When Do Long-Term Care Benefits Kick In?

Life insurance claims are pretty easy to process. Either there is a death certificate on the insured, or there isn't. But with some types of insurance, events that qualify you for coverage aren't so easy to get a handle on.

For example, with long-term care insurance, benefits often become payable after a long and gradual decline in the insured's health and ability to care for themselves. While there are always going to be some gray areas, the answer for LTC insurance lies in the language of the contract itself.

ADLs

The first concept to become familiar with is the term ADL, which stands for "activities of daily living." ADL is simply shorthand for the routine, mundane tasks most of us take for granted вЂ” until we can't do them anymore.

For the purposes of LTC insurance underwriting, the IRS requires tax-qualified policies to use the ADLs listed below:

- Continence: The ability to hold urine.
- Transferring: The ability to get out of bed independently, or to transfer oneself from a bed to a chair.
- Toileting: The ability to toilet oneself.
- Dressing: The ability to dress oneself without assistance.
- Bathing: The ability to attend to basic tasks of personal hygiene.
- Eating: The ability to feed oneself.

Absent a debilitating cognitive impairment, such as Alzheimer's or dementia, the IRS requires tax-qualified policies to initiate benefits if the insured is unable to perform any two of these ADLs without assistance.

Generally though, policies do have a provision in place to begin awarding benefits to those diagnosed with severe cognitive impairments, even if they are still able to perform five or more of the ADLs by themselves.

Your policy will define the specific instances in which a long-term care benefit becomes payable for those with these kinds of medical issues.

Hands-on vs. supervised assistance

Some policies become payable only when two or more of these ADLs require "hands-on" assistance for the insured individual to perform. Other policies become payable when the insured requires supervision and prompting, but not necessarily hands-on assistance.

All things being equal, the latter version of the contract is preferable. But these policies typically come with higher premiums, since they are more likely to have to pay out benefits, or have to pay them out over a longer period of time. Premiums must, in the long run, reflect that higher likelihood.

Likelihood of needing long-term care

The likelihood of needing LTC assistance increases rapidly, though, once you get older. According to the AARP, the likelihood of a 65-year-old needing LTC services at some point in their remaining life is 68%. This is one reason why the insurance is expensive.

Exclusion period

Typically, LTC policies aren't payable immediately upon diagnosis. The insured is expected to retain some of the risk. For example, policies may have an exclusion period of 60, 90 or 180 days.

During this period, the insured pays out of pocket, or finds some other resources to pay LTC costs. This helps keep premiums affordable by keeping minor events requiring rehabilitative care rather than chronic, long-term conditions out of the risk pool.

The insured should strive to have liquid savings or other resources sufficient to cover LTC costs during the exclusionary period.

Long-term care and Medicare

Note that Medicare also has limited LTC benefits.

However, Medicare will only pay for up to 100 days of long-term care, and only pursuant to a qualified hospitalization. It does not provide significant benefits for chronic conditions that are truly long-term in nature.

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Medicare Expands Eligibility for Lung Cancer Screenings

The Centers for Medicare and Medicaid Services has expanded coverage for Medicare recipients who qualify for low-dose CT scan lung cancer screenings.

The change lowers the starting age for screening with a low-dose CT scan from 55 to 50, and reduces the tobacco smoking history from at least 30 packs per year to at least 20 packs.

The move to expand coverage came on the heels of new recommendations by the United States Preventive Services Task Force that heavy smokers should receive preventative screenings for lung cancer. It recommended the new regimen as an important step saving lives through early detection.

Under the new rules, Medicare will cover low-dose CT scan lung cancer screenings for Medicare beneficiaries who:

- Are between the ages of 50 and 77,
- Show no signs of lung cancer,
- Have an extensive tobacco smoking history (20 packs per year),
- Are current smokers or smokers who quit within the past 15 years, and
- Receive a provider's order to undergo CT scan screening.

Procedures

To be eligible for coverage, before the first screening beneficiaries must receive a counseling on lung screening and abstinence or quitting smoking by their doctor in a process called "shared decision-making."

This must be documented in the beneficiary's medical records.

Shared decision-making must include the use of one or more decision aids:

- Counseling on the importance of adherence to annual lung cancer low-dose CT screening, the impact of comorbidities, and the ability or willingness to undergo diagnosis and treatment;
- Counseling on the importance of continuing not to smoke cigarettes for people who have quit; and
- Counseling on the importance of giving up the habit if the beneficiary is a current smoker. That can include furnishing them with information about tobacco cessation interventions.

Why it's important

This change in coverage is important considering that 87% of Medicaid beneficiaries who were eligible to receive lung cancer screenings did not receive one, according to a 2021 study by Epic Health.

Lung cancer screening for heavy smokers saves lives. Detecting cancer early can result in a much better quality of life and survival rate than if it's caught later.

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High 'Health Insurance Literacy' Tied to Better Medicare Choices

People who have a strong understanding about health insurance and how it works are more likely to enroll in Medicare Advantage than people who don't, according to a new study.

They are also more likely to select lower-cost plans that also have high Medicare Advantage star ratings (a ranking of plans based on their quality of care and customer service), according to the study that was published in the *Journal of American Medicine Association's Network Open*.

The study also found that a poor understanding of health insurance leads to high costs for Medicare enrollees or poor-quality coverage choices.

The findings illustrate the importance of doing your research and reaching out to us to help you make a more informed decision about your Medicare options. The findings also drive home the fact that if you don't make informed decisions about your coverage, your pocketbook вЂ” and your health вЂ” may suffer.

The importance of 'health insurance literacy'

The study looked at "health insurance literacy," a term that describes the level an individual's ability to seek, obtain and understand insurance coverage.

According to the study, people with higher health insurance literacy вЂ” particularly, those who engage in annual review and comparison of coverage choices вЂ” are the most likely to enroll in low-cost Medicare Advantage plans with high star ratings.

The study found that low health insurance literacy more often resulted in people enrolling in traditional Medicare and/or making poor plan choices, which can hurt their overall health and also result in higher outlays for their medical care.

An earlier study found that Medicare beneficiaries in counties with higher health literacy:

- Received 31% more flu shots,
- Experienced 26% fewer unnecessary hospitalizations,
- Had 18% fewer emergency department visits overall, and
- Had 9% fewer hospital readmissions.

The new study found that:

- 38% of individuals who reviewed or compared coverage options annually enrolled in Medicare Advantage, compared with 27.8% for those who did not.

- Individuals who enrolled in Medicare Advantage and who had high health insurance literacy who reviewed or compared coverage options annually, were more likely to enroll in plans with 4 to 4.5 stars and in unrated plans.
- Individuals who enrolled in Medicare Advantage and who had high health insurance literacy were more likely to choose plans with monthly premiums of between $1 and $50.
- Health insurance literacy was limited among beneficiaries with low socioeconomic status. The likelihood of reviewing or comparing health care coverage options annually was lower among beneficiaries with less than a high school education, dually eligible for Medicare and Medicaid, and older than 80.

Your choice

The main reasons that people choose Medicare Advantage are that:

- They have multiple plans to choose from with varying premiums, benefits and extra features, and
- They can use the star rating system to gauge the strength and performance of plans with guidance.

Choosing the wrong plan can have a negative impact on both your health and your finances.

Even if you do not have high health insurance literacy, you can make a smart choice by calling us to see how a Medicare Advantage plan may benefit you.

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How to File a Life Insurance Claim

Following the death of an insured loved one, it is important to file a life insurance claim in a timely manner. There is paperwork involved, and the process may seem burdensome at such a difficult time.

However, beneficiaries must file the necessary paperwork in order to receive their funds, comply with the law and meet tax rules. When faced with this process, it is important to know what to do and have a checklist. This will help beneficiaries make sure they are doing everything necessary to complete the process efficiently.

Contact us

The first step in filing a claim includes a call to the life insurance agent. Ask what paperwork is required. If a loved one's policy was part of a workplace benefits package, it is also necessary to contact the deceased's previous employer to obtain information about any specific steps to take.

Find all the policies

When filing claims, some people may not know what types of insurance a loved one carried. Credit card companies offer special life insurance policies, so check with the deceased's card sponsors for existing coverage.

Group life insurance policies are sponsored by employers. Some private financial institutions also offer a variety of life insurance policies. It is important to obtain data about all of these and understand the differences between the various types of coverage.

To find these policies, review the deceased's credit card records, bank statements and employment records. Also, it is helpful to check files or folders with stored information.

Additional provisions

Some additional specialized types of life coverage a person may carry include mortgage life insurance, travel life insurance, credit life insurance and accidental death coverage.

Each type comes with its own benefits and fine print, which must be reviewed carefully. In many cases, part or all of remaining account balances may be covered.

If any of these types of insurance may be relevant to the deceased and cannot be found, contact lenders to ask about death benefits before filing a claim.

Organize the paperwork

Contact the funeral director handling the final arrangements to obtain a certified copy of the death certificate. If the deceased was a spouse, a copy of the marriage certificate will be helpful to include.

Any relevant loan paperwork, employee insurance information or credit card statements are also helpful. Make sure the death certificate that is submitted is a certified copy and not a photocopy.

A proof of death form must also be submitted. To obtain this form, contact us if you bought the policy with our help.

Choosing a benefit disbursement plan

With most policies, the benefits can be distributed in four ways:

Lump sum вЂ” The entire benefit amount is provided in a single payment.

Specific income provision вЂ” The insurer pays the beneficiary both the interest and principal using a set schedule of payments.

Interest income option вЂ” The life insurance carrier holds the proceeds and pays the beneficiary interest on the sum. The entire benefit amount remains the same and is disbursed to a secondary beneficiary upon the death of the initial beneficiary.

Life income option вЂ” With this option, the beneficiary receives a set income for life. The amount depends on the benefit sum, the beneficiary's age and the beneficiary's gender at the time of the policyholder's death.

Processing the claim

After the claim has been submitted, processing usually takes about one week. Insurance companies must analyze the claim, confirm the policy and ensure requirements are met. If requirements have not been met, the process will take longer. During the delay, additional information will be collected.

For answers to any questions regarding claims, please give us a call.

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Why Everyone Needs Life Insurance

Most financial experts say that life insurance is a cornerstone of solid financial planning as it protects dependents from financial ruin after the death of a breadwinner.

But even if you are single or don't have dependents, it can still be a valuable component of your financial planning and safety net.

1. Life insurance replaces income for surviving family members or dependents вЂў If you have others who depend on your income, it is important that you have a plan to continue providing for dependents in the event of an untimely death. This is especially important for families with young children and a spouse who stays at home to care for them.

It can also be important for couples. If one person earns more, the survivor would face financial hardship in meeting monthly obligations.

In addition to this, people who provide financial support to their aging parents should also purchase life insurance to make sure they receive the continued support they need.

2. Life insurance builds an inheritance for heirs вЂ” For those who want to pass something on to heirs but do not have many assets, life insurance is an easy way to do that.

By naming specific heirs as beneficiaries, the named individuals will receive the money the policyholder wants them to have.

3. Life insurance pays for final expenses вЂ” With the price tag for most funerals hovering close to $10,000, it is important for every person to have at least enough life insurance to cover final costs.

These can be burdensome to survivors, but life coverage makes it easy for family members to pay probate costs, administrative costs and funeral expenses.

4. Life insurance covers death taxes вЂ” Even death is taxed. It is taxed at both a federal and state level. Without life coverage, survivors would have to sell the deceased's assets to try to pay for these costs.

In some cases, they may have to take a smaller inheritance instead. However, life insurance can be put in place to cover these costs and take the burden off of survivors' shoulders.

5. Life insurance builds savings вЂ” There are types of life insurance that yield a cash value. If this amount is not paid out as a death benefit, it can be withdrawn or borrowed by the policyholder. And the interest is tax-deferred.

For sums paid out as death benefits, the interest is tax-exempt.

6. Life insurance makes charitable contributions possible вЂ” If you name charities as beneficiaries on your policies, you can provide larger sums than you may have otherwise been able to out of pocket.

Many single people who do not have dependents or family members to name as beneficiaries choose this option to leave a positive mark on the world.

The final word

Life insurance is something that can benefit any adult regardless of age, marital status and family status.

To learn more about what options best fit individual needs, call us today.

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New Rules Expand Services Covered with No Cost-Sharing

The Department of Health and Human Services has issued some new "frequently asked questions" for its Affordable Care Act pages, and new guidelines that require health plans to expand what they are required to cover with no cost-sharing.

The new FAQ section expands the age group for which insurers must cover colonoscopies and adds some women's services that must also be covered with no out-of-pocket costs on the part of the insured patient.

Additionally, the HHS updated its rules on women's breastfeeding supplies, coverage for obesity treatment in some women, as well as adding screening for suicide risk for some age groups.

Here's a rundown of the new rules:

Colonoscopy rules

Under current Affordable Care Act rules, non-grandfathered health plans are required to cover without cost-sharing regular colorectoral screening starting at the age of 50 and through the age of 75. That includes:

- Required specialist consultant prior to the screening procedure;
- Bowel preparation medications prescribed for the screening procedure;
- Anesthesia services performed in connection with a preventive colonoscopy;
- Polyp removal performed during the screening procedure; and
- Any pathology exam on a polyp biopsy performed as part of the screening procedure.

The new rules extend that coverage to people between the ages of 45 and 49 if they get abnormal results from a stool-based test.

These new rules take effect on health plan years that start on or after May 31, 2022. That means most people won't see the changes until Jan. 1, 2023 since most plans run on calendar years.

Coverage of contraceptives

The ACA requires health plans to cover FDA-approved contraceptives with no cost-sharing. More importantly, if a patient's doctor recommends a particular service or specific FDA-approved based on their determination that is of medical necessity, the plan must cover that service with no patient out-of-pocket costs.

However, the HHS says it's been receiving complaints about health plans sometimes denying some of these FDA-approved services despite the patients' doctors determining it to be of medical necessity. In some cases, the insurer is requiring patients to try other services first or fail in their use of other services before approving use of the FDA-approved contraceptive method.

The HHS is reminding plans and insurers of their obligation to cover these contraceptives, regardless of if they are in the current FDA Birth Control Guide or not, as it does not include every FDA-approved method.

Other changes

HHS guidelines allow for certain breastfeeding services and supplies to be covered with no cost-sharing. There are a number of services and supplies already covered, but the new guidelines add coverage for double breast pumps.

The HHS also approved a new guideline aiming to prevent and reduce obesity in midlife women (ages 40 to 60) through counseling with no cost-sharing required.

The HHS has also issued new guidelines requiring universal screening for suicide risk to the current Depression Screening category for individuals ages 12 to 21, and new guidance for behavioral, social and emotional screening. There are also new guidelines for assessing risks for cardiac arrest or death for individuals ages 11 to 21 and assessing risks for hepatitis B virus infection in newborns to 21-year-olds.

These too are services that would have to be covered with no out-of-pocket costs to the insured patient.

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