address and telephone number of the agent and the company he or she represents.

Consumer Tip

If you purchase a policy you have a 30-day “free-look” period. Be sure to review the policy and make sure it is what you intended to purchase.

HOW TO COMPARE LONG-TERM CARE POLICIES

Use this worksheet to compare policies

	Policy A	Policy B	Policy C
What services are covered?			
Skilled nursing care			
Intermediate nursing care			
Custodial care			
Home health care			
Adult day care			
Other			
How much does this policy pay each day?			
Skilled nursing care			
Intermediate nursing care			
Custodial care			
Home health care			
Adult day care			
Other			
How many years will the benefits last?			
Skilled nursing care			
Intermediate nursing care			
Custodial care			
Home health care			
Adult day care			
Other			
Does the policy have a maximum lifetime benefit? If so, what is it?			
Does the policy have a maximum length of coverage for each period of confinement? If so, what is it?			
How long is the waiting period before benefits are paid?			
How long is the pre-existing conditions waiting period?			
Do you pay premiums while you are institutionalized? If so, for how long?			
Nursing home care			
Home health care			
Is prior care required before benefits are paid?			
A prior hospital stay before home health care is paid			
A prior nursing home stay before home health care is paid			
Is there inflation protection?			
What is the rate of increase?			
Is it a simple or compound interest rate?			
How often is it applied?			
Is there an additional cost?			
Is there a non-forfeiture clause that allows you to discontinue coverage but retain some benefits?			
What does the policy cost per month/year?			
With inflation protection			
Without inflation protection			

GLOSSARY OF TERMS

ADLs – Everyday functions and activities individuals usually do without help. ADL functions include bathing, dressing, transferring, eating and continence.

Adult Day Care - Care provided to adults in a community-based center who cannot remain alone but do not require round-the-clock nursing care.

Benefit Period - A specified amount of time for which benefits will be payable during confinement or period of illness.

Cognitive Impairment - Alzheimer's, dementia and other mental incapacities.

Co-insurance - A percentage of all expenses that an insured person is required to pay; for example, 20 percent of the "reasonable" charges under Medicare.

Custodial Care - Care to help individuals meet personal needs such as eating, bathing, dressing and taking medication. The care may be provided by nonmedical personnel, but must be based upon doctor's orders.

Disclosure Form - Describes the benefits, exclusions and provisions in a policy.

Elimination Period/waiting period - Specified period of time a policyholder must wait before a policy pays benefits.

Exclusion - A condition, circumstance or medical expense the policy does not cover.

Guaranteed Renewable - The company guarantees that the policy is renewable for life so long as the premiums are paid. The premiums can increase only if there is a rate increase for everyone.

Home Health Care – Services for nursing care or occupational, physical, respiratory or speech therapy. Also includes medical, social worker, home health aide, and homemaker services.

Intermediate Nursing Care - Medical care provided in a nursing facility to patients who require daily medical supervision, but not 24-hour care. The care is supervised by registered nurses and ordered by a doctor.

Lien Estate Recovery - Medicaid is required by law to recover assets of recipients to help pay for the cost of their care. Recovery is done by filing liens on homes of certain nursing home recipients and by filing claims against the estates of certain recipients who die at or after age 55, or who reside in a nursing home. Recovery is not made when there is a surviving spouse or certain dependents.

Medicaid - A joint federal/state medical assistance program administered by the state. It provides health care services to those with low incomes or with very high medical bills relative to income and assets. Medicaid provides benefits for long-term nursing facility care if income and assets meet eligibility criteria. It also provides home health care.

Medicare - The federal program providing hospital and medical insurance to people 65 years and older. Medicare provides only limited benefits for nursing home and home health care services under specific circumstances.

Premium - The dollar amount charged (usually monthly) for an insurance policy.

Rider - A document attached to a policy that changes the provisions of the policy. A rider may add coverage, remove coverage or redefine what sort of coverage the insurance policy provides.

Skilled Care - Care provided to a patient on a 24-hour basis by, or under the supervision of, skilled medical personnel based upon a physician's orders.

CONSUMER RESOURCES

- Office of the Montana State Auditor, Commissioner of Securities and Insurance
(800) 332-6148 or (406) 444-2040
- Montana Department of Public Health & Human Services
 - Office on Aging, Senior Long-Term Care Division
Phone: (406) 444-0998 or the Aging Hotline: (800) 332-2272
website: www.dphhs.mt.gov/sltc
 - Medicaid Services Division: 444-1700 or (800) 326-8312
 - Medicaid Lien and Estate Recovery Program: (800) 694-3084
 - State Health Insurance Assistance Program (SHIP): (800) 551-3191
 - Long-Term Care Ombudsmen, Office on Aging: 444-7785 or (800) 332-2272
 - Area Agencies on Aging: (800) 551-3191
- Department of Veteran Affairs: www.va.gov/geriatrics
- American Association for Long-Term Care Insurance: www.aaltci.org/

**For specific information on LTC rates in Montana,
please refer to the *Montana Long-Term Care
Insurance Rate Comparison Guide* available at
<http://csimt.gov/wp-content/uploads/2017-LTC-Rate-Guide.pdf>
or by calling 800-332-6148.**

Information Sources:

- <http://www.aaltci.org/news/long-term-care-insurance-association-news/2017-tax-deduction-limits-for-traditional-long-term-care-insurance>
- <http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php>
- <http://longtermcareinsurancepartner.com/long-term-care-insurance/2017-long-term-care-insurance-tax-deduction>



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