21st Century Long Term Care
This text is designed to provide accurate information in regard to the subject matter covered. The readers of this book understand that the author is not engaged in rendering legal or financial services. You should seek competent tax or legal advice with respect to any and all matters pertaining to the subject covered in this book.

This book is updated periodically to reflect changes in laws and regulations. You can call the author at 410-989-0559 to verify that you have the most recent update.

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In the back of the book are 50-questions examinations that are to be completed by agents who seek C.E. A grade of 70 or higher is required to receive Continuing Education credits.

You are to place your answers on the answer sheet that is included in the back of this text.

YOU CAN ALSO TAKE THE TEST ON-LINE BY CLICKING ON THE FOLLOWING TEST-SITE:

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<table>
<thead>
<tr>
<th>Section</th>
<th>Table of Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>LTC Basics</td>
</tr>
<tr>
<td>2</td>
<td>Nursing Home &amp; Rehabilitation Centers</td>
</tr>
<tr>
<td>3</td>
<td>Assisted Living</td>
</tr>
<tr>
<td>4</td>
<td>Medicaid</td>
</tr>
<tr>
<td>5</td>
<td>Medicare</td>
</tr>
<tr>
<td>6</td>
<td>Long Term Care Insurance</td>
</tr>
<tr>
<td>7</td>
<td>Tax Treatment</td>
</tr>
<tr>
<td>8</td>
<td>Power of Attorney &amp; Will</td>
</tr>
</tbody>
</table>

Examination
Long Term Care Basics

What is LTC

Long term care is different from traditional medical care. This service helps the insured live as he or she is presently. It is not design to help to correct or improve medical impairments. Long-term care services may include help with activities of daily living, home health care, respite care, adult day care, care in a nursing home, in an assisted living facility and hospice care. For example, there may come a time when a person needs help getting in and out of bed, eating or bathing. It also includes the kind of care that a person may need if he or she had a severe cognitive impairment like Alzheimer’s disease or dementia.

Long term care may also include care management services, which will evaluate the needs, monitor and coordinate the services. People with cognitive impairment usually need to be watched, supervised, protected or reminded to do daily activities.

The need for long term care usually arises from injury, disability, age or chronic illness. Approximately 60% of Americans who reach age 65 will need long term care before they die.

The need for long term care services can strike at any time. About 40% of people receiving long term care services are working age adults, between the age of 18 and 64.

Long term care is the type of care that people may need if they can no longer perform activities of daily living by themselves. The following is a list of examples of Activities of Daily Living.

Bathing:
• getting into a tub or shower; and
• getting out of a tub or shower; and
• washing your body in a tub, shower or by sponge both; and
• washing your hair in a tub, shower or sink

Dressing:
• putting on and taking off any necessary item of clothing,

Transferring:
• getting in and out of bed, wheelchair or chair

Toileting:
• getting to and from the toilet; and
• getting on and off the toilet; and
• performing associated personal hygiene.

Continence:
• maintaining control of bowel and bladder function; or
• when unable to maintain control of bowel or bladder function, performing associated personal hygiene

Eating:
• feeding yourself by getting food into your mouth from a container (such as a plate or cup), including use of utensils when appropriate (such as a spoon or fork); or
• when unable to feed yourself from a container, feeding yourself by a feeding tube or intravenously.

If the insured needs substantial assistance from another person to complete any one of these daily activities, he or she is considered to be dependent for Activities of Daily Living.

Cognitive Impairment

Many long term care insurance policies will pay benefits for “cognitive impairment” or mental inability. If you are unable to pass certain tests of mental function, the insurance police will then start paying you benefits. Cognitive impairment means a deterioration or loss in intellectual capacity (such as may occur with Alzheimer’s disease or dementia) that (a) places a person in
jeopardy of harming him/herself or others and therefore the person requires 
substantial supervision by another person; and (b) is measured by clinical 
evidence and standardized tests which reliably measure impairment in: (1) short 
or long term memory; (2) orientation to people, places or time; and (3) deductive 
or abstract reasoning.

Most states do not allow long term care policies to limit benefits because the 
insured has a cognitive impairment, such as, Alzheimer’s disease. 
Alzheimer’s disease is the # 1 reason for long term care claims – cancer, 
strokes, and accidents are some other reasons. Every day on average, 986 
Americans are diagnosed with Alzheimer’s, and the decision to tell friends, 
relatives, employers is often an agonizing one. They fear they’ll be branded with a 
scarlet A. Alzheimer’s disease steals a person’s lucidity thought by thought. 
Since Alzheimer’s was identified in 1906, most families and patients have 
suffered silently until the symptoms were too noticeable for others to ignore or 
deny. But in recent years, emboldened by the examples of former President 
Ronald Reagan and actor Charleston Heston, more people with early-stage 
Alzheimer’s have chosen to speak for themselves while they still can.

**About 75% of care for people with Alzheimer’s disease is provided for at home.**

Long term care services can be received in a variety of setting, including your 
own home, assisted living facilities, adult day care centers or hospice facilities. 
The services can be covered completely or in part by long term care insurance. 
Many plans let you choose the amount of the coverage you want, as well as how and where you want to use your benefits. A comprehensive long term care policy includes benefits for all levels of care, custodial to skilled medical care.

Long term care isn’t the type of care that people receive in the hospital or their 
doctor’s office. It isn’t the medical care they need to get well from a sickness or an injury. It isn’t short-term rehabilitation from an accident or recuperation from surgery. Surprisingly, long term is not always administered in a nursing home. **In fact, more than 80% of all people receiving long care benefits and assistance are not in nursing homes.**
NURSING HOMES  
SECTION 2

What is a Nursing Home?

A nursing home is a residence that provides room, meals, help with activities of daily living, recreational activities, protective supervision, and monitoring of residents. Typically, nursing home residents have mental and physical impairments which keep them from living independently at home. Nursing homes are certified to provide different levels of care, from custodial to skilled nursing. They are designed to meet the needs of acute or chronically ill patients. People who require less than skilled care, or who require skilled care for a brief or long period of time, should consider a nursing home. For some, a nursing home may be a viable alternative to home health care, especially if the person has a chronic or acute illness that requires a level of care that cannot be easily provided at home.

Nursing Homes & Rehabilitation Centers

A visit to a nursing home will provide an opportunity for the caregiver and patient to talk to nursing home staff, and observe the people who live and receive care at that facility. Visitors will also be given the opportunity to examine the nursing home’s most recent survey report. By law, this report must be posted in the nursing home in an area that is accessible to visitors and residents.

Each resident is evaluated by the medical and professional team – Physicians, Nurses, Psychiatrist, Physical Therapist, Social Service Workers, and Recreation Coordinators.
What is a Survey report?

All nursing homes that are certified to participate in the Medicare or Medicaid programs are visited by a team of trained State surveyors approximately once a year. These surveyors examine the nursing home for several days. They will inspect the performance of the nursing home in numerous areas—including the quality of life and quality of care. At the conclusion of the survey, the team reports its findings to the Medicare or Medicaid Administration. Nursing homes that receive a deficiency report are subject to fines and other penalties if they are not corrected in a specified period of time.

Rights of nursing home residents

Over the last decade, different laws and regulations have been enacted to raise the standards of nursing home care, particularly with respect to quality of life. The law currently requires that residents receive the necessary care and services that will enable them to reach and maintain their highest practicable level of physical, mental and social well-being. In addition, civil rights law ensures equal access in all nursing homes regardless of race, color, or national origin.

Nursing Home and Rehabilitation Centers will usually accept the following insurances for payment:

- Social Security
- Medicare
- HMO’s
- PPO’s
ASSISTED LIVING SECTION 3

Assisted Living facilities provide a variety of services that emphasize both comfort, and convenience. The following is a list of the typical things that are offered to all residents:

- A choice of apartments complete with full bath and kitchenettes
- Senior-focused features like: showers with seats, grab bars in the bathroom, night lights, raised electrical outlets.
- Individually controlled heating and air conditioning
- Personal emergency response system
- Periodic housekeeping and linen service
- Attractive community areas, including:
  1. Dining room
  2. Library & activity rooms
  3. Main living room for socializing
- Beautifully landscaped courtyard and walking paths
- Fire alarms and sprinkler systems
- Washers & dryers available for personal use
- Full-service beauty/barber shop (usually for an additional fee)
Standard services for residents include:

- Three meals daily
- Between-meal snacks
- Access to trained staff 24 hours a day
- Licensed nurses
- Daily physical fitness, creative, social, learning, and spiritual activities and programs
- Resident-sponsored clubs for a variety of interested persons
- Scheduled group trips
- Scheduled transportation for errands and medical appointments
- Social and educational programs for families
Custodial and medical services

- Personal hygiene
- Bathing and showering
- Dressing and undressing
- Nighttime care
- Mobility and transferring
- Continence
- Orientation (i.e. ability to recognize people, places, things)
- Communication
- Socialization and activities
- Monitoring of safety
- Eating
- Medications
- Treatments, monitoring and responding to health needs
- Alzheimer’s Care

According to a 2001 survey by the National Center for Assisted Living, about two-thirds of assisted-living residents pay for their stay out of pocket. Most long-term care insurance contracts provide coverage for assisted living, but Medicare does not.
The Cold Facts

There are numerous myths about long term care. Some people think that only senior citizens need to worry about long term care so they put off preparing for the possibility. The cold fact is that unforeseen accidents or illnesses can strike at any age. While 60% of people who will need long term care are 65 or older, 40% are working age adults between the ages of 18 and 64.

People of any age can develop serious conditions that require assistance with routine daily activities for an extended period of time and such help could be very costly. Long term care insurance can help cover the cost of this care and protect ones assets.

Some believe that once they are stricken with an accident or sickness, their family will take care of them. In today’s society, children may live across the country or around the globe. And many women are active in the workforce, with less time to fulfill their traditional caregiver role.

More cold facts:

- By 2030, American age 65 and older will double.
- Americans age 85 and older will triple by 2030
- The longer people live, the greater the chance of becoming ill.
- Approximately 43% of Americans 65 and older will need long term care before they die.
- The average stay in a nursing home is approximately 456 days.
- 30% of the elderly people who stay three months or longer in a nursing home would become impoverished.
- 80% would be impoverished with a stay of 104 weeks
• Over 25% of Americans households are providing traditional long term, approximately 22.5 million families.
• Women generally outlive men, and they face a 50% greater probability than men of entering a nursing home after age 65
• By 2005 approximately nine million Americans will need some kind of long-term care. By 2020, 12 million will need long-term care.
• A study by the Dept. of Health and Human Services indicates that 10% of the people, age 65 and residing in a nursing home, will stay there five years of longer.
• The longer you live, the greater the chance that you will need some type of long-term care.

Since 1987, the number of Americans who’ve purchased a long term care policy has grown at an annual rate of 18%, according to the Health Insurance Association of America, but the vast majority of that growth has taken place in recent years. In 1999, more than 750,000 policies were purchased. This was a 40% increase from the previous year. More than seven million Americans have now purchased a Long Term Care Policy. Currently there are over 35 million Americans age 65, so the market is still enormous.

Cost of Long Term Care

The national average cost of a semi-private room in a nursing home is $52,000 annually. This depends upon where a person lives and the type of facility that the person prefers, costs can be considerably higher.
Medicaid is a jointly-funded, Federal-State health program for certain low-income and needy people. The federal Government funds 59% of the program and each state funds about 41%. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

Medicaid is designed to protect those with minimal assets or disabled. To qualify, many people have to spend down nearly all of their assets. Because spouses have a legal responsibility to support each other, both must spend down their assets before an ill spouse may qualify for medicaid benefits.

Medicaid eligibility

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, States are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

- Low income families with children;
- Supplemental Security income (SSI) recipients;
- infants born to Medicaid-eligible pregnant women;
• children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level;
• recipients of adoption assistance and foster care under the Social Security Act;
• certain Medicare beneficiaries

Medically Needy Eligibility

The option to have a “medically needy” program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory provisions. **This option allows them to “spend down” to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State’s Medicaid plan.** States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

Amplification on Medicaid eligibility

Coverage may start retroactive to any or all of the 3 months prior to application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person’s circumstances change. Most States have additional “State-only” programs to provide medical assistance for specified poor persons who do not
qualify for the Medicaid program. No Federal funds are provided for those programs.

Medicaid-Medicare Relationship

Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical from their State Medicaid program. There are various benefits available to “dual eligibles” that are entitled to Medicare and are eligible for some type of Medicaid benefit.

According to the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, national spending on health care has risen to more than $1 trillion each year, and is expected to double to more than $2.2 trillion by 2008. Spending in the Medicaid program has risen from $3.9 billion in 1968 to more than $178 billion in 1998.

Cut-backs on Medicaid programs

State governments typically provide half of the funds for Medicaid health insurance programs for the poor, with the federal government making up the difference. But when the economy sags, state budgets cuts are unavoidable.

Costs of operating state Medicaid programs, which pay for drugs, hospital stays and medical devices, have jumped more than 25% since early 2001. Higher drug prices and greater use of Medicaid services are the main reasons for these enormous increases.
The State of Maryland Medicaid Program

The State of Maryland has over 580,000 uninsured residents. Usually the State’s Medicaid Program places a limit on the number of hospital days it will pay for a Medicaid patient. Once that limit has been reached, hospitals are then forced to give more uncompensated care, which eventually leads to higher hospital rates to insured patients. This will eventually cause health insureds to pay higher insurance premiums. The Maryland Health Services Cost Review Commission sets hospital rates. When hospitals are forced by the State to provide more uncompensated health care services to uninsured patients, the hospitals will usually request for a rate increase. This will basically cause those insured patients who are hospitalized to pay for the uninsured and for shortfalls in the Medicaid Reimbursement Program. Each State has its own method of passing on these costs to its residents.

All State Medicaid Programs depend heavily on Federal assistance in areas such as prescriptions and hospital cost.

Producers who sell Long Term Care Policies should become very familiar with the State Medicaid Program in his area of business.
Washington State’s Medicaid Program for nursing home residents

To get Medicaid for nursing home care in the State of Washington, the applicant and his/her resources must be within limits set by law.

In counting the applicant’s income for a month, the State’s Dept. of Social and Health Services looks at what the applicant has on the first of the month that he already had in the previous month. Resources typically include such things as real estate, bank accounts and stocks.

A. Income

The applicant monthly income must be less than the following total:

The Medicaid rate for nursing home care plus the applicant’s regular monthly medical expenses. The Medicaid rate—the rate charged for Medicaid residents—is different for different nursing homes. The applicant would have to find out the rate for a particular nursing home by asking the nursing home or calling DSHS.

Example:

Seaside Nursing Home Medicaid rate $3,200.00
The applicant’s monthly pharmacy bill 75.00
Total $3,275.00

If the applicant’s monthly income is less than $3,275.00, his income is within the Medicaid eligibility limit for care at Seaside Nursing Home.

Once the applicant is determined eligible for Medicaid nursing home coverage, he will be allowed to keep $41.62 per month for his personal needs. The rest of his income will be used as follows:
(1) an amount for his spouse if he has one;

(2) an amount for any dependent family members living with his spouse;

(3) an amount to pay health insurance premiums;

(4) an amount to pay medical bills for services not covered by Medicaid, if the bills are still owed and not covered by any Insurance;

(5) an amount to cover certain miscellaneous items, such as guardianship fees that satisfy certain requirements.

Any remaining income must be paid to the nursing home for the applicant’s care. The part of the care that is paid by the applicant is called his “participation.” Medicaid covers the rest.

Once the person has been determined eligible for Medicaid nursing home coverage, the person will be allowed to keep $41.62 per month for his personal needs. The rest of your income will be used as follows:

(1) an amount for your spouse if you have one

(2) an amount for any dependent family members living with your spouse:

(3) for a single person or an institutionalized couple only, an amount (not more than $696) for the maintenance of a home for up to 6 months, but only if a physician has certified that the person or a member of the couple is likely to return to the home within the 6-month period: even without any physician’s certification, if there is rental income from a home to which a Medicaid recipient or spouse intends to return, that income may be used for payment of home maintenance, taxes and insurance:
(4) an amount to pay health insurance premiums:

(5) an amount to pay medical bills for services not covered by Medicaid (usually services provided before you became eligible for Medicaid), if the bills are still owed and not covered by any insurance:

(6) an amount to cover certain miscellaneous items, such as guardianship fees that satisfy certain requirements.

Any remaining income must be paid to the nursing home for your care. The part of your care you pay for is called your “participation.” Medicaid covers the rest.

B. Resources

The limit for resources (assets, property, and savings) that a single person may have is $2,000. Certain “exempt” resources are not counted in determining whether you fall within this limit.

When a married person applies for Medicaid for nursing home care, his or her spouse is allowed to have substantially more resources.
The Medicare Program

Medicare is a health insurance program for:

- people age 65 or older.
- Some people under age 65 with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare has Four parts

- **Part A** Hospital Insurance,
  Most people do not have to pay for Part A
- **Part B** Medical insurance
  Most people pay monthly for Part B
- **Part C** Medicare+Choice
- **Part D** Prescription Drugs

**Medicare Part A**

Medicare Part A (hospital insurance) helps cover inpatient care in the hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care- certain conditions must be met.

**Cost:** Most people do not have to pay a monthly payment, (called a premium) for Part A. This is because they or their spouse paid Medicare taxes while they were working.
If a person did not pay Medicare taxes while they were working and they are age 65 older, they still may be able to buy Part A.

What does Medicare Part A covers?

**Hospital Stays:** Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care received in critical access hospitals and mental health care. This does not include private duty nursing or a television or telephone in room. It also does not include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

**Skilled Nursing Facility Care:** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies. Person must have had a related 3-day inpatient hospital stay prior to entering a skilled nursing facility.

**Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language, home health aide services medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

**Hospice Care:** For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in the patient’s home. However, short-term hospital and inpatient respite care (care given to a hospice
patient so that the usual caregiver can rest) are covered when needed.

**Blood:** Pints of blood you get at a hospital or skilled nursing facility during a covered stay. Patient must pays for the first three pints of blood.
Medicare Part B

Medicare Part B (Medical Insurance) helps cover the patient’s doctor’s services, and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Cost: Person has to pay the Medicare Part B premium of $58.70 per month in 2003. This amount may change January 1, 2004. In some cases, this amount may be higher for those who did not sign up for Part B when they first became eligible. The cost of Part B may go up 10% for each 12-month period that the person could have had Part B but did not sign up for it. The person will have to pay this extra amount as long as he or she has Part B, except in special cases.

Enrollment in Part B

Enrolling in Part B is optional. If a person is already getting Social Security or Railroad Retirement benefits, he or she are automatically enrolled in Part B starting the first day of the month they turn age 65. If they are under age 65 and disabled, they are automatically enrolled in Part B after they get Social Security or Railroad Retirement benefits for 24 months.

Premiums for Medicare Part B are taken out of the person’s monthly Social Security, Railroad Retirement, or Civil Service Retirement
check. If a person does not get any of these payments, Medicare will send a bill for Part B premium every three months.

**Important Telephone numbers:**

* Social Security Administration 1-800-772-1213  
* Railroad Retirement Board 1-800-808-0772

What Medicare Part B Covers:

**Medical and other Services:** Doctors’ services (not routine physical examinations), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy.

**Clinical Laboratory Services:** Blood tests, urinalysis, and more.

**Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and others services.

**Outpatient Hospital Services:** Hospital services and supplies received as an outpatient, as part of a doctor’s care.

**Blood:** Pints of blood received as an outpatient or as part of a Part B covered service.
Preventive Services:

Medicare Part B Covered Preventive Services

**Bone Mass Measurements:** Once every 24 months for qualified individuals and more frequently if medically necessary.

**Colorectal Cancer Screening:** Fecal Occult Blood Test – Once every 12 months.

**Flexible Sigmoidoscopy**- Once every 48 months

**Colonoscopy** – Once every 24 months if person is at high risk for colon cancer.

**Barium Enema:** Doctor can use this instead of a flexible sigmoidoscopy.

**Diabetes Services and Supplies:**
Coverage for glucose monitors, test strips, and lancets.

**Glaucoma Screening:** Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in the patient’s state.

Mammogram Screening: Once every 12 months.

**Medicare also covers new digital technologies for mammogram screening.**
Pap Test and Pelvic Examination
(includes a clinical breast exam): Once every 24 months. Once every 12 months if the person is at high risk for cervical or vaginal cancer, or if the person is of childbearing age and has had an abnormal Pap test in the past 36 months.

Prostate Cancer Screening: Digital Rectal Examination- Once every 12 months.

Shots (vaccinations):

Flu Shots – Once a year in the fall or winter.
Pneumococcal pneumonia Shot – One shot may be all a person may ever need.

Hepatitis B Shot

The Flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. People need a Flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only provides protection from the flu for about one year.
Medicare Part C

Also called Medicare+Choice, it offers plans that operate with Medicare Part A & B. Medicare+Choice was created in 1999 in response to rising health care cost and the need to incorporate a degree of managed care for its beneficiaries. It provides a way for health insurers, managed care groups, physicians and hospitals to offer services to Medicare beneficiaries. This is not a fee-for-service program. The government pays these providers a certain specified amount, based on locale or region of the country. Providers who participate in this program assume the responsibility for providing Medicare services.

Medicare Part D

The new Medicare drug benefit doesn't go into effect until 2006, so you won't have to rush to sign up. That's a good thing, because the benefit is complicated, and digesting it will take time. Coverage won't operate the way health insurance usually does. Congress could change the plan before it's implemented. And you'll have to do your homework to determine whether enrolling will be a good deal for you. Outlined below are the program's key elements. THE BASIC STRUCTURE

The new drug benefit is called Medicare Part D. It will be offered by private plans. In most cases, beneficiaries sign up for the program when they join Medicare Part B.

If the program started today, the estimated monthly premium would be about $35, with an annual deductible of $250 before drug coverage starts. In fact, when the program begins in 2006, the premium and deductible will likely be higher.
Once the annual deductible is met, the plan will cover 75% of the prescription-drug costs, up to $2,250; above that amount, beneficiaries will have to pick up the whole tab until out-of-pocket expenses exceeds $2,850. After the beneficiaries have paid $3,600 on drugs out-of-pocket including the deductible, the government will pay all but 5% of the additional drug costs.

Medicare Part D will add $724 billion to Medicare costs over the next ten years, according to recent estimates.

**Insurer’s Financial Health**

Purchasing long term care insurance may be unwise if the decision is solely base on price. When buying a long term care policy, life insurance, annuity or other products where benefits might not be paid out for a long time, it’s important to make sure the insurer is financially sound. You want to be sure the insurer will be around when you file a claim. Experts believe the important factor in selecting an insurer is the financial strength of the company.

For consumers, the best way to check on an insurer’s health is to look at its credit rating, an opinion by a rating agency on the insurer’s financial strength and ability to pay claims.

There has been renewed interest in credit rating by insurance agents and consumers because of the weak economy, large insurers filing for chapter 11 and a mass of downgrades by rating firms.

In 2002, for example, more insurers’ rating was downgraded than upgraded by rating agency A.M. Best. Fitch Ratings downgraded 35 life insurers in North America, or 42 percent of those it rates. Standard & Poor’s downgraded 24 U.S. life insurers, its highest in a decade, compared with eight in 2001.
Insurers have been hurt by investments in the stock market, and in the bonds of some high-profile failures, such as WorldCom Inc. and Enron Corp.

Insurers selling variable annuities got burned by guarantees made in the late 1990s to provide minimum death benefits no matter what happened to investments in the stock market. Those guarantees came back to haunt insurers when the market tanked. The collapse of the stock market forced them to set aside more money in reserve.

Both insurance agents and consumers should check an insurer’s rating with at least three agencies to make sure that one isn’t giving a company a good rating while others are raising warning flags.

The five major rating agencies are A.M. Best, Fitch Ratings, Moody’s Investors Service, Standard & Poor’s and Weiss Ratings Inc. The first four are paid by insurers to conduct a rating, and the agencies’ ratings are available free online.

Weiss makes money instead by selling its ratings to consumers and others. Weiss offers its ratings, for a nominal fee, at www.weissratings.com. Beth’s newsletters also publish an annual ratings issue for a fee at www.insuranceforum.com.

Once a policy is purchased the consumer should review the insurer’s rating annually. If the rating is lowered, it doesn’t necessarily mean the policyholders should dump the company. The reason for the downgrade should pay some part in whether to keep or discard the policy. For example, an insurer that’s downgraded for massive claims and is unable to add to its reserves may be a reason to switch insurers. Before switching insurers, one must weigh the cost and consequences. Dumping a long term care policy and other insurances may be costly. Consumers might find it hard to replace a canceled policy.
**Qualified Long-Term Care Insurance Contract**

A contract issued after 1996 is a qualified long term care insurance contract if it meets the requirements of section 7702B, including the requirement that the insured must be a chronically ill individual. A contract issued before 1997 generally is treated as a qualified long-term care insurance contract if it met state law requirements for long-term care insurance contracts and it has not been materially changed.

**Chronically ill individual**

A chronically ill individual is someone who has been certified (at least annually) by a licensed health care practitioner as:

1. Being unable to perform, without substantial assistance from another individual, at least two daily living activities (eating, toileting, transferring, bathing, dressing, and continence) for at least 90 days due to a loss of functional capacity; or
2. Having a level of disability similar to the level of disability in 1 above (as prescribed by regulations); or
3. Requiring a substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

**Terminally ill individual**

A terminally ill individual is someone who has been certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in 24 months or less.
People who choose long term care insurance to cover any future needs often do so for some of the following reasons:

1. They want to preserve their assets for spouses and heirs.
2. They want to avoid being dependent on medicaid or their family or friends.
3. They desire to be cared for at home as long as possible.
4. They want to be assured of getting into a desirable nursing home of their choice.
5. They want to have a peace of mind.
6. They want to prevent the care giver (loved ones) from impoverishing them while being cared for.

Long Term Care Premiums

Premiums for long term care insurance vary greatly among insurers. Premiums are based on age at time of application, prior and current health conditions, the benefits selected, the number of years the insurer has to pay-out benefits.

People who purchase long-term care insurance should plan on paying premiums for the rest of their lives or until they need to use the benefits. Premiums may also increase in the future.
Types of services covered

Most long-term care policies offer coverage for a full range of care services. They include the following:

1. Home care
2. Care provided at adult day care center.
3. Care provided at assisted living center.
4. Skilled nursing.
5. Hospice facilities

Assisted living facilities have become increasingly popular since they provide help with ADL’s (activities of daily living, such as bathing, eating, dressing etc.) or supervision for the cognitively impaired. Which include diseases such as Alzheimer’s, while encouraging independence and privacy in a home like environment.

Eligibility for Benefits

Typically benefits are payable to the insured when he or she is unable to perform a certain number of the ADL’s such as two out of five or two out of six.

The insured is eligible for benefits if:

1. A licensed health care practitioner has certified within the last 12 months that the insured is unable to perform, without substantial assistance from another person, at least two activities of daily living for an expected period of at least 90 days due to a loss of functional capacity. Or the insured requires substantial supervision due to severe cognitive impairment.
The insurance company must agree with certification and approve a Written Plan of Care established by a licensed Health Care Practitioner or their own care coordinator.

Often the insurance company has the right to reassess whether the insured is still eligible for benefits. They usually review the insured’s condition every 12 months.

Notice of Benefit Eligibility Decision

The insurance company will send a written notice of their decision on whether the insured is eligible for benefits after receiving all the information from the insured.

If the insurer determines that the insured is eligible for benefits, the notice will state the date as of which the insured is eligible for benefits and will include claim forms.

If the insurer determines that the insured is not eligible for benefits, the notice will provide the reason(s) for the denial. The insured may appeal the insurer’s decision to an appeals committee independent third party, or seek judicial review from the courts.

Waiting Period

The waiting period is the number of days during which the insured must be eligible for benefits and receiving covered services before the insurer will start paying benefits. The waiting period options offered to consumers varies considerably. The typical waiting period options might be 20 or 90 days.
Usually the insured has to satisfy the waiting period once in his or her lifetime.

The waiting period usually does not apply to Hospice Care, Respite Services and Caregiver Training.

Hospice care

When the insured is in a Hospice facility, the insurer will pay for:

1. Room and board
2. Hospice care
3. Drugs, incontinence supplies, dietary supplements, personal medical equipment and laundry services.

Services Provided by a Formal Caregiver At Home

The insurer will pay for the following services provided to the insured by a formal Caregiver at home:

1. Nursing Care
2. Maintenance or Personal Care
3. Therapy Services

Hospice Care at Home

The insurer will pay for Hospice Care provided to the insured at home.

Bed Reservations

The insurer will pay for actual charges incurred for Bed Reservations. Sometimes the insurer has to stay in the hospital for a period of time, leaving the bed at the nursing home vacant. With this benefit, the insured will be assured of having a bed when he or she returns.
Benefits for Bed Reservations are usually limited to 30 days per calendar year.

**Caregiver Training**

The insurer usually will pay for Caregiver Training. Benefits for Caregiver training are usually limited to an amount equal to seven to ten times the insured’s Daily Benefit Amount.

**Respite Services**

Insurance companies will pay for Respite Services:

1. Provided in a Nursing Home, assisted living facility or hospice facility.
2. Provided by a formal caregiver at home
3. Provided at an Adult Day Care Center.

**Adult Day Care Center**

Benefits will usually cover services provided to the insured at an adult day care center.

Adult Day Care Centers offer a variety of custodial and medical services for seniors. These services are provided during the day and evenings. A typical center will offer the following services:

- Comprehensive, professional medical care
- Safe and dependable door-to-door transportation
- Special programs for seniors with Alzheimer’s disease
- Comfortable and secure places to spend the day
- Nutritious meals
- Trained professional staff
- Extended and flexible hours
- Caregiver assistance
- Full schedule of interesting activities for the seniors
Usually, these centers will cost much less than home care or a nursing home. A typical daily fee at an adult daycare center is between $70.00 and $75.00. Transportation cost is extra, and it can range between $15.00 to $17.00 per day. The typical daily rate for a nursing home is $150.00 and up for residents in 2005. There are approximately 3,500 adult daycare centers in the United States but recent studies have projected a demand for 10,000.

**International Benefits**

Insurers will pay benefits for covered services received outside the United States. When the insured receives such services, the insurance company will pay benefits up to 80% of the insured’s daily benefit amounts.

**Maximum Benefit**

Consumers are usually offered a wide choice of maximum daily benefit amount for covered home health care and nursing home stay.

A typical LTC (Long Term Care) policy might offer the consumer a daily benefit of $100/day, $150/day, $250/day etc.

**Length of Benefit Period**

The consumer usually can decide the length of time the daily benefits will be paid to the insured. The typical period is three to five years or a lifetime.

**Grace Period**

There is a 30-day grace period for payment of premiums. This means that the insurer must receive the premium by the 30\textsuperscript{th} day after the date it is due. Otherwise the insurer will issue the insured a written notice of termination of coverage. Then the insured will usually have 30 to
40 days from the date of termination letter to pay the premium, or the coverage will end.

It is advisable for the insured to designate a person to whom the insurer will also send any notice of termination that is sent to the insured. The designated person will not be responsible for premium payments.

**Waiver of Premium**

After a confinement of 60, 90 or 180 days, the insurer usually waives all premiums until the insured has recovered from his or her disability.

Some insurers will give clients a 10% discount on their premiums if they are in good health when they apply for coverage. If both the husband and wife are eligible and they apply for individual coverage, some insurers will give them as much as 25% discount on their premiums.

**Nonforfeiture Benefits**

If, for whatever reason, the policyowner drops the coverage and he has a nonforfeiture benefit in his policy, he will receive some value for the money that was paid into the policy. Without this benefit, the policy owner will receive nothing even if he had paid premiums for 15 or 25 years before dropping the policy. In some nonforfeiture benefits, when the policyowner stop paying premiums, the insurance company gives him a paid-up LTC policy with a shorter benefit period. How many years depends on how long the premiums were paid. **Since it is paid-up, the policyowner will not have to pay any more premiums.**

**Exclusions**

The common exclusion in LTC policies:

1. War and acts of war
2. Care or treatment for alcoholism or drug addiction
3. Illness, treatment or medical condition arising from:
a. Participating in a felony  
b. Riot or insurrection  
c. Attempted suicide

**Inflation Protection**

Purchasing Inflation Protection before age 75 is essential when a person buys long-term care insurance. It ensures that the insured has adequate coverage in the future. This protection is intended to keep pace with the cost of inflation. This protection increases the cost of the policy, but gives the insured coverage that will mean something when he or she needs it.

**Free look - Period**

Buyers of long term care policies are required to have a free - look period to decide if they want it or not. During the free look, they can cancel the policy and get their money back. In some states the insurance company must tell the buyer about the free-look period on the cover page of the policy. In most states buyers have 30 days to cancel, but in some it is less time.

How to cancel,

- Send the policy to the insurance company along with a short letter asking for a refund.
- Send both the policy and letter by certified mail. Keep the mailing receipt.
- Keep a copy of all letters.

It usually takes four to six weeks to get the refund.
Tax treatment

Policies issued after January 1, 1997, which provide tax incentives, are classified as “Tax-Qualified Policies (TQ), and those without any tax incentives are classified as “Non-Qualified Policies” (NTQ).

Premiums for TQ policies may be included as a medical expense if the person itemizes his or her deductions and if medical expenses exceed 7.5% of adjusted gross income, the excess is deductible on the federal income tax return. The amount depends on the person age, as shown below.

<table>
<thead>
<tr>
<th>Age</th>
<th>maximum that can be claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 40 or older</td>
<td>$ 210</td>
</tr>
<tr>
<td>Older than 40 but more than 50</td>
<td>$ 400</td>
</tr>
<tr>
<td>Older than 50 but not more than 60</td>
<td>$ 800</td>
</tr>
<tr>
<td>Older than 60 but not more than 70</td>
<td>$ 2120</td>
</tr>
<tr>
<td>Older than 70</td>
<td>$ 2660</td>
</tr>
</tbody>
</table>

Long Term Care policy benefit payments, when received are free from federal income tax. Premiums from NTQ cannot be deducted as a medical expense, and it is unclear if benefits received will or will not
be taxable. Most policies issued before 1997 are considered “Tax Qualified Policies.”

The state of Maryland gives consumers who purchase Qualified long-term care policies after July 1, 2000 tax credit against state income taxes. Credit capped at $500. A person can claim 100% of premium for self, spouse, parents or children up to $500 cap. State will monitor legislation to see how many people claim credit and evaluate the impact if any on medicaid program.

MARKETING LONG TERM CARE INSURANCE

The number of Americans who purchased long-term care insurance increased more than tenfold in the last 15 years, according to a survey from the Health Insurance Association of America.

The total number of long term care policies sold has grown from 815,000 in 1987 to nearly 8.3 million in 2001.

Although premiums varied widely based primarily on benefit design and entry age, the HIAA found the average premium paid in 2001 remained nearly constant when compared with the average premium paid two years ago.

HIAA estimates that roughly 70% of all individual long term care policies sold remain in effect today.
Minimum & Maximum ages to buy Long Term Care Policies

Many experts suggest that the individual LTC market begins at age 40. Consumers will not even consider their long term care needs until around that age. Here is a list of reasons why:

1. People are more concerned about paying off their debts
2. Their kids are in college or about to start, and they may have to use some of their nest egg to fund their kids’ education.
3. They are just beginning to put money away for their retirement.
4. They still think that they have immortality. Therefore, they procrastinate.
5. They just don’t know the purpose for a long term care policy. And people usually don’t buy things that they don’t understand.

The most common maximum ages in more recent LTC policies are between 79 and 84. Policies purchased at these ages are very expensive.

The Ideal buyer of Long Term Care Policies

- Between the ages of 50 and 64
- In good health
- Have discretionary income
- Don’t want to be a burden to the family
- Has assets to protect

People who retired early are often excellent buyers of LTC policies.
They are usually well-off financially and LTC premiums are reasonable between age 50 and 60. These people also plan ahead for a rainy day.

**The cost for Long Term Care Insurance**

The premium will be lower if purchased at a younger age, higher if purchased at an older age. *If the policy is purchased at age 75, the premium will usually be much higher and can be more than double than if bought at age 65.*

If the policy has a large daily benefit, a longer maximum benefit period, or a home health care benefit, it will also cost more. Inflation protection can add 25% to 40% to the premium. Nonforfeiture benefits can add 10% to 100% to the premium.
What is a Medigap Policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage.

There are 10 standardized Medigap plans called “A” through “J.” The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.” Each plan A through J has a different set of benefits. Plan A covers only the basic (core) benefits. These basic benefits are included in all the Plans, A through J, Plan J offers the most benefits.

When consumers purchase a Medigap policy, they pay a premium to the insurance company. As long as they pay their premium, a policy bought after 1990 is automatically renewed each year.
Medigap policies only help pay health care cost if the person have the original Medicare Plan. Consumers don’t need to buy a Medigap policy if they are in a Medicare + Choice plan. In fact, it is illegal for insurance agents to sell a Medigap policy if they know the client is in one of these plans.

Power of Attorney & a Living Will

After helping the client to determine which long term care policy is right for him, the insurance agent should make it clear to the client the necessity of obtaining documents that will instruct his loved ones and doctors what life-prolonging measures he wants. This may help to avoid problems in the event that he (client) can’t speak for himself.

Basically, there are two documents that will be needed: a health care power of attorney and a living will. These two documents often can be combined into one document. In some states, this document is called an advanced directive. Since state law governs matters of this nature, the document often has different names and rules.

The living will allows the client to make his wishes known about what medical treatments he wants, or does not want, and in matters, such as being in a vegetative state or terminally ill with no chance of recovery.

By addressing these matters in advance, the client may be able to make it clear what he wants and who he wants to make those important decisions. By doing so, he can save his family a great deal of difficult decision-making, stress, and self-doubt.
In Maryland, the signing of an advance directive must be witnessed by **two independent individuals**. This means that they can not be the client’s doctor or an heir.

The client doesn’t need a lawyer to draw up these documents. He can buy software with the documents, and some states put their forms on-line. Hospitals and nursing homes generally offer the documents during admissions. The documents can also be found on Kaplan’s group website: [www.partnershipforcaring.org](http://www.partnershipforcaring.org).

It might be worth it to the client to have a lawyer draw up the documents because the fee for this service is usually nominal, and the client can be assured the documents comply with state law.

The client should give copies of the documents to those who will need them. Lawyers often make several original copies, keeping one for themselves, one for the client’s doctor and one for the health care agent, or caregiver.

The client should keep the documents in a safe deposit box that both he and the caregiver has access. It is very important for the client to choose someone who will be mentally and emotionally able to comply with his wishes. Experts suggest that an alternate health care agent or caregiver be named, in case the first choice can’t make the decisions.

**GLOSSARY**

**Accelerated Death Benefit** A feature of a life insurance policy that lets you use some of the policy’s death benefit prior to death.

**Activities of Daily Living (ADLs)** Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring. Many policies use the inability to do a certain number of ADLs (such as 2 of 6) to decide when to pay benefits.
Adult Day Care  Care during the day for adults, usually at senior or community centers.

Alzheimer’s Disease  A progressive, degenerative form of dementia that causes severe intellectual deterioration.

Assisted Living Facility  A residential living arrangement that provides individualized personal care and health services for people who require assistance with activities of daily living.

Benefit Triggers  Term used by insurance companies to describe when to pay benefits.

Care Management Services  A service in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long-term care services.

Cash Surrender Value  The amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value will be determined as stated in the policy.

Chronic Illness  An illness with one or more of the following characteristics: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation, or care.

Cognitive Impairment  A deficiency in a person’s short-or long-term memory; orientation as to person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

Community-Based Services  Services designed to help older people stay independent and in their own homes.

Custodial Care  (Personal Care)  Care to help individuals meet personal needs such as bathing, dressing, and eating. Care may be provided by someone without professional training.

Daily Benefit  The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

Dementia  Deterioration of intellectual faculties due to a disorder of the brain.

Elimination Period  A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period in a policy, the lower the premium.

Guaranteed Renewable  When a policy cannot be cancelled and must be renewed when it expires unless benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than nonpayment of premiums (including health conditions and/or marital or employment status).

Health Insurance Portability and Accountability Act (HIPAA)  Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

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

Homemaker Services  Household services done by someone other than yourself because you’re unable to do them.

Inflation Protection  A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

Lapse  Termination of a policy when a renewal premium is not paid.

Medicaid  A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

Medicare  The federal program providing hospital and medical insurance to people aged 65 or older and to
certain ill or disabled persons. Benefits for nursing home and home health services are limited.

**Medicare Supplement Insurance** A private insurance policy that covers many of the gaps in Medicare coverage.

**National Association of Insurance Commissioners (NAIC)** Membership organization of insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

**Noncancellable Policies** Insurance contract that cannot be cancelled and the rates cannot be changed by the insurance company.

**Nonforfeiture Benefits** A policy feature that returns at least part of the premiums to you if you cancel your policy or let it lapse.

**Pre-existing Condition** Illnesses or disability for which you were treated or advised within a time period before applying for a life or health insurance policy.

**Rescind** When the insurance company voids (cancels) a policy.

**Respite Care** Offers a few hours to several days of help to relieve family caregivers.

**Rider** Addition to an insurance policy that changes the provisions of the policy.

**Spend Down** A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

**State Health Insurance Assistance Program** Federally funded program to train volunteers to provide counseling on the insurance needs of senior citizens. See pages 31-37 for a list of State Health Insurance Assistance Programs (SHIP).

**Substantial Assistance** Means hands-on or stand-by help required to do ADLs.

**Substantial Supervision** The presence of a person directing and watching over another who has a cognitive impairment.

**Tax-Qualified Long-Term Care Insurance Policy** A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

**Term Life Insurance** Covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build a cash value.

**Third Party Notice** A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment. This can be a relative, friend, or professional such as a lawyer or accountant, for example.

**Underwriting** The process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

**Universal Life Insurance** A kind of flexible policy that lets you vary your premium payments and adjust the face amount of your coverage.

**Waiver of Premium** A provision in an insurance policy that relieves the insured of paying the premiums while receiving benefits.

**Whole Life Insurance** Policies that build a cash value and cover a person for as long as he or she lives if premiums continue to he paid.
1. Approximately what percentage of Americans who reach age 65 will need long-term care before they die?
   a. 25%
   b. 45%
   c. 60%
   d. 75%

2. Long-term care service helps the insured live?
   a. like a millionaire
   b. like a poor person
   c. a normal life
   d. unknown

3. Which of the following is not an ADL?
   a. Bathing
   b. Toileting
   c. Continence
   d. Golfing

4. Cognitive impairment means a deterioration or loss in?
   a. Speech
   b. Running
   c. Bathing
   d. Intellectual capacity
5. Most states do not allow long-term care policies to limit benefits because the insured has?
   a. heart disease
   b. kidney disease
   c. Alzheimer’s disease
   d. hearing problems

6. _____% of all people receiving long term care benefits and are not in nursing homes.
   a. 10%
   b. 25%
   c. 60%
   d. 80%

7. Americans age 85 and older will __________ by 2030.
   a. double
   b. triple
   c. decrease
   d. stay the same

8. What is the average stay in a nursing home?
   a. 365 days
   b. 150 days
   c. 456 days
   d. 776 days

9. Eighty percent of the elderly would be impoverished with a stay of __________ weeks in a nursing home.
   a. 10
   b. 30
   c. 50
   d. 104
10. By 2020, ______ million Americans will need long term care.
   a. one
   b. five
   c. twelve
   d. six

11. The average stay in a nursing home is how many days?
   a. 456
   b. 350
   c. 150
   d. 550

12. What is the average cost to stay in a nursing home for one year?
   a. $15,000
   b. $35,000
   c. $52,000
   d. $45,000

13. Medicaid covers approximately _____ million individuals
   a. 36
   b. 50
   c. 65
   d. 75

14. States fund what percentage of the Medicaid insurance program?
   a. 10%
   b. 30%
   c. 50%
   d. 75%
15. During a covered stay at a nursing home, the patient must pay for the first .......pints of blood.
   a. two  
   b. three  
   c. four  
   d. five

16. For Medicare Part B, a person has to pay a premium of_____ per month in 2003
   a. 25  
   b. 50.25  
   c. 58.70  
   d. 68.90

17. Enrollment in Medicare Part B is______.
   a. not optional  
   b. optional  
   c. will be determined by the person’s doctor  
   d. is automatic when the person reaches age 64

18. Premiums for Medicare Part B are taken out of the person’s ______.
   a. savings account  
   b. checking account  
   c. Social Security check  
   d. money market account
19. Which former president was diagnosed of having Alzheimer’s disease?
   a. John Kennedy  
   b. George Washington  
   c. Ronald Reagan  
   d. Franklin Roosevelt  

20. Every day on average, ______Americans are diagnosed having Alzheimer’s disease.
   a. 986  
   b. 456  
   c. 786  
   d. 667  

21. Which disease is the # 1 reason for long-term care claims?
   a. strokes  
   b. cancer  
   c. Alzheimer’s disease  
   d. high blood pressure  

22. Medicare Part B covers preventive services for mammogram Screening_________________.
   a. once per month  
   b. once every 12 months  
   c. once every 6 months  
   d. once every 24 months
23. Medicare Part B covers preventive services for Flu Shots_____.
   a. once a year
   b. twice a year
   c. once every 24 months
   d. not covered

24. Flu is a serious illness that can lead to pneumonia. It can be dangerous for people age ___or older.
   a. 20
   b. 30
   c. 40
   d. 50

25. Flu shots only provide protection from the flu for about
   a. one year
   b. two years
   c. three years
   d. four years

26. Consumers should check an insurer’s rating with at least____ agencies.
   a. two
   b. three
   c. four
   d. five
27. Qualified Long-term care benefit payments are free from __________ income taxes when received.

   a. county  
   b. city  
   c. federal  
   d. township

28. The state of Maryland gives consumers an tax credit up to _______ if they purchase a qualified long-term care policy.

   a. $ 100  
   b. $ 200  
   c. $ 300  
   d. $ 500

29. Insurers will waive payment of premiums after the insured has been confined for a period of _______ days in a nursing home.

   a. 10  
   b. 30  
   c. 40  
   d. 60

30. The following common exclusions will be found in most LCT polices except

   a. war  
   b. acts of war  
   c. Alzheimer’s disease  
   d. care or treatment for alcoholism
31. All long-term care policies have at least a _____ day grace period.
   a. 10
   b. 15
   c. 30
   d. 45

32. The typical benefit period for LTC policies are between ............. to ........... years.
   a. one, two
   b. two, three
   c. three, four
   d. three, five

33. Insurers will typically pay what percentage of the insured’s daily benefit amount if the insured receives covered services outside the United States.
   a. 50%
   b. 60%
   c. 70%
   d. 80%

34. Benefits for bed reservations are usually limited to how many days per calendar year?
   a. 15
   b. 20
   c. 25
   d. 30
35. About ____% of people receiving long-term care services are working age adults, between the age of 18 and 64.

   a. 25  
   b. 35  
   c. 40  
   d. 50  

36. The cost of operating state Medicaid programs has jumped more than ____% since early 2001.

   a. 5%  
   b. 15%  
   c. 20%  
   d. 25%  

37. Medigap policies are sold by .......... 

   a. banks  
   b. private insurance companies  
   c. agencies of the U.S. government  
   d. stock brokers  

38. When a person buys a Medigap policy, premiums are paid to......

   a. the employer  
   b. the insurance company  
   c. a state agency  
   d. a federal agency
39. If medical expenses are more than 7.5% of adjusted gross income, what is the maximum amount a 40 year old can claim?

   a. $ 100 
   b. $ 210 
   c. $ 300 
   d. $ 400 

40. Experts believe the important factor in selecting an insurer is the ________________of the company.

   a. president 
   b. background 
   c. name 
   d. financial strength 

41. Once a long-term care policy is purchased the consumer should review the insurer’s rating__________.

   a. once a month 
   b. every six months 
   c. once a year 
   d. every two years 

42. Women face a ____ greater probability than men of entering a nursing home after age 65.

   a. 10% 
   b. 20% 
   c. 40% 
   d. 50%
43. Which former president was diagnosed of having Alzheimer’s disease?

   a. John Kennedy  
   b. George Washington  
   c. Ronald Reagan  
   d. Franklin Roosevelt

44. Since 1997, the number of Americans who’ve purchased LTC policies has grown at an annual rate of ________.  

   a. 10%  
   b. 18%  
   c. 50%  
   d. 100%

45. In 1999, there were how many Americans age 65?

   a. 1 million  
   b. 8 million  
   c. 35 million  
   d. 100 million

46. How many LTC policies were sold in 1999?

   a. 750,000  
   b. 2,000,000  
   c. 10,000,000  
   d. 50,000,000
47. There are ___ standardized Medigap plans.
   a. 5
   b. 10
   c. 15
   d. 20

48. It is illegal for an insurance agent to sell a ___ policy to a person who has a Medicare +Choice plan.
   a. life
   b. homeowner
   c. Medigap
   d. auto
PLEASE FULLY COMPLETE THE FOLLOW AND ANSWER THE 50 QUESTIONS. YOU MUST RECEIVE A SCORE OF 70% OR BETTER IN ORDER TO RECEIVE A CERTIFICATE FOR 4 C.E. CREDITS. TO BE GRADED FAX THIS PAGE TO: 410-734-7966

COURSE NAME: 21ST CENTURY LONG TERM CARE

NAME..................................................................................................................
ADDRESS...........................................................................................................
CITY....................................................................................................................STATE..................................
TELEPHONE.................................................................................................FAX...........................................
SOCIAL SECURITY #........................................................................INSURANCE LICENSE #.............................

HOW DID YOU PAY FOR THIS COURSE? PLEASE CHECK ONE:

___CREDIT CARD  ___CHECK/CASH

ANSWER SHEET

1. __ 16_____ 21.__ 36.__ 
2. __ 17_____ 22.__ 37.__ 
3. __ 18_____ 23.__ 38.__ 
4. __ 19_____ 24.__ 39.__ 
5. __ 20_____ 25.__ 40.__ 
6. __ 26.__ 36.__ 41.__ 
7. __ 27.__ 37.__ 42.__ 
8. __ 28.__ 38.__ 43.__ 
9. __ 29.__ 39.__ 44.__ 
10.__ 30.__ 40.__ 45.__ 
11.__ 31.__ 41.__ 46.__ 
12.__ 32.__ 42.__ 47.__ 
13.__ 33.__ 43.__ 48.__ 
14.__ 34.__ 
15.__ 35.__