Chapter 21
Private Plans for Seniors

Medicare Supplement Policies

- Private plans designed to supplement parts A & B only
- Can not sell to someone who has Medicare Advantage (Part C); Illegal
- Eight (8) N.A.I.C. Standardized Plans
- Each plan MUST cover basic benefits
- Benefits adjusted to satisfy statutory changes in Medicare
- Pre-existing exclusions max six (6) months
- 30 day free look minimum
- Must be guaranteed renewable – Premiums may go up for the entire class, NOT just for the insured alone

Long-Term Care Insurance

- Acute illness – can recover from; ex, pneumonia
- Chronic illness – treatable but not curable; ex. diabetes, heart disease
- Activities of Daily Living (ADLs)
  - Feeding
  - Toileting
  - Bathing
  - Dressing
  - walking
- Unable to perform at least two ADLs
- Pays a daily amount; $100, $200, $300 per day benefit

Three types of care

- **Skilled nursing**: continuous around the clock care
- **Intermediate nursing care:** nurses under the supervision of a dr.; not 24 hour care
- **Custodial care:** provides assistance with everyday living requirements; adult day care; respite centers;

Respite (Rest) Care

- Provides for rest period for family care giver

Provisions and Tax Treatment of Benefits

- Benefits are **tax free** if LTC plan is qualified, meaning the plan adheres to guidelines of HIPAA
- Also Must conform to N.A.I.C model regulations:
  - Policy must be guaranteed renewable

  - Must adhere to prohibitions on replacement & exclusions

Qualifying for Benefits

- Diagnosis of chronic illness one of two levels
  1. **Physical**: unable to perform at least two activities of daily living
  2. **Cognitive**: requiring substantial supervision to protect insured from harm with a diagnosis within the previous 12 months; ex. Alzheimer's

All LTC policies must be **guaranteed renewable**

Elimination Periods

- 0 - 180 days
- Maximum is 180 days

Exclusions

- Drug & alcohol dependency
- Self-inflicted injuries: ex. failed suicide attempt
- Acts of war'
- Nonorganic mental condition; ex Manic Depressive.

State Long Term Care Partnership – a brief summary

To qualify for Medicaid to pay for a Long-Term Facility, one generally must be impoverished. Assets below a very low number, perhaps $2000. Some folks spend their entire savings paying for a long term care facility and when assets are at the $2000 level, they are broke. And Medicaid "kicks in".

The idea is to get folks to buy long term care insurance and not "go broke". And, stay off Medicaid. This helps the states too.

To do this, some states have implemented a plan where if an insured buys a long term care partnership policy they will be allowed to keep assets equaling the amount of total benefits from the LTC policy and then qualify for Medicaid.

For example: A person bought a LTC policy totaling $100,000 in benefits. They enter a long-term care facility. If the benefits run out, they don't have to spend all their money down to $2000 to qualify for Medicaid. They would spend down to $100,000 and then qualify for Medicaid. They are allowed to keep an equal amount.