

# Are Benefit Triggers Important In A Long-Term Care Plan?

## What are “Benefit Triggers”, anyway?

“Benefit triggers” is a term used by insurers to describe the conditions under which, your long-term care plan will pay benefits. This becomes very important to you, because you need to know what circumstances, health conditions or disabilities would make you eligible to receive benefits. Since insurance policies are legal contracts between the insured and the insurance company, it is very important to know what language or legal terminology is used in a particular plan. Most policies will pay benefits when you are totally disabled, but what about those instances where you are not bedridden or in a wheelchair? In my opinion, benefit triggers are the single most important part of any long term care policy, because if you don’t qualify according to the definitions in your policy – you don’t get paid anything.

The phrase – “**Words mean something**” is very true, especially in a legal document. The main goal is to understand the terminology, so that there will be no surprises at the time the plan is needed. A long-term care consumer should position him/herself to be in the most favorable light with the broadest interpretation and most options available. Waiting until a claim is imminent is counter-productive and is no time to be questioning the meaning of some specific legal terminology. Insurance companies hire lawyers to write the terminology in their plans and - **if they think that it’s important, you should too.**

Obviously, some legal terminology is necessary to protect you and the company from higher costs due to fraud and other illegal activities that may damage the company’s financial position. Also, you have to have some kind of medical or mental incapacity to qualify for benefits – no company will pay benefits if you just get tired of mowing your grass and doing your housework (you don’t get something for nothing). The point to remember is that **not all policies have the same terminology** and it is best to find one with language most favorable to you.

## COMMON TYPES OF TRIGGERS ON LONG TERM CARE & HOME HEALTH CARE PLANS

### 1. ACTIVITIES OF DAILY LIVING (ADL’S)

An ADL requirement is the most common method of determining eligibility for benefits. ADL’s simply speaking are those things that you commonly do for yourself everyday – i.e.: wake up & get out of bed, go to the bathroom, get something to eat, take a shower or bath, get dressed & leave home. There are seven typical ADL’s used by insurance companies, although all of them are not required to be included in a long-term care policy: bathing, continence, dressing, eating, ambulating, toileting and transferring. Typically, the benefits are payable when you are unable to perform a specified number of ADL’s, such as two of the seven or three of the seven. There are a few policies, which only require one ADL to be disabled and they are considered to be superior, since less requirements make it easier to qualify for benefits.

All policies use an ADL basis for triggering benefits, but some use five of the seven ADL’s listed above as qualifiers. It is very important to have “bathing” included as an ADL choice, since research has shown that bathing is usually the first ADL that a person is unable to perform. If bathing is not included, it may make qualifying for benefits much more difficult than on a policy which includes bathing. Also, it is important to know whether a policy requires “substantial hands-on” assistance – which means that someone actually has to help you perform the activity. This is more restrictive than a policy, which requires “stand-by” assistance where someone only has to supervise the activity.

**NOTE:** Tax-qualified plans are more restrictive in that they use a 2 ADL trigger, but also require a 90 day certification from a medical professional that your disability will last at least that long and require re-certification every 90 days that you are chronically ill and your care is **medically necessary**. This may eliminate claims for assisted living - where you may only

need assistance with minor ADL's and your care is not considered to be "medically necessary".

## 2. COGNITIVE IMPAIRMENT

This trigger is based on testing to assess mental function. You qualify for benefits based on your inability to mentally take care of your normal business activities. Alzheimer's disease is an example, along with any other form of dementia. This provision is important because a person with Alzheimer's disease may be physically healthy and able to perform the normal ADL's and would not qualify for benefits without this provision.

**NOTE:** Some policies use the word "**severe**" in describing cognitive impairment and this is a very restrictive definition. **All tax-qualified policies use this definition** and define "severe" as a condition where you are considered to be a threat to yourself and to others. Many Alzheimer's patients would not be considered to be threatening by this definition and would, therefore, not qualify for benefits.

## 3. DOCTOR CERTIFICATION OF MEDICAL NECESSITY

This provision allows your family doctor to assess your condition and order the care as being "medically necessary". This is an additional third trigger, not to be confused with the restrictive "medically necessary" wording in Tax-Qualified plans. This additional trigger can be important to you if you "fall through the cracks" and do not have an ADL loss or cognitive impairment, but still need the care because of a medical condition. There are many people in nursing homes that would not otherwise qualify for benefits if a policy only used ADL's and cognitive impairment to trigger benefits. It is always better to have more possible triggers, even if you don't ever use them, than to choose a more restrictive policy and "trust the odds".

**NOTE:** Quite a few policies are now using **only** two triggers – ADL loss and cognitive impairment and have totally eliminated "medical necessity" as a third trigger. The terminology "**ADL loss due to medical necessity**" is not the same and is very restrictive. All tax-qualified policies are prohibited by law from using medical necessity as a third available trigger and are, therefore, much more restrictive than most non-qualified plans. Even though this seems confusing and somewhat contradictory, it is nevertheless, a very important distinction.

In summary, the less number of restrictions to trigger benefits and the availability of three benefit triggers in any policy is much more desirable. All long term care policies are not created equal and some of the most consumer-friendly plans are issued by very highly rated companies whose names may not be the most well known. All policies have to be approved by the insurance commissioner in the states where they conduct business, but they are not standardized on premium rates or benefits. Tax-qualified plans have standardized benefits and triggers, but not premium rates. Non-qualified plans are generally less restrictive than tax-qualified plans. Most importantly, read and understand the definitions in your policy. A policy with a lot of added features, but restrictive triggers, may not perform as well as a basic plan that has more liberal definitions.

<u>LESS RESTRICTIVE</u>	⇌-----⇌-----⇌	<u>MORE RESTRICTIVE</u>
Loss of <b>1</b> ADL      ⇌	Loss of <b>2</b> ADL's      ⇌	Loss of <b>3</b> ADL's
" <b>Bathing</b> " as an ADL		" <b>Incontinence</b> " as an ADL
"Cognitive Impairment"		" <b>Severe</b> Cognitive Impairment"
"Standby Assistance" or "Assistance With"		" <b>Substantial</b> Assistance With"
Medical Necessity 3 <sup>rd</sup> Trigger		Loss of ADL's <b>Due To Medical Necessity</b>
<b>No</b> Required 90 Certification		<b>90 Day Certification</b>
Non Tax-Qualified Plans		Tax-Qualified Plans
Three Benefit Triggers		Two Benefit Triggers
Assisted Living – Custodial Care ⇌ Intermediate Care ⇌		Skilled Care
		<b>Chronic Illness</b>