FLORIDA DEPARTMENT OF FINANCIAL SERVICES

Division of Consumer Services

LONG-TERM CARE

a guide for consumers

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NOTE: Most insurance rates and forms in Florida are regulated by the Office of Insurance Regulation (OIR). Other financial services are regulated by the Office of Financial Regulation (OFR). Although both work closely with the Department of Financial Services (DFS), they are separate entities that are a part of the Financial Services Commission. Because DFS handles consumer-related matters, consumers should remember that DFS is their point of contact for all problems and questions.

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LONG–TERM CARE

WHAT IS LONG-TERM CARE?

Long-term care encompasses a wide range of medical, personal and social services. People may need this care if they suffer from a prolonged illness, disability or cognitive impairment. This care includes services provided by home health care agencies, adult day care centers, traditional nursing homes and continuing care retirement communities. (For definitions, please see the glossary.) In addition, family members often provide long-term care.

Types of Nursing Care

As you begin to plan for your long-term care needs, you will hear references to various types of nursing care, including skilled, intermediate and custodial.

Skilled care generally involves medical conditions that require care by trained medical personnel, such as registered nurses or professional therapists. A physician orders this 24-hour-a-day care as part of an overall treatment plan. People may need skilled care for a short time after an acute illness or injury, such as a stroke or hip fracture. However, some may require it for longer periods. A patient may obtain such care in a skilled nursing facility, nursing home or in an individual's home with help from visiting nurses or therapists.

Intermediate care refers to treatment needed daily, but not necessarily 24 hours a day. A physician orders this care and registered nurses provide supervision. It involves less specialization than skilled care, but often requires more attention to personal needs.

Custodial care involves helping a person perform the activities of daily living, such as bathing, eating, dressing and transferring (i.e., moving into or out of a bed, chair or wheelchair). It involves less intensive or complicated services than skilled or intermediate care, and can take place in many settings, including nursing homes, adult day care centers or private residences. Custodial care is sometimes called personal care. In Florida, nursing homes must be licensed for both skilled nursing care and intermediate care. To verify whether a nursing home is licensed, call the Agency for Health Care Administration (ACHA) toll-free at 1-888-419-3456.

Long-term care policies must also provide at least one service of Personal Care, (also referred to as a "lower level of care" and can be performed by someone without professional training), which may be delivered by adult congregate living facilities, adult day care centers, adult foster homes, assisted living facilities, home health agencies, nursing services or social service agencies. Personal Care may include (but is not limited to) such services as meals, transportation, dressing and general homemaker duties.

WHAT IS LONG-TERM CARE INSURANCE?

Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a range of services not covered by your regular health insurance, Medicare or Medicare supplement insurance.

Under Florida law, all insurance sold in Florida must be purchased from an insurance agent licensed by the Department of Financial Services (DFS). Long-term care policies may be distributed by an agent, through the mail or on the Internet. Some companies sell these policies through senior citizen organizations, fraternal societies and continuing care retirement communities. Some employers now offer these policies to their employees.

Standard Provisions

Long-term care policies are not standardized, resulting in many different policy designs. It is very important for the consumer to know the different types of coverage available, and then compare each policy, before purchasing, to make sure the policy being quoted has the benefits they are seeking. Please see pages 12, 13 and 14, for questions to ask when shopping for long-term care insurance policies.

Coverage

While long-term care policies vary in coverage, they usually will pay either a fixed-dollar amount (an indemnity) or the actual costs of care. However, policies that pay for actual costs usually have a specified daily benefit amount that puts limits on how much can be paid out each day. There may also be a limit on how many days the benefits will cover.

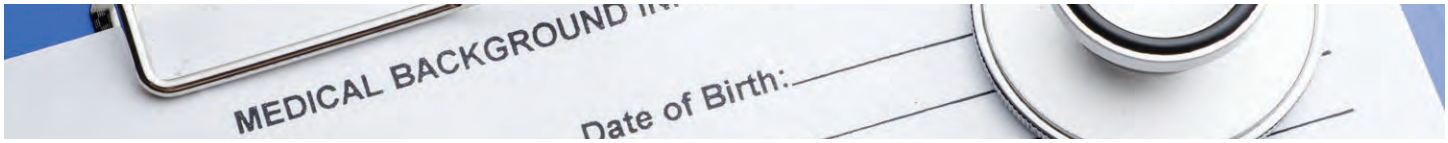
Tax Advantages

As a result of the federal Health Insurance Portability and Accountability Act of 1996, some insurance companies offer policies with certain tax advantages, called "qualified policies." Generally, these offer the same benefits as long-term care policies, but the eligibility requirements may differ. For example, the insured must be chronically ill or unable to perform at least two activities of daily living, such as bathing or dressing, to receive benefits.

To learn more, contact a trusted and reputable insurance agent, attorney, accountant or financial planner. You can also contact the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

BEFORE YOU BUY LONG-TERM CARE INSURANCE

Before spending any money on a long-term care policy, you should first ask yourself if you need one and can afford it. Also find out if the policy provides the desired benefits.



Will you need a long-term care insurance policy?

The possibility of needing long-term care increases with age. Individuals who are alive at age 65 can expect to live another 20.9 years based on a study published by the U.S. Department of Health and Human Services in 2015. 70 percent can anticipate having at least some needs for long term support services during their lifetime while 19 percent are expected to have needs that last less than a year and 14 percent are expected to have needs exceeding beyond five years.

You may not need long-term care insurance if you have enough savings to cover your health care. Nationally, the 2018 average cost of a private room in a nursing home may be about $100,375 a year or more, according to America's Health Insurance Plans (AHIP). Medicaid is the only government program available to pay long-term care costs for those who meet certain federal poverty guidelines and cannot afford to buy private insurance or pay the costs out-of-pocket. Contact your local Social Security office or your Area Agency on Aging for more information on Medicaid. To obtain the Area Agency on Aging phone listing in your area, call the Florida Department of Elder Affairs toll-free at 1-800-96-ELDER (1-800-963-5337). Before committing yourself to a policy, investigate what services your community provides for seniors. Area Agencies on Aging may be able to provide information.

According to the U.S. Department of Health and Human Services, in 2018 informal caregivers, such as family and friends, provided about 80 percent of all long-term care. On average, caregivers spend 20 hours a week giving care. You should discuss with your spouse, children or friends what assistance they would provide if you became sick or injured and need care.

What kind of policies can you buy?

There are many combinations of benefits available for long-term care insurance, and many types of policies.

Fixed dollar amount - Most policies pay a specific amount, or indemnity, for each day you receive coverage.

Individual life insurance and annuities - Under this arrangement, a percentage of the policy's benefits goes toward long-term care costs. However, the benefits and the cash values are reduced when long-term care benefits are paid. Check with your agent to find out if you qualify for this coverage. These are generally sold as acceleration riders to the life insurance coverage because they accelerate the death benefits.

An acceleration rider is paid as a monthly benefit to an insured person who requires round-the-clock care due to a medical condition. The kinds of care covered by this rider are specified by the rider and may provide, for example, benefits for the insured person to be cared for in either an approved nursing facility or in their home by a licensed home health agency.

The specific requirements that an insured person must meet to qualify for acceleration rider benefits depend on the terms of the acceleration rider. For example, the rider may require that care be "medically necessary." A common feature is the requirement that insured persons be unable to perform a number of "activities of daily living" to prove the necessity of long-term care (see the section "Types of Nursing Care" in this guide). Finally, most riders require a 90-day waiting period before accelerated rider benefits are payable.

Limited benefit policy - This is any policy that limits coverage to care in a nursing home or to one or more lower levels of care. For example, "nursing home only" or a home health care policy would be considered limited benefit policies.

Can you afford long-term care insurance?

Some financial experts recommend that you spend no more than 5 percent of your income on a policy. Following this recommendation means that you would need an annual income of at least $60,000 to afford a $3,000 policy that would provide all the benefits for a range of care. Of course, the price of your policy will depend partly on your health status, your age and the benefits you choose.

Carefully evaluate your sources of income. If you have large investments to protect, such as houses, businesses or stocks, it might be a good idea to buy a long-term care policy.

This is especially true if you do not want to use all of your savings and assets to pay for long-term care. However, if you are living on a limited income, such as Social Security benefits or a small pension, a long-term care policy may not be the best way to spend your money.

During your application review process, you will be provided with two important forms. One is a personal worksheet; the other is a disclosure. The personal worksheet will collect financial information to determine if the policy is suitable for you. The disclosure will provide, among other things, a list of the company's prior premium rate increases. This information is valuable when comparing products and companies.

Can you qualify for a policy?

Companies selling long-term care insurance underwrite their coverage. This means that you may have to answer a few questions about your health for the "short-form" underwriting process. The company may also collect a more detailed health history from you for an extensive underwriting process. The detailed underwriting procedure includes an examination of your current medical records and a statement from your doctor regarding your health.

If you have only minor health problems, most companies will issue you a policy. However, there will be a waiting period for most pre-existing conditions. A pre-existing condition refers to a case in which medical advice or treatment was needed, recommended by or received from a health care provider within six months before the date the insured person's coverage took effect.

Will a long-term care policy help provide the care you need?

Although long-term care policies have mandated coverage requirements in Florida, they may provide limited types of care. Discuss your needs with your family and friends before signing a contract, and make sure the policy will fill any gaps in care you have.

LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM

The Long-Term Care Insurance Partnership Program is designed to help protect the assets of long-term care insurance policyholders who subsequently seek Medicaid benefits. The federal Deficit Reduction Act of 2005 allows states to establish Qualified State Long-Term Care Insurance Partnership programs. However, having a qualified Long-Term Care Partnership Program policy does not guarantee that the insured will meet their state's Medicaid program requirements.

Long-Term Care Partnership Program policies must be tax-qualified (see glossary) and contain annual compound inflation protection for persons under age 61, and compound inflation protection for those age 61-75. Inflation protection is optional for those 76 and older.

There are no cost or underwriting differences associated with a Long-Term Care Partnership insurance policy and a non-Partnership policy.

While Florida participates in the Long-Term Care Partnership Program, not all states do. If you plan to move to another state, check with its Medicaid eligibility agency to find out if they participate in the program. Also, while not all states recognize policies purchased in other states, Florida does honor long-term care partnership policies purchased in other reciprocal states.

Agents selling qualified Long-Term Care Partnership Program policies are required to have extra training. Be sure you ask to see their certificate or contact the insurance company whose policy they are selling to verify they have received specific long-term care partnership training.

Do you qualify for Medicaid?

Seniors who do not have the financial resources to pay their long-term health care expenses may qualify for Medicaid.

To qualify for Medicaid, you will need to contact two state agencies. The Department of Elder Affairs (DOEA) determines medical eligibility and the Department of Children and Families (DCF) decides financial eligibility for Medicaid. Medicaid will pay for care only in Medicaid-approved facilities that provide the level of care you need. Under certain circumstances, Medicaid will pay for home health care.

The rules governing Medicaid are complex. For more information about qualifying, call the Department of Elder Affairs Medicaid Contact Center at 877-254-1055 and the Department of Children and Families at 866-762-2237.

You should consider what benefits the policy offers and the criteria for receiving those benefits before you buy a policy. You should also consider the exclusions and limitations of the policy. Discuss the policy with relatives, friends or your attorney before signing. Do not be afraid to tell an agent that you need time to think about your decision before you sign.

What activates payment of benefits?

Long-term care policies vary in the types of care they cover, the daily benefit amount they pay and the length of time the coverage lasts. Read the policy carefully to see under what conditions benefits are paid.

Even though you pay for the benefits, the insurer does not guarantee coverage unless you satisfy certain requirements. For example, most policies require that you be unable to perform a given number of activities of daily living without assistance. Some policies specify that they will cover only "medically necessary" care. Before buying such a policy, make sure you understand how the policy defines "medically necessary."

Most policies also have a benefit trigger for cognitive impairment. Policyholders can only qualify for these benefits if they are unable to pass tests assessing their mental functioning.

This standard is important if a person has Alzheimer's disease. An insurance company may deny an application for coverage to an individual who already has Alzheimer's disease, symptoms of cognitive impairment or any other pre-existing condition. Insurance regulations require long-term care policies to cover Alzheimer's for existing policyholders. Read and understand the terms used in the policy and how they apply to your coverage. A policy usually includes a section that lists and defines terms.

The same terms may be defined differently in various policies. For example, the term "care coordinator" may be a case manager or a benefits advisor. Please be aware that you are not bound to the insurance company's assessment of your eligibility for benefits. You may use your own licensed health care practitioner to assess your eligibility (see glossary).

How long does coverage last?

When you apply for a long-term care policy, you will have a choice in designing your policy. You decide on:

- the daily benefit amount,
- the maximum benefit period and
- the elimination period (explained below) that would best suit your needs.

The benefit may be a set dollar amount or may be stated as the number of years, months or days you will receive benefits. However, you must satisfy an elimination period, if there is one, before the benefits start. An elimination period is the length of time between when you enter a nursing home or are using home health care services and when you qualify for payment of benefits. The elimination period will range from zero to 180 days.

What is not covered?

Read the exclusion section of the policy carefully. Policies sold in Florida cannot exclude coverage for named conditions (stated in the policy) or diseases such as Alzheimer's or similar organic brain disorders, like severe dementia. Most long-term care policies will exclude coverage for:

- mental and nervous disorders or diseases (except organic brain disorders),
- alcoholism and drug addiction,
- illnesses caused by an act of war,
- treatment already paid for by the government and
- attempted suicide or the result of an intentionally self-inflicted injury.

CONSUMER ALERT

Although a company cannot exclude coverage for named diseases and conditions, such as Alzheimer's disease, it has the right to refuse to sell you coverage if you have failing health. Therefore, it is wise to consider your long-term care needs while you are in good health.

How are premium costs determined?

Premiums for long-term care insurance vary, usually depending on your age when you buy the policy, your health, the benefits provided, the length of the elimination period and any additional options you choose. These variables are outlined below.

Age - Each company sets the age limits that determine the cost. Usually, the younger you are when you buy a policy, the lower the premium. All long-term care policies sold in Florida are "issue age," which means that your premium amount does not increase because you get older, but instead continues to be based on your age when you first bought the policy. However, the premiums of "attained age" policies do increase as you age.

Health condition - Companies may set health underwriting criteria. Your general state of health may be determined by filling out an application. It is very important to state facts correctly and to not omit anything. Any omission can result in your policy being cancelled.

Benefits - Know what your policy will pay and the length of time you will be covered. Generally, when the policy pays more benefits, either through a larger daily benefit amount or a longer benefit period, the policy will have more expensive premiums.

Elimination period - The elimination period is the number of days you must be in a nursing home or receive a lower level of care before you begin receiving benefits from your policy. Usually, the longer the elimination period, the lower the premium.

Additional options - Additional options include "inflation protection," "non-forfeiture" and "premium-waiver" benefits. Your premium costs may increase after you purchase your policy, but they must increase for all people with the same policy in the state. This means that you cannot be singled out for a premium increase if you develop an illness or medical condition. Before you buy a policy, know the average cost of nursing homes in your area. This can help you better determine the amount of benefits you need.

What other features should I look for?

Florida law requires companies to offer inflation protection and non-forfeiture benefits on long-term care policies. You should also inquire about a premium-waiver benefit. These options may better meet your long-term care needs, but will require a higher premium.

Inflation protection automatically increases your benefits each year by a specific percentage. Insurance companies must offer a 5-percent compounded inflation protection feature.

Without such protection, the dollar amount of care for your policy remains the same. This means that 10 years after your purchase, your policy would not pay as much of your bill as it originally would have, due to the increased cost of care.

The **non-forfeiture benefit** provides a reduced amount of long-term care benefits or a shortened coverage period, if your policy is cancelled because you are unable to continue to pay your premiums. For more information, contact your insurance agent or company.

A **premium-waiver clause** allows you to stop paying premiums while you receive benefits. The National Association of Insurance Commissioners (NAIC) recommends that you obtain such a waiver with your policy.

A **contingent benefit**, provides new benefit options to existing policyholders if they are faced with a significant rate increase. This means the policyholder can choose to continue the current policy, accept a modified benefit plan at the existing premium, or accept a paid-up policy equal to the sum of all the premiums paid during the life of the policy. For more information about contingent benefits, please call the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

RENEWING YOUR POLICY

In Florida, all long-term care policies are "guaranteed renewable." This means that your insurance company cannot cancel your policy unless you do not pay your premiums, deliberately provide false information or leave out key facts about your health history. Once you exhaust the maximum benefit period, the company can terminate your policy.

When renewing your policy, you should not be pressured into dropping your current policy to buy a "new and improved" version. If you're thinking about switching policies, take time to read the new policy and determine whether it will provide key benefits that your current policy does not offer. Also, check to see if you must satisfy another waiting period for pre-existing conditions that you already satisfied under your current policy.

If you decide to switch policies, make sure your new policy has taken effect before discontinuing the old one.

QUESTIONS TO ASK WHEN SHOPPING FOR LONG-TERM CARE INSURANCE POLICIES

The following checklist is for comparison shopping purposes only. It provides a rough idea of what a long-term care policy may offer. It also points out some benefits that you may want to compare among the policies you review.

Please contact your insurance agent or company for the most current premiums available for your needs.

The amount you pay will be based on your age, sex, geographic location and the type of coverage. Usually, the older you are when you buy long-term care insurance, the higher the premium.

See the GLOSSARY for definitions.

		Company A		Company B		Company C	
1. In addition to nursing home care, which of the following are covered?	Home Health Care	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Adult foster home	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Adult day care	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Adult congregate living facility	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Nursing services	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
2. For these services, how much does the policy pay per day?	Nursing home care	**$**	**$**	**$**	**$**	**$**	**$**
	Home health care	**$**	**$**	**$**	**$**	**$**	**$**
	Adult day care	**$**	**$**	**$**	**$**	**$**	**$**
	Adult congregate living facility	**$**	**$**	**$**	**$**	**$**	**$**
	Nursing service	**$**	**$**	**$**	**$**	**$**	**$**
	Other	**$**	**$**	**$**	**$**	**$**	**$**
3. What are the lengths of the benefit periods?	Nursing home care	**___ Months**		**___ Months**		**___ Months**	
	Lower levels of care	**___ Months**		**___ Months**		**___ Months**	

	Company A		Company B		Company C	
4. What is the waiting period before pre-existing conditions are covered?	___ Months		___ Months		___ Months	
5. How many days is the elimination period before benefits begin?	___ Days		___ Days		___ Days	
6. How much does the base policy cost per year?	$		$		$	
7. How much extra does non-forfeiture protection cost?	$		$		$	
8. How much extra does inflation protection cost?	$		$		$	
Total	$		$		$	
9. Are there special conditions that I must meet before I can begin receiving benefits?	Yes	No	Yes	No	Yes	No
10. Does an activities-of-daily-living assessment need to be completed?	Yes	No	Yes	No	Yes	No
11. Will the company have its care coordinator conduct this evaluation?	Yes	No	Yes	No	Yes	No

NOTES

QUESTIONS TO ASK WHEN SHOPPING FOR LONG-TERM CARE INSURANCE POLICIES

		Company A		Company B		Company C	
12. Which benefit trigger does the policy use to decide my eligibility for benefits? (It may have more than one.)	Unable to perform activities of daily living	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Cognitive impairment (older policies may exclude coverage for Alzheimer's but newer ones cannot)	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Licensed health care practitioner certification of medical necessity	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	Prior hospital stay	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
13. How long before I can receive coverage for a pre-existing condition? (Usually six months)		**___ Months**		**___ Months**		**___ Months**	
14. How long is the company's review of my medical history to determine a pre-existing condition? (Usually six months)		**___ Months**		**___ Months**		**___ Months**	
15. Does the policy have a premium-waiver clause?		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
16. Is the policy tax qualified?		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**

NOTES

COMPANIES OFFERING LONG-TERM CARE INSURANCE

To find out whether a company is licensed in Florida or to investigate its complaint history, call the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

SENIORS: NEED HELP WITH YOUR INSURANCE QUESTIONS?

The Florida Department of Elder Affairs developed a program to help seniors with their Medicare and health insurance questions. SHINE (Serving Health Insurance Needs of Elders) trains senior volunteers to assist other seniors with their questions about Medicare, Medicare supplement, long-term care and other health insurance issues.

To find out if a SHINE program is operating in your community, please contact the Florida Department of Elder Affairs Helpline toll-free at 1-800-96-ELDER (1-800-963-5337).

YOUR RIGHTS AND RESPONSIBILITIES

Long-Term Care Insurance Rights

You have the right to receive an outline of the coverage written in easy-to-understand language. The outline explains your policy's benefits, exclusions and limitations.

You have the right to receive copies of all forms and applications signed by you or your insurance agent.

You have the right to a 30-day "free look period" to review your policy. If you decide you do not want to keep the policy, return it to the company by certified or registered mail with the return receipt requested. You must do this within 30 days of receiving the policy to be eligible for a full refund.

You have the right to have your policy renewed unless you don't pay your premiums or deliberately give misleading information on your application. Your rate may change, but only if the company changes everyone else's premium in your policy class. You cannot be singled out and have your premium increased because of your health or the number of claims you have filed. A company cannot cancel your policy because of your age or any medical condition that occurs after you obtain your policy. Your policy will state the conditions under which the company may raise your premiums.

You have the right to appeal any claim denied as not medically necessary to a licensed physician designated by your insurer.

You have the right to a policy with the following information stamped on the front page: "Notice to buyer – This policy may not cover all of the costs associated with long-term care that may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this policy in relation to changes in the cost of long-term care." In addition, your policy should state: "This policy has been approved as a long-term care insurance policy meeting the requirements of Florida law."

You have the right to have pre-existing conditions excluded for a certain period of time after your policy goes into effect. A pre-existing condition is an illness known about, diagnosed or treated before you buy a policy. Report all illnesses when applying for long-term care insurance. If your company learns of an unreported pre-existing condition, it may either refuse to pay claims or cancel your policy.

You have the right to a 30-day grace period to pay premiums. When this period expires, your insurance company may only cancel your policy for non-payment of premium. To do so, your company must mail you a notice of possible lapse in coverage, which gives you an additional 30 days for payment. The company must also send this notice to a secondary addressee if chosen by you at the time of purchase or at the policy renewal.

Long-Term Care Insurance Responsibilities

You are responsible for reading and understanding your insurance policy.

You are responsible for reading and understanding all "explanation of benefits" forms sent by your insurance company. Such a form will usually state: "This is not a bill." However, you should closely study it to find out whether you received the services described. You should contact your company for help if you don't understand the form or have trouble reading or speaking English. Careful scrutiny of these forms can help you and the insurance company detect and fight fraud.

You are responsible for reporting suspected fraud. For example, you may examine your health insurance records and discover that your insurance company was billed for services you never received. If you suspect such a crime has occurred, call the Florida Department of Financial Services Insurance Fraud Hotline toll-free at 1-800-378-0445.

You are responsible for making sure your application for insurance is correct. This includes information on pre-existing conditions. If you make a fraudulent statement, the company may cancel your policy or refuse to pay a claim.

You are responsible for knowing what your policy covers and what it excludes.

You are responsible for maintaining continuous coverage. If you purchase a new policy, do not cancel your old policy before the company has accepted your application and your new policy is in force.

You are responsible for paying your premiums, even while involved in a dispute with your company.

You are responsible for verifying licenses of an insurance agent and company by calling the Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236). A business card is not a license.

You are responsible for knowing the length of your policy's elimination period. This is the time you must wait, after you begin receiving care covered by your policy, before you can start receiving benefits. The elimination period cannot exceed six months (180 days).

HOW TO SELECT AN INSURANCE AGENT

When selecting an agent, choose one who is licensed to sell insurance in Florida. In addition to an insurance license, some agents have professional insurance designations such as the following:

CEBS .....Certified Employee Benefits Specialist
CFP.....Certified Financial Planner
ChFC .....Chartered Financial Consultant
CIC .....Certified Insurance Counselor
CLU .....Chartered Life Underwriter
CPCU .....Chartered Property and Casualty Underwriter
LUTCF.....Life Underwriting Training Council Fellow
RHU .....Registered Health Underwriter

Make sure you select an agent with whom you feel comfortable and who will be available to answer your questions. Remember: An agent may represent more than one company. To verify whether an agent is licensed, call the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236). You can also go to MyFloridaCFO.com/Division/Consumers/PurchasingInsurance/ and select Licensee Search to verify and search for licensing information.

HOW TO SELECT AN INSURANCE COMPANY

When selecting an insurance company, it is wise to know that company's rating. Several organizations publish insurance company ratings on the Internet. These organizations include: A.M. Best Company, Standard & Poor's, Weiss Ratings Inc., Moody's Investors Service and Duff & Phelps. Companies are rated on several of elements, such as financial data (including assets and liabilities), management operations and the company's history.

Before buying insurance, verify whether a company is licensed to sell insurance in Florida by calling the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236). Be sure to have the full, legal name of the insurance company when you call. You can also go to MyFloridaCFO.com/Division/Consumers/PurchasingInsurance/ and select Company Search to verify and search for licensing information.

CONSUMER TIPS

Shop carefully before you buy. Compare benefits, services and costs.

Take your time. Professional agents do not pressure their customers. If you are unsure about a policy, ask your agent to explain it to you again in the presence of a friend or relative whose judgment you respect.

Mail-order policies may lack service. Companies that sell mail-order policies may not have local agents or toll-free numbers, making it difficult to get answers to your questions. If a policy is sold through the mail, a toll-free number should be available.

Read your policy and be sure you understand what it covers and what it excludes. Know how your policy coordinates with other coverage you have.

Make sure all information on your application form is correct. An incorrect form could cause your insurance company to cancel your policy or leave you with unpaid claims. Do not be misled by agents who tell you your health history does not matter. Describe your health status accurately. It is best to fill out this information yourself. If the agent fills it out, do not sign it until you have made sure all the information is correct.

Do not pay cash. Pay by check, money order or bank draft made payable to the company, not the agent. Do not give your agent a blank check or access to your account. If you have an automated teller machine (ATM) card, do not give out your access number.

If you do not receive your policy in 45 to 60 days, contact the company or agent. If you have no success in receiving your policy, or suspect fraud, contact the Florida Department of Financial Services Insurance Fraud Hotline toll-free at 1-800-378-0445.

Get help. If you have questions or cannot resolve a problem with your insurance company or agent, call the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

CONTINUING CARE RETIREMENT COMMUNITIES (CCRCs)

WHAT IS A CCRC?

According to the National Center for Health Statistics, 811,000 individuals resided in residential care communities in 2016. For these individuals, CCRCs offer a way to meet future long-term care needs. Florida law defines CCRCs, also known as life-care facilities, as retirement facilities that furnish residents with shelter and health care in return for an entrance fee and monthly payments.

Potential residents often describe the promise of independent living and financial and psychological security as major attractions. Such residents may fear the prospect of entering an unfamiliar nursing home, separated from spouses, friends and loved ones. For this reason, CCRCs usually maintain a long-term nursing care facility on the premises that residents may use. Those residents who require nursing home care can receive the care they need while keeping in close contact with spouses, supportive friends and neighbors.

During the last several years, the CCRC market has dramatically changed. Originally, religious communities and fraternal organizations sponsored most of these communities through not-for-profit companies. They promised "total life care" through contractual arrangements for occupancy and services. However, for-profit businesses have also entered this market. Such businesses continue to change and expand the definition and function of these communities to meet consumer demands.

However, CCRCs don't solve the long-term care needs for all seniors. The relatively high cost of the entrance fees and ongoing monthly expenses make these communities unaffordable or impractical for many.

HOW TO SELECT A CCRC

Knowing your rights will help you determine if you can afford or benefit from a CCRC. To make an informed decision, you will need to know what information a CCRC must provide and what questions to ask. For example, you should find out about the development of any new or expanding communities under consideration.

Educate yourself on the state laws that form the basic regulations governing CCRCs. The Office of Insurance Regulation (OIR) regulates the financial solvency of CCRCs. This includes complaints against a CCRC from a resident or family member. The Department becomes involved after a contractual agreement has been signed by both parties or during the mediation process. For more information, contact the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

The Agency for Health Care Administration (AHCA), on the other hand, regulates other CCRC aspects, such as assisted living, skilled nursing care, quality-of- care issues and concerns with medical facilities. The Agency for Health Care Administration can be reached toll-free at 1-888-419-3456.

FINANCIAL CONSIDERATIONS

The agreement of residents in CCRCs to become lifelong occupants in these facilities usually requires fees that can be quite expensive. Under the traditional CCRC concept, the entrance fee can range from $2,000 to $500,000 or more. Many contracts offer plans that include refunds of entrance fee options up to 100 percent. In return for their payments, residents receive various levels of services, depending upon which option is chosen. In addition, the monthly fees can range from $250 to $5,000 or more. Facilities may offer additional benefits, such as health clubs, transportation and regular social activities.

There are four types of payment plans to consider when reviewing a CCRC facility. They are extensive, modified, fee-for-service and pay-as-you-go.

Payment plans

Extensive plan - It is easily the most expensive, but tends to offer the most services. Fees usually cover housing, certain amenities and services, and unlimited nursing home care. As the facility's costs increase due to inflation, the monthly fee may increase as well.

Modified plan - This plan offers housing and certain services and amenities, but varies in how much long-term nursing care is available. Because it only offers a specified amount of services for the initial fee, residents will be charged extra for any services provided in addition to those services originally contracted.

Fee-for-service plan - This plan is less expensive because it allows residents to pay only for services they will benefit from or use. Residents do not contract for long-term nursing care in advance, and must pay daily if this service is required.

Pay-as-you-go plan - With this plan, residents do not pay an entrance fee; however, a signed contract is still mandatory. A monthly fee is collected from the resident, and services and amenities may vary. These facilities may or may not be apartments offering leases and may or may not be licensed as providers in Florida.

Factors to consider

To determine the financial condition of the licensee and the CCRC, you should ask for a full information packet from each CCRC that interests you, including application forms, financial statements, the latest state examination and the continuing care contract.

Fees may vary, and when making comparisons, you should consider the amenities, whether you can obtain a refund of entrance fees, and the number of meals included in the basic monthly fee, as well as services. You should especially review health and nursing care terms included with the basic fees. The history of monthly maintenance fee increases should also be investigated, including the frequency and amounts. Florida law requires 60-day advance notice of changes in fees or the type of care or services. Talk to current CCRC residents about fee increases, and focus on the relevant contract provisions.

If you are considering a new CCRC, ask about the conditions for funds release. This could prove especially important if the facility does not offer occupancy when you make your initial deposit.

Learn the time schedule for completion and estimated occupancy when you make your initial deposit. Find out how the CCRC will provide housing, health care and other services during any interim construction periods. Most importantly, obtain written receipts for any funds deposited with the CCRC or its agents, and make all checks payable to the escrow agent.

Contracts

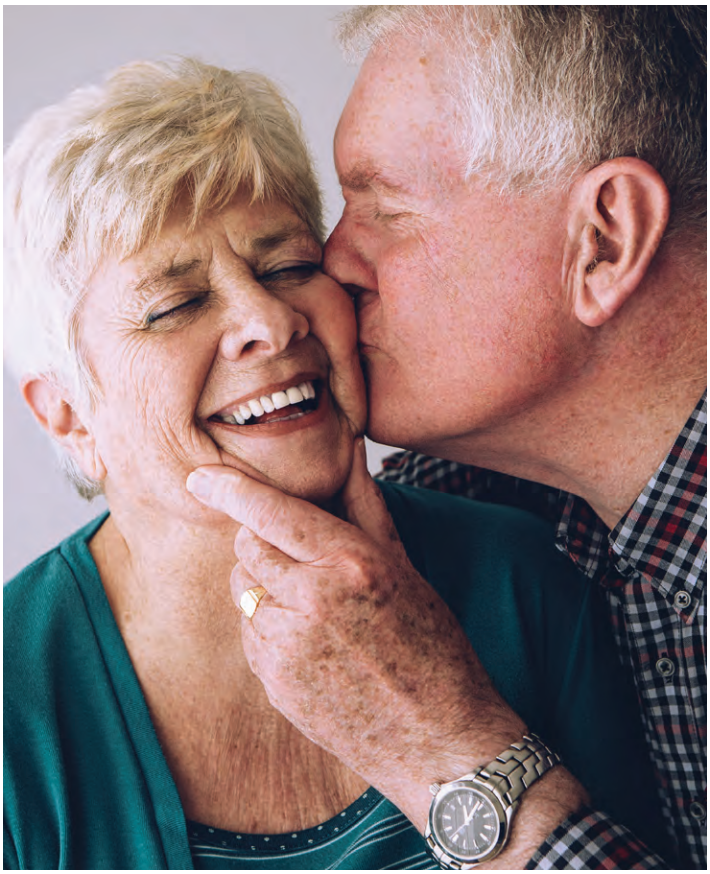
The Office of Insurance Regulation must approve all residency and reservation contracts before a CCRC can enter into them with potential residents. CCRCs must have 50 percent reserved occupancy and be fully licensed before construction can be initiated after receiving a provisional license for the company to begin marketing reservations to seniors. These licenses detail the various required events that must occur before the CCRC can begin to enter into contract negotiations.

Liability issues

Some CCRCs may prohibit you from holding the facility responsible for injuries resulting from its own negligence or that of third parties through a special contract provision. Verify who will be responsible for situations occurring where liability may become an issue. Do not assume that if an injury occurs to you or a visiting family member or friend at the facility, that it will be an obligation of the CCRC to pay for any costs incurred as a result of the injury. Determine if costs can be recovered due to the facility's negligence. Also, ask what liability the resident must incur if he or she loses or damages property owned by the facility through carelessness or negligence. These are all extremely important items to consider because they could lead to additional expenses.

The following questions will help you in planning for the financial considerations of a CCRC:

1. Does the CCRC and licensee inform residents about their financial condition?
2. How often and in what format do they provide this information?
3. What financial or monetary reserve does the licensee maintain? Do the CCRC and licensee fully meet the reserve requirements of Florida law? What is the location and balance of these reserves? Who could file a lawful claim in an event of default? Under what conditions can the CCRC draw upon these reserves?
4. How is the facility financed and who holds the first mortgage?
5. Are all principal and interest, insurance and tax payments current?
6. Are there any additional debts or obligations for the facility other than a first mortgage?
7. Do residents receive any ownership interest or rights?
8. Are any expansions planned, and will the CCRC finance them? How will that impact you?
9. What is the total entrance fee and what happens to it when paid? Does the CCRC take complete control of the funds immediately upon payment? Or, does it deposit the money into an escrow account? Under what circumstances or conditions are funds released, and to whom?
10. Which services will your monthly fee cover? Which services must you pay for out of your own pocket? For example, you should ask about barbershop, hair salon and cosmetic services. Can you afford to pay for these additional expenses for a long period?
11. Are assignments of your financial or personal decision-making authority to the CCRC required if you become incapable of handling your own affairs or making health care decisions? Does the CCRC require you to obtain a will or a durable power of attorney? You should consider obtaining and completing these documents even if it is not stated in the CCRC contract.
12. Does the contract provide a specific description of the living unit? Ask for floor plans and prices of all units.
13. Are you allowed to move from one unit to another? If your spouse dies and you want a smaller apartment, are you allowed to make that change? If so, are you eligible for a refund and reduction in monthly fees? If you marry, how can you obtain a larger unit and under what circumstances?
14. Can the CCRC eliminate or cut back on services? If so, under what conditions?
15. To what extent may you decorate or redecorate your unit? Can you make any changes to the outside of the building (such as hanging plants or bird feeders)?
16. Can visitors stay overnight or eat meals at the facility? Are pets allowed? If so, how many and what kind?
17. What security and safety measures will the facility provide? For example, does the CCRC offer a secured or guarded entrance, emergency call system or accommodations for the disabled?



The following questions will help in planning management considerations of a CCRC:

1. Who are the CCRC's officers, directors, owners, providers, "licensee" or party holding the license, and manager? What is their experience and relationship to each other?
2. What is the organizational structure of the CCRC and licensee? If a board of directors exists, who serves on it and how often are meetings held? If not, how does the CCRC establish policies and directives?
3. What grievance procedures exist? How can you file a complaint with management and what obligations, if any, do they have to respond? Florida law allows you to file complaints without fear of retaliation.
4. How much do residents participate in CCRC activities? Is there an active residents' council, and how often does it meet? Is there a chapter of the Florida Life Care Residents Association (FLiCRA)?
5. Does the CCRC have a newsletter? You should ask for previous issues of the newsletter to learn about community events and management policy or changes. While you wait to move in, ask the CCRC to place you on the newsletter's mailing list.
6. Who will develop and construct current or future facilities? What is their business arrangement or connection with the CCRC? What are their funding sources? If necessary, do the developers have enough collateral to continue borrowing money until they complete the project?

HEALTH CARE CONSIDERATIONS

It is important to consider all aspects of your health and to anticipate any future health issues that may arise. Health care is a top priority for seniors entering a CCRC due to the lifelong commitment this contract represents. Be aware of the various provisions and health options that are available.

Pre-existing conditions

Find out if the CCRC will limit its responsibility for pre-existing health conditions. If so, make sure you consider your current or previous health problems. The CCRC may not provide the services you need or want the most due to such health problems.

Fees

Verify whether a move to a CCRC's nursing home would affect your monthly fees and whether you qualify for an entrance fee refund.

Insurance requirements

Some CCRCs may require residents to purchase and maintain certain types of insurance, such as Medicare supplement or long-term care insurance. In Florida, the law requires companies that issue these policies to file them with the Office of Insurance Regulation for approval.

The following questions will help you in planning for the health care considerations of a CCRC:

1. Can unit residents receive help with drug dispensing (for example, receiving shots for diabetes)? Will the CCRC deliver specially prepared meals, if necessary, to a resident's room? Or, would the CCRC require the resident to receive such services at a specific onsite location? Are there additional costs for these services?
2. What are the factors and procedures used to determine when a resident must transfer from independent to assisted living or a nursing home? How much control do you have in this process? Is your spouse, family or others close to you, and your private physician allowed to participate in this decision, as they should be?
3. What specific types of health care and assisted care will the CCRC provide? Under what circumstances can the staff transfer you to an acute care facility?
4. What nursing home benefits will Medicare pay? Can you obtain any other government benefits?
5. Does the CCRC provide physicians or nurses for nursing home residents only? What are their qualifications? Can you see your own physician?
6. Do the premises include a nursing home? What happens if it fills up and you cannot obtain a bed when needed? After the first five years of operation, will the CCRC require you to share your room with persons who lack a continuing care contract? What levels of health care exist?
7. What responsibility will the CCRC have in paying for outside health care if it can't provide needed services on the premises?
8. How would your move to a nursing home affect your spouse who continues to reside at the CCRC's living unit?
9. What is the average age of the resident population?

OPTIONAL ACCREDITATION

The process of accreditation, which is a "seal of approval" from the Continuing Care Accreditation Commission (CCAC), means that a provider completes a voluntary self-evaluation of a CCRC's policies and procedures to verify that they meet certain criteria established by the CCAC. There are three areas reviewed in this process:

- health and wellness,
- finance and strategy, and
- governance

This involves the community's staff, residents, board of directors and an on-site review by trained CCAC evaluators. Accreditation is awarded for five years, and each CCRC must submit annual progress and financial reports to demonstrate ongoing compliance with standards. After five years, the CCRC must seek reaccreditation. Medicare and Medicaid may also require their own certification before an institution can qualify for payment under these programs.

DISPUTE MEDIATION/OMBUDSMAN

DFS helps residents who face difficulty resolving disputes with CCRC providers through a special mediation program. Under most circumstances, the program is available at no cost to the resident because the fee is paid by the CCRC. This program brings a resident and provider's representative together in an informal session with a trained mediator. This neutral third party—not affiliated with the CCRC—will strive for a resolution agreeable to both parties. However, the mediator will not dictate the final outcome.

Mediation is a non-binding process, which means neither you nor the CCRC must accept an unsatisfactory outcome to comply with Florida law. This process allows you to explain your understanding of your rights under the CCRC contract.

Either CCRC residents or a CCRC may request mediation, but disputes over rising monthly maintenance fees are not eligible for mediation hearings.

State law requires that mediators must complete special courses in mediation theory, processes and standards, in addition to other requirements.

The CCRC's representative and anyone with an interest in the dispute should attend the mediation session. You should bring all relevant documents, including a copy of your contract, letters, photographs, CCRC advertisements and sales materials, and other papers. The mediator will notify you and all interested parties of the date, time and place of the session. You may obtain additional information and a Complaint Form by calling the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

Additionally, the Florida Department of Elder Affairs Long-Term Care Ombudsman Program is an advocacy organization for Floridians who live in long-term care facilities, including adult family care homes, nursing homes and assisted-living centers. All complaints are confidential. For more information about this program, please call 1-888-831-0404, or visit its website at Ombudsman.ElderAffairs.org.

Your CCRC Rights

You have the right to receive and examine the annual report and other financial documents of the facility's licensed provider.

You have the right to talk to your state regulators financial status of the facility or if it has had complaints lodged against it. You may also want to consult the local Better Business Bureau or chamber of commerce.

You have the right to spend some time at the facility and talk to other residents to find out what they think about it. If possible, spend the weekend at the prospective CCRC and participate in some of its planned activities.

You have the right to ask your attorney, accountant or other trusted financial advisor to review the contracts and other written documents. Don't be afraid to ask questions or spend time making your decision. Remember, you can plan on spending a great deal of money and time (i.e., the rest of your life) at a given CCRC. You should know as much as possible about the facility before you make a commitment.

You have the right as a prospective resident to obtain a copy of the contract to carefully study before signing. In addition, the CCRC must disclose certain information about the ownership, financial condition, rules, regulations, expansion plans, the status of all licensing requirements, and the results of any audits or inspections conducted by the Office of Insurance Regulation or any other governmental agency.

You have the right to receive a copy of the Resident's Bill of Rights per section 651.083, Florida Statutes. This document explains your rights as a CCRC resident in Florida and it should be included in the "disclosure package," that must be presented to residents before entering into a CCRC contract. The disclosure package should include all the mandatory documents a CCRC is required to provide under Florida law. Once again, ask your trusted legal or financial adviser and family members to review this information.

You have the right to receive certain documents and information as a current or prospective resident before you sign a continuing care contract. You should make sure you understand the information made available to you before you sign anything.

Your CCRC Responsibilities

You are responsible for researching the financial stability of a CCRC.

You are responsible for knowing what levels of care are available and the cost of that care.

You are responsible for reading and understanding all disclosures and the "Resident's Bill of Rights."

CCRCS IN FLORIDA

To find out whether a CCRC is licensed in Florida or to investigate its complaint history, call the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or visit the Office of Insurance website at **https://floir.gov/home/continuing-care-retirement-communities** and click on county or facility name for location information for Florida's Continuing Care Retirement Communities.

MEDICAL PRIVACY AND THE MEDICAL INFORMATION BUREAU

The Medical Information Bureau (MIB) is a data bank of medical and non-medical information collected from the MIB's 430-member insurance companies. The information is accessible only to authorized personnel of the member company to which an individual has applied for insurance and has authorized the use of MIB as an information source.

Member companies send the MIB information you have written on applications, enrollment forms, and requests for upgrading coverage for health, life or disability insurance. The MIB also records information from medical exams, blood and lab tests, and hospital reports, when such information is legally obtainable.

If you have been denied life or disability insurance and wonder why, your file at the MIB may be the answer. You have the right to make sure the information in your MIB file is correct. Call the MIB at (866) 692-6901 and ask for a copy of your records, or access its website at MIB.com.

FOR MORE INFORMATION

Florida Department of Financial Services
Insurance Consumer Helpline
200 East Gaines Street
Tallahassee, FL 32399-0322
1-877-MY-FL-CFO (1-877-693-5236)
MyFloridaCFO.com/Division/Consumers/

Florida Department of Financial Services
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399-0331
1-877-MY-FL-CFO (1-877-693-5236)
FLOIR.com/Life-Health/Long-Term-Care

Agency for Health Care Administration (AHCA)
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
ACHA.MyFlorida.com

AARP Florida
200 West College Ave., Suite 304
Tallahassee, FL 32301
1-866-595-7678
States.AARP.org/Florida/AARP-Florida-state-offices

Commission on Accreditation of Rehabilitation Facilities (CARF)/Continuing Care Accreditation Commission (CCAC)
1730 Rhode Island Ave. N.W., Suite 410
Washington, DC 20036
1-888-281-6531
CARF.org

LeadingAge
2519 Connecticut Ave. N.W.
Washington, DC 20008
(202) 783-2242
LeadingAge.org

Florida Association of Aging Services Providers
1018 Thomasville Road, Suite 110
Tallahassee, FL 32303
(850) 222-3524
FASP.net

Florida Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
(850) 414-2000 or 1-800-96-ELDER (1-800-963-5337)
ElderAffairs.org

Florida Life Care Residents Association (FLiCRA)
325 John Knox Road, L-103
Tallahassee, FL 32303
(850) 906-9315
FLiCRA.com

National Consumers League
1701 K Street N.W., Suite 1200
Washington, DC 20006
(202) 835-3323
www.NCLnet.org

INSURANCE FRAUD COSTS US ALL!

The Coalition Against Insurance Fraud estimates over $308 billion is lost annually in the United States due to insurance fraud. This includes all lines of insurance. It's also a conservative figure because much insurance fraud goes undetected and unreported. Insurance companies generally pass the costs of bogus claims – and fighting fraud – onto its policyholders. This includes the money you pay for life, auto, health, homeowners and other types of insurance. You can protect your personal and family finances by learning about the many different types of fraud schemes and scams. Some common examples include:

False statements - An agent sells a long-term care insurance policy by misrepresenting the terms of the insurance contract on such important issues as the elimination period, the benefit period and inflated premium increases.

Retirement facility goes bankrupt - CCRCs are closely examined by the Office of Insurance Regulation to ensure their financial stability. However, if the CCRC is in financial trouble and misrepresents its financial status, residents may find that the facility will be unable to meet their needs.

Applicant fraud - A consumer applying for a long-term care policy deliberately withholds information out of fear of being denied coverage.

Unlicensed agent - Long-term care insurance agents must be licensed by the Department of Financial Services. An unlicensed agent can defraud or otherwise financially harm an insurance consumer.

Denied benefits - An insurance company refuses to pay a claim on a long-term care policy that should be paid, under the terms of the insurance policy.

There are many other types of insurance fraud. If you suspect such a crime has occurred, call the DFS Fraud Hotline toll-free at 1-800-378-0445 or visit first.fldfs.com.

INSURANCE DISCRIMINATION AGAINST VICTIMS OF ABUSE

Florida law prevents insurance companies from discriminating against victims of domestic violence or abuse. If you are denied insurance, if your rates are raised, or if the insurer refuses to pay a claim, demand in writing that the insurer explain in writing why it took this action. If you believe you have been discriminated against, call the Florida Domestic Violence Hotline at 1-800-500-1119. You can also file a complaint through the Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or go to the Department's website at MyFloridaCFO.com.

PROTECTING YOUR PRIVACY

Your Insurers and Financial institutions

Under federal law, some banks and insurance companies may have the right to share sensitive and personal information about you with other entities and business interests, without your permission. As the policyholder, you must take the lead in protecting your personal information.

Many companies will send you a privacy notice that will give you the opportunity to tell them that you want your personal information kept confidential. Unless you complete and return these forms, your personal financial and medical information may be shared with other companies. You may have to complete these forms on an annual basis.

When you receive a privacy notice form, read it carefully before signing it to avoid unintentionally giving the company permission to share information about you. If you have questions or concerns about these forms, call the Florida Department of Financial Services Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

Activities of Daily Living (ADLs)
Normal, everyday tasks, such as bathing, eating, dressing, transferring from one place to another (for example, moving from a chair to a bed), etc.

Actual Charge
The amount a health care provider bills a patient for a medical service or procedure.

Adult Congregate Living Facility
A licensed facility that provides housing, food, personal services and sometimes limited nursing care.

Adult Day Care Center
A licensed facility that provides social and leisure activities, self-care training, nutritional service, and sometimes speech and physical therapy.

Adult Foster Home
A licensed facility that provides living arrangements in a private home with supervision and attention to daily needs.

Amenities
Facility features, such as a pool, golf course, senior center, etc., that make the appeal of a location more valuable to the individual.

Assisted Living Facility
A private or boarding home, home for the aged, or other nonmedical facility, which provides residents with housing, meals and one or more personal services, such as recreational activities. It must provide such services for more than 24 hours to one or more adults who are not relatives of the owner or administrator.

Benefit Maximum
The limit a policy will pay for a given benefit. A benefit maximum can be expressed either as a length of time, for example, four years, or as a dollar amount, such as $1 million.

Care Coordinator (Optional Benefit)
A person who assesses a patient's need for long-term care, devises a treatment plan, helps with nursing services and monitors the 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.

Co-insurance
A percentage or dollar amount of an expense or service covered by insurance that you are required to pay.

Continuing Care Retirement Community (CCRC)
A retirement facility that contracts to furnish a resident with shelter and health care in return for an entrance fee and monthly fees. They are also known as "life-care facilities."

Contract Provision
A clause in a contractual document stipulating when and how certain actions are to be taken.

Coordination of Benefits
A method of integrating payments by more than one insurance policy so that benefits from all sources do not exceed 100 percent of the bills.

Chronically Ill
A person is certified by a licensed health care practitioner as being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or as requiring substantial supervision for protection from threats to health and safety due to severe cognitive impairment.

Custodial Care
Care that does not require a nurse that is provided in a nursing home, a private home, or other residence at a CCRC. These fees range from $2,000 to $500,000 or more.

Escrow
Money, property, a deed, etc., in the possession of a third party until an obligation is met for receipt of the item. For example, money to pay for the entrance fee of a CCRC can be held in escrow by a bank or other institution until the individual is ready to reside at the facility.

Exclusion
Any condition or expense for which the policy will not pay. For example, long-term care policies will not pay for treatment that should be paid for by the government (except Medicaid).

Free Look Period
A period of time after receiving a policy that you must decide whether to keep it or not. The law allows you 30 days to make your decision. If you paid a premium during that 30 days and decide not to keep the policy, you may receive a full refund. Be sure to return the policy to the company by certified mail within 30 days to guarantee your refund.

Grievance
A complaint that is filed to make an action or supposed circumstance known to others for possible resolution.

Group Insurance
Insurance that covers a number of people or groups under one policy. Most health insurance available from employers is group insurance. Group insurance usually costs less than individual insurance.

Guaranteed Renewable Policy
A policy in which the insurance company agrees to insure a policyholder for life. Premiums may change, if changed for all people within the same class of risks in the state. The company may cancel a guaranteed renewable policy for two reasons: The policyholder or a secondary addressee, if chosen, failed to pay premiums within 30 days of receiving a notice of possible lapse in coverage; or the policyholder deliberately misrepresented or left out key information on the application. All long-term care policies sold in Florida are guaranteed renewable.

Home Health Agency
A licensed facility providing such services as part-time nursing care; physical, occupational or speech therapy; or medical and home health aide.

Home Health Care
Intermediate or custodial care received at home from a nurse, therapist or home health aide under a doctor's supervision.

Individual Insurance
Insurance that covers one person under one policy.

Inflation Protection
A policy provision that automatically increases benefits each year by a specified percentage to stay in line with the increasing costs of long-term health care.

Intermediate Care
Care that is less than 24-hours, daily nursing and rehabilitative care performed by or under the supervision of skilled medical personnel. A registered nurse or a doctor must supervise care.

Lapse
The non-renewal of a policy by the policyholder.

Liability
An obligation that renders one responsible for a particular act or agreement.

Licensed Health Care Practitioner
A doctor, nurse, psychotherapist or social worker who assesses a patient's need for long-term care and develops a plan of care.

Licensee
An individual or entity to whom a license is granted.

Long-Term Care
The kind of care individuals need daily in the event of a chronic illness or disability. Long-term care can be provided in a nursing home, a private home or community setting.

Mediation
The attempt to bring about a compromise or resolution between two parties in disagreement. This involves the interaction of a neutral third party.

Non-forfeiture Benefit
A long-term care policy feature that allows the policyholder to lapse the policy after a certain number of years but still receive some benefits, usually equal to the premiums paid into the policy.

Nursing Service
A service by licensed individuals who provide nursing services in a private home.

Personal Care and Social Services
Services provided by personal care and social service community organizations.

Pre-existing Condition
A condition in which medical advice or treatment was needed, recommended by or received from a health care provider within a six-month period before the date the insured's coverage took effect. Pre-existing conditions usually are not covered until sometime after the policy has been in effect. Florida Statutes state that no pre-existing conditions apply if a policy is being replaced by the same company, or a company that is in the same "family" of companies as the original company unless it is a voluntary replacement by the insured.

Premium-Waiver
The suspension of premium payments after you have been receiving benefits from the policy for the period specified in the contract. Premiums will resume per the specifics of the contract. The National Association of Insurance Commissioners (NAIC) recommends that you buy a policy with a premium-waiver benefit.

Rider
An attachment to an insurance policy that adds benefits to the original contract.

Secondary Addressee
A person designated by the insurance policyholder to receive any notice of possible lapse in coverage.

Skilled Nursing Care
Daily (around-the-clock) nursing and rehabilitative care performed by or under the supervision of a registered nurse or a doctor.

Solvency
The capability of an organization or company to meet financial obligations.

Tax-Qualified
Part of the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA) ensures that long-term care policies that meet certain standards receive favorable tax benefits. For tax-qualified long-term care insurance plans, benefits are not generally considered taxable income. You can also deduct a portion of the premiums as medical expenses. Consult your tax advisor for additional information.

Third Party
A neutral party that is not affiliated with the two parties in disagreement.

Written Plan of Care
A plan developed by a licensed health care practitioner, outlining the care the patient needs, the length of time for needed care and other appropriate information. This plan may be needed before a patient can be admitted into a Medicaid-approved facility for long-term care.

NOTES

SEPTEMBER 2022