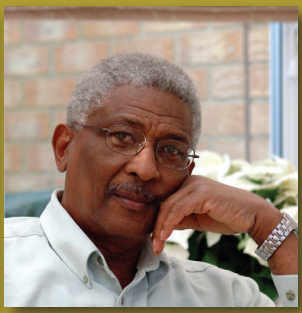
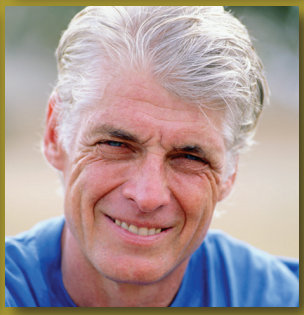
A CONSUMER GUIDE TO THE

MARYLAND LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM








Maryland

INSURANCE ADMINISTRATION

A CONSUMER GUIDE TO THE

MARYLAND LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM

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WHO WE ARE

The Maryland Insurance Administration (MIA) is the state agency that regulates the business of insurance in Maryland. If you are having a problem related to insurance, the MIA will try to help you to solve it.

HOW WE HELP CONSUMERS

We provide assistance to consumers, businesses, health care providers (doctors, hospitals), and producers (agents and/or brokers) in all areas of insurance; including life, health, disability, automobile, homeowners, and property.

- We can provide you with answers to your general insurance questions and suggest actions or processes that you may wish to follow in order to address and resolve your insurance questions or problems.

- We can provide you with educational materials (such as homeowners and automobile consumer guides) to help you understand the types of coverages you may be purchasing and your rights and obligations with respect to various types of insurance policies, as well as what you may wish to consider and the types of questions to ask when you are shopping for insurance.

- We can provide you with guides that may help you to compare rates among insurance companies writing automobile, homeowners, health coverage for small employers, and for Medicare supplement insurance policies.

- We may be able to investigate any circumstance that you bring to our attention, in writing, to ensure that the companies and individuals engaged in the business of insurance in our state obey Maryland laws and regulations.

- We may be able to investigate written allegations that your insurance carrier, insurance producer (agent), or other entity engaged in the business of insurance:
  - did not pay or authorize the payment for medically necessary services;
  - has improperly denied or delayed payment of all or some portion of your claim;
  - has improperly terminated your insurance policy;
  - has improperly raised your insurance premiums;
  - has made false statements to you in connection with the sale of insurance or the processing of insurance claims;
  - overcharged you for services, including premium finance charges.

WHAT IS LONG-TERM CARE?

Individuals with a prolonged illness, disability or cognitive condition (for example, Alzheimer's disease) often need someone to help with daily activities (such as dressing, bathing, etc.), as well as to provide skilled medical attention. Long-term care services may include care management, rehabilitation services, adult day care or hospice. These services may be delivered in an assisted living facility, at home or in a nursing home.

HOW MUCH DOES LONG-TERM CARE COST?

The cost of long-term care depends on a number of factors, including the type of care you receive, where you receive this care, who provides this care and the length of time you need to receive this care. According to the United States Department of Health & Human Services, the national average costs for long-term care services in 2016 are as follows:

- $225 a day or $6,844 per month for a semi-private room in a nursing home
- $253 a day or $7,698 per month for a private room in a nursing home
- $119 a day or $3,628 for care in an assisted living facility (for a one-bedroom unit)
- $20.50 an hour for a home health aide
- $20 an hour for a homemaker services
- $68 per day for services in an adult day health care center.

WHAT CAN I DO TO PAY FOR MY LONG-TERM CARE COSTS?

Paying for long-term care does not need to be overwhelming. Several options are available to make paying for long-term care more manageable. Some of the options include:

1. You may choose to fund the costs of your long-term care through investments you have made, such as an annuity. For more information about annuities, see the Maryland Insurance Administration's publication, A Consumer Guide to Annuities, available online: *www.insurance.maryland.gov/Consumer/Documents/publications/consumerguidetoannuities.pdf.*

2. You may decide to sell certain assets, such as your home or other real estate.

3. You may decide to obtain a reverse mortgage. See: *http://longtermcare.acl.gov/costs-how-to-pay/paying-privately/reverse-mortages/*.

4. You may be able to use your life insurance policy to pay for your long-term care by using one of the following methods:
   a. Combination life/long-term care insurance policies.
   b. Accelerated death benefits from a life insurance policy.
   c. Life settlement.
   d. Viatical settlement.

5. You could purchase a long-term care insurance policy. Find out more at: *www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf*.

DOES MEDICARE COVER LONG-TERM CARE?

If you are eligible for Medicare, Medicare may provide limited coverage for skilled nursing and rehabilitation services that are provided in an approved facility. But, Medicare does not cover custodial care services, intermediate care or services for a prolonged period of time. For additional information about Medicare, visit the Center for Medicare and Medicaid web site, *www.cms.gov/home/medicare.asp*.

WHAT IF I HAVE A MEDICARE SUPPLEMENTAL POLICY?

If you have a Medicare supplemental policy, keep in mind that while some supplemental policies provide a limited benefit to help pay for at-home recovery on a short-term basis, not all do. Also, while some of the Medicare supplemental policies provide a limited benefit while you are confined in a skilled nursing facility, the benefit only will be payable for the 20th through the 100th day of skilled nursing care in a nursing home. Under such a policy, you would not receive any benefits if you are receiving custodial or intermediate care or if you need care after the 100th day of confinement. It is important that you carefully review and understand the terms of your policy, what it covers and how much it pays.

WHAT DOES LONG-TERM CARE INSURANCE PAY FOR?

Long-term insurance policies, long-term care insurance riders to life insurance policies and annuity contracts provide coverage for certain long-term care expenses that usually are not covered by traditional health insurance and HMO contracts, Medicare, or Medicare supplemental policies. Coverage is provided when you are unable to do a certain number of activities of daily living (such as bathing, eating, or dressing yourself) or are cognitively impaired. While the exact terms and conditions of coverage depend upon your individual policy, long-term care insurance generally covers services such as nursing home stays for custodial, intermediate and skilled nursing care. These policies also may cover home health care and adult day care. Long-term care insurance can be purchased as a separate stand-alone policy or as a rider to a life insurance policy or annuity contract. For more information on long-term care insurance, see A Shopper's Guide to Long-Term Care Insurance, produced by the National Association of Insurance Commissioners at: *www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf*.

SHOULD I PURCHASE LONG-TERM CARE INSURANCE OR A LONG-TERM CARE INSURANCE RIDER TO MY LIFE INSURANCE OR ANNUITY CONTRACT?

Long-term care insurance is not for everyone. Before buying a long-term care insurance policy or a rider to your life insurance policy or annuity contract, it is important to understand what the policy or contract covers, know the limits of the policy or contract and understand any conditions the policy or contract may exclude. It is also important to make sure you can afford the premium payments.

It is also a good idea to consult with a tax advisor, as well as an insurance advisor, when deciding whether a long-term care insurance policy is right

for you. You may be eligible for federal and state tax benefits. Maryland law provides for a one-time tax credit of up to $500 after you purchase a long-term care insurance policy. In addition, federal law provides tax advantages if you purchase a qualified long-term care insurance plan.

QUESTIONS YOU NEED TO ASK BEFORE YOU PURCHASE LONG-TERM CARE INSURANCE OR A LONG-TERM CARE INSURANCE RIDER TO YOUR LIFE INSURANCE OR ANNUITY CONTRACT:

- What type of care is covered?
- Is there a waiting period before I can start using the benefits?
- What happens if I am late paying the premium?
- Is there a maximum number of days the policy or contract covers?
- Does the policy or contract have a per day limit? If so, does it take inflation into account?
- What are the rules about pre-existing conditions?
- What must happen in order for me to receive benefits under the policy or contract, i.e. doctor's certification, unable to perform daily activity?
- Has the insurer received approval to sell long-term care insurance in Maryland?

WHAT IS THE MARYLAND LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM?

The Maryland Long-Term Care Insurance Partnership Program is an innovative partnership between Maryland and private insurance companies that issue long-term care insurance policies. A policy sold under the Long-Term Care Insurance Partnership Program, by law, must meet the same standards as a long-term care policy not sold under the program. In addition, a partnership policy must meet certain specific federal and state requirements, and be certified as a "long-term care partnership policy" by the Commissioner of the Maryland Insurance Administration (MIA). Partnership policies provide an additional level of protection, when compared to regular long-term care insurance policies. In particular, Partnership policies permit you to protect additional assets from spend-down requirements under Maryland's Medicaid program if you should need assistance under this program, and you qualify.

HOW DOES ASSET PROTECTION WORK FOR THE LONG-TERM CARE PARTNERSHIP PROGRAM?

The asset eligibility and recovery provisions of the Medicaid program of Maryland are applied by disregarding an additional amount of assets equaling the amount of insurance benefits you have received from your Partnership Policy. For example, if you had received $200,000 of insurance benefits from your Partnership Policy at the time of application for Medicaid, you generally would be able to retain $200,000 of assets above and beyond the amount of assets normally permitted for Medicaid eligibility.

DO THE OTHER MEDICAID ELIGIBILITY REQUIREMENTS STILL APPLY TO ME IF I PURCHASE A PARTNERSHIP POLICY?

Yes, including special rules that may apply if the equity in your home exceeds a certain threshold. (As of 2018, the equity value limit was $572,000, but this limit may change over time based on federal standards.)[1] In addition, you must meet the Medicaid program's income requirements and may be required to contribute some of your income to the costs of your care once you become eligible for Medicaid.

ARE THERE ANY OTHER BENEFITS OF PURCHASING A PARTNERSHIP POLICY?

Yes. There may be tax benefits. By law, to qualify as a Partnership Policy, the policy must be a qualified long-term care insurance contract under federal tax law, and as such, the insurance benefits you receive from the policy generally will be subject to beneficial income tax treatment. (Please note that a policy can be a qualified long-term care insurance contract under federal tax law, with the same beneficial income tax treatment, even if it is not a Partnership Policy.) In addition, if you were under age 76 when you purchased your Partnership Policy, it must provide inflation protection to help protect against potential future increases in the cost of long-term care. (For older purchasers, an offer of inflation protection is required.)

WHAT COULD DISQUALIFY YOUR POLICY AS A PARTNERSHIP POLICY?

If you make any changes to your policy or certificate, such changes could affect whether your policy or certificate continues to qualify as a Partnership Policy. Before you make any changes, you should consult with the issuer of your policy to determine the effect of a proposed change. In addition, if you move to a state that

[1] *https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/ssi-and-spousal-impoverishment-standards.pdf*

does not maintain a Qualified Partnership or does not recognize your policy as a Partnership Policy, you would not receive Medicaid asset protection in that state. Also, changes in federal or state law could affect the Medicaid asset protection available with respect to your Partnership Policy.

WHAT IF I HAVE AN EXISTING LONG-TERM CARE INSURANCE POLICY? CAN I TURN IT INTO A PARTNERSHIP POLICY?

No. Federal rules require that any Partnership Policy be issued after the date of the State Plan Amendment. If you purchased a policy before January 1, 2009, or before the date your particular insurer was certified to sell a partnership policy in Maryland, it would not qualify as a Partnership Policy.

WHERE CAN I PURCHASE A PARTNERSHIP PLAN?

Companies wishing to sell Partnership long-term care policies are required to go through a stringent review process. The Maryland Insurance Administration will maintain a list of approved companies. You may obtain a copy of that list by contacting us at 800-492-6116 or by visiting the Maryland Insurance Administration's website at *www.insurance.maryland.gov*.

HOW WILL I KNOW I HAVE PURCHASED A PARTNERSHIP POLICY?

The schedule page of the policy is required to contain a notice if the policy is a Partnership Policy. The notice on the schedule page will indicate whether the policy is intended to meet the standards to be a Partnership Policy in Maryland.

Under state law, the carrier also is required to provide a separate notice, on its letterhead, that explains the benefits and the special rights of a Partnership Policy.

OTHER QUESTION

Q: CAN MY LONG-TERM CARE INSURER CANCEL MY POLICY BECAUSE OF MY AGE OR HEALTH CONDITIONS?

A: No. Under Maryland regulations, COMAR 31.14.01.04F (1), a long-term care insurance policy can only be terminated by the insurer in three instances: (1) nonpayment of premiums by the insured; (2) material misrepresentation in the application (within the contestable period); or (3) fraud in the application.

QUESTIONS ABOUT LONG-TERM CARE INSURANCE RATES

Q: WHY ARE LONG-TERM CARE INSURANCE PREMIUMS INCREASING?

A: When long-term care insurance policies were initially introduced across the country in the late 1970's and early 1980's, they were the first of their kind. Insurance companies had no prior data from which to draw assumptions and make predictions about how the insurance market would behave 30 to 40 years into the future. Unfortunately, many of these assumptions and predictions were inaccurate and resulted in companies being unable to price the long-term care insurance products appropriately. As a result, long-term care insurers are raising premiums, to ensure that they will be sufficient to pay future claims. Some original incorrect pricing assumptions and predictions included:

Higher than anticipated persistency: Fewer policyholders have allowed their policies to lapse than originally anticipated.

Policyholders are living longer than originally assumed, resulting in a higher rate of utilization of long-term care benefits. Additionally, the length of time a policyholder utilizes long-term care benefits is much longer than originally assumed.

Long-term care insurers' investment return rates are significantly lower than originally assumed.

Q: WHAT FACTORS DO INSURANCE COMPANIES CONSIDER TO DETERMINE THE PREMIUM RATES?

A: When insurance companies initially develop rates for long-term care insurance premiums, the main actuarial assumptions taken into account include lapse assumptions, mortality assumptions, morbidity assumptions and interest rate assumptions. Additionally, an insurance company may offer you discounts when you are initially purchasing a long-term care insurance policy, for being a very healthy applicant (i.e. passing more rigorous underwriting criteria), being married, or living with someone. Finally, long-term care insurance is generally offered on an issue-age basis, meaning the younger you are when you buy the policy, , the lower the insurance premium.

Q: IS THERE A MAXIMUM ALLOWED ANNUAL PREMIUM INCREASE FOR MY LONG-TERM CARE INSURANCE?

A: Yes. Maryland regulations, COMAR 31.14.01.04(A)(5), provides that except under certain exceptional circumstances, a long-term care insurer cannot raise your premium by more than 15% in a 12-month period. Furthermore, COMAR 31.14.02.06(B)(2)(d) states that, except under limited circumstances, your renewal premium rate cannot be greater than new business premium rates, except for differences attributable to benefits.

Q: DO I HAVE ANY OPTIONS OTHER THAN ACCEPTING THE PREMIUM RATE INCREASE?

A: Yes. If you would not like to accept the full premium rate increase, COMAR 31.14.01.36 requires every long-term care insurance policy and certificate to include a provision allowing the policyholder to reduce coverage and lower the policy premium in at least one of the following ways:

Reducing the maximum benefit; or

Reducing the daily, weekly, or monthly benefit amount.

Additionally, a long-term care insurer may voluntarily offer you other ways to reduce the impact of a premium rate increase by including options in the policy to lower the inflation protection rate, or by providing an option to reduce the inflation protection from compound to simple inflation. Before you make any decision involving reduction of benefits, you should understand the long term impact of doing so.

Q: WHAT DOES THE MIA DO WHEN IT RECEIVES A REQUEST FROM AN INSURANCE COMPANY TO CHANGE ITS LONG-TERM CARE INSURANCE PREMIUM RATES?

The process to file a premium rate change request is as follows:

1. All insurance carriers doing business in Maryland's individual and group long-term care insurance market must submit premium rate change requests to the MIA through the System for Electronic Rate and Form Filing (SERFF).

2. After an MIA analyst confirms that all required documents have been submitted, the filing is assigned to an initial reviewer. For a detailed description of the initial review process, see the MIA's power point entitled, "Long-Term Care Insurance Rate Review Process-Maryland" (October 27, 2016), available online: *http://insurance.maryland.gov/Consumer/Documents/agencyhearings/Long-Term-Care-Insurance-Rate-Review-Process-SarahLi.pdf*.

3. After completing an initial review, the initial reviewer provides a rate review summary form to all other MIA actuarial staff for peer review.

4. After peer review is completed, a public hearing may be conducted, during which MIA staff, the long-term care insurer that has requested the premium rate change, and consumers discuss the rate filing, and the long-term care insurer responds to questions from the MIA staff regarding the rate increase request.

5. After considering the information provided in the hearing, and any additional public comments, the Insurance Commissioner makes a final decision to approve or disapprove the premium rate increase request.

This consumer guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

People with disabilities may request this document in an alternative format. Requests should be submitted in writing to the Chief, Communications and Public Engagement at the address listed below.

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MIA-LT-1 (11/19)