

Gatekeepers

"Gatekeepers" are what consumers typically refer to as the "fine print" when they are denied benefits they believe they are entitled to receive. To the insurance company expert these terms are the key aspects of the policy because they limit the rights of consumers to collect benefits; they specifically define what coverage is provided, and where it can be received. Gatekeeper rules are the reasons why claims are denied, and they can render policies virtually worthless. Important gatekeeper limitations are often contained in the "definitions" section of the policies which many consumers do not carefully read. It is important to purchase a policy with as few gatekeepers as possible.

Consider a non-tax qualified plan, as they typically are more liberal in the way they define covered stays and the so-called "tax deduction" from a tax-qualified plan is virtually meaningless.

The most important gatekeepers a well-informed consumer needs to understand and recognize are:

- **Requiring prior hospitalization in order to qualify** for nursing home and/or home care stays. According to a Congressional study, "57% of all those who enter a nursing home were not hospitalized before their admittance." However, most states now require LTC policies to eliminate that language. If you have an older policy with that type of limitation, you would be well advised to replace it with a new policy.
- **Requiring an acute condition before services would be covered.** "Acute" is often defined as "medically necessary," and refers to a specific illness with severe onset over a defined period of time, usually brief. A heart attack is an acute condition that requires immediate medical attention. But keep in mind that 47% of all nursing home residents have chronic illnesses. Chronic illnesses are those that are ongoing, long lasting and not likely to subside, including Alzheimer's disease, senile dementia, immune system dysfunctions, and a host of slowly progressive illnesses that simply do not get better. As the patient ages these diseases take their toll. If a policy requires a hospital admission for an acute condition as a pre-condition for nursing care services and long-term care, do not buy this policy. As long as you are going to be giving away your money, give it to someone you love or someone that needs it more than an insurance company. The

probability of seeing any benefits with both restrictions in place is highly doubtful.

- **Limiting services to those provided by registered nurses or licensed practical nurses.** There are many custodial and home care needs that do not have to be performed by licensed nurses, these include cooking, cleaning, and general supervision at home or in a nursing home.
- **Requiring providers to be certified by Medicare.** Hundreds of nursing home and home care providers are not Medicare-certified. Nonetheless they are capable of providing necessary services. By limiting coverage to Medicare-certified agencies carriers restrict the freedom to choose appropriate care providers.
- **Covering only "skilled" care.** "Skilled" care is insurance language meaning services provided by a doctor or a nurse. Most "skilled" care is already covered by Medicare and most Medicare supplemental insurance, making policies covering only "skilled" coverage absolutely and totally worthless. Nearly 50% of people receiving nursing home services do not require skilled care.
- **The inability to perform three or more Activities of Daily Living (ADLs).** The commonly recognized ADLs are: bathing, dressing, toileting, transferring (getting in and out of a chair or bed), and continence (voluntary bowel and bladder functions). Approximately 2.9 million U.S. citizens need assistance with only one or two ADLs. A policy that requires assistance with three or more ADLs is designed and intended to rarely offer benefits to the policyholder. Also, a policy that eliminates "bathing" from the list of ADL's is much more restrictive, since bathing is usually the first thing that a person needs assistance with.
- **Vaguely defining the inability to perform an Activity of Daily Living.** What constitutes "needing assistance" with performing an ADL can be made a subjective standard by the insurance company, when it should be subject to objective verification. Many carriers define the inability to perform an activity as needing "continual one-on-one assistance." This is tantamount to denying coverage since it is an impossible restriction. A person would have to be unable to do an activity such as getting up from a chair without always having the direct physical assistance of another person. So if a consumer often could not get out of a chair, but at times could get up with the help of a cane, then that person would not qualify as

needing "continual one-on-one assistance," and would not qualify for benefits. This type of gatekeeper is in reality a stone wall since a person would have to be so severely ill as to require an intensive care unit or be at death's door in order to meet the requirement. Under such conditions a hospital and not a nursing home would be needed. It would be virtually impossible under such a policy to qualify for benefits covering home care assistance for a portion of a day.

- **Having the right to have insurance company controlled doctors determine the health needs of the insured.** Patients have close relationships with their doctors and expect to be covered for services their doctors prescribe. All companies reserve the right to demand that policyholders be examined by company's physician or "benefit advisors" who can overrule a consumer's own doctor. This restriction places the decision for health care in the hands of insurance companies motivated by cutting costs and maximizing profits.
- **"Service based" not "disability based" coverage.** The most liberal coverage would be provided by policies that allowed policyholders to obtain services wherever they wish when disabled. This is known as disability-based coverage. Most current policies are "service-based," so that regardless of the type or level of disability, policyholders are limited to receiving particularly defined services at specific facilities or from specified providers.
- **Requiring "Severe Cognitive Impairment" before paying benefits, instead of "cognitive impairment."** All tax qualified long term care policies are required by law to include this language. What possible reason does the government have to require this language? This restricts patients from getting paid unless they are a "danger to themselves or others." In other words, if you have dementia or memory loss and can't take care of yourself, you would not be paid in assisted living, because you aren't "severely" impaired.
- **Write your elected officials and demand that the language in Tax Qualified Long Term Care plans be revised to match the best Non-Qualified plans.** After all, when you purchase a policy, you are protecting the taxpayers as well as your family. Also, the "tax deduction" is smoke and mirrors, since it requires the premium to exceed 7.5% of your adjusted gross income to be deductible. Most people who purchase LTC are never going to realize any tax deduction at all, because of their income level or the use of the standard

deduction. LTC premium should be a tax credit off the top of your tax liability.