

Definitions In Long Term Care

One of the challenges of long term care insurance is mastering a new language. LTC has unique terminology that often defies our past experience as well as familiar insurance related terms that do not always mean exactly what we've come to understand. What follows is a glossary of long term care terms including some practical ideas on their application. It is a composite of many other long term care glossaries that we've collected throughout the years and have now given a "California" perspective.

A Accelerated Death Benefit: A provision in some life insurance policies that gives the policy holder the option to have a portion of the proceeds paid before death when certain conditions are met. These conditions may include terminal illness, permanent confinement to a nursing home, a need for long term care services, or catastrophic illness. Proceeds paid under this provision reduce the amount of death benefits payable.

Activities of Daily Living (ADLs): Everyday activities that are used to measure an individual's ability to function independently. ADLs define the disability in long term care insurance. The loss of some number of ADLs is an insuring or triggering event in all long term care policies. In 1993, California Senate Bill 1943(Mello-1992)) established seven standardized activities of daily living (eating, bathing, dressing, toileting, continence, transferring, ambulating) for any LTC policy that purports to cover home care in it's provisions. A loss of 2 of 7 of the ADLs will qualify an insured for benefits. With the passage of the Health Insurance Portability and Accountability Act of 1996 and enabling legislation passed by the California state legislature in 1997, Californians may now choose between 7 ADL policies which are not tax qualified and 6 ADL policies which are tax qualified (ambulating is not an ADL in tax qualified policies).

Standardization of the definitions of the ADL's has also been an issue. California Assembly Bill 1483(Gallegos-1997) has established mandatory definitions that carriers must use in both tax qualified and non-qualified long term care products. These statutory definitions will be discussed and compared later in the course.

Acute Care: Care that has recovery as its primary goal and for illness or injury that develops rapidly, has pronounced symptoms and is finite in length. Generally, it requires the services of a physician, nurse or other skilled professional. It is usually provided in a hospital and is usually short term. Traditional medical insurance, Medicare and Medicare supplements are designed to provide coverage for acute illnesses.

Administration On Aging: Federal agency under the Secretary of Health and Human Services (HHS) responsible for administering the programs under the Older Americans Act of 1965, as amended. Serves as the federal body for programs and services for older adults.

Adult Day Care: Social, recreational and/or rehabilitative services provided for persons who benefit from daytime supervision. An alternative between care in the home or in a institution.

Adult Day Health Care: Services in an adult day care center that includes a level of day care including medical, skilled nursing and therapy services in addition to those services listed under adult day care above.



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A **Adverse Selection:** Tendency of people who are poorer-than-average risks to apply for or maintain insurance. Also referred to as anti-selection.

Ageism: Prejudice against people because of their age.

Aging In Place: When an older individual continues to live at home or within the community, outside an institution.

Alternate Care Benefit: Payment for a special arrangement of services specifically designed to allow the person to reside in a setting other than a nursing facility (i.e. services to provide assistance, capital improvements such as a ramp, and/or durable medical equipment).

Alternate Care Facility: A licensed residence other than a nursing facility where care services are delivered (i.e. hospice, assisted living, Alzheimer's or Christian Science setting).

Alzheimer's Disease: A progressive, irreversible disease involving the deterioration of the brain cells resulting in premature mental deterioration. It was first described in 1906 by German neurologist, Alois Alzheimer. Typically, it leads to impairment or loss of mental functions such as orientation to person, place or time; short and long term memory loss and ability to reason. Persons could cause harm to self or others. In California, as well as most of the rest of the United States, Alzheimer's Disease is considered a cognitive impairment, thus triggering benefits under a long term care insurance policy.

Alzheimer's Units: A special living unit within nursing facilities or alternate care facilities specifically providing care and services for those with Alzheimer's Disease.

Aphasia: Loss of the ability to use or understand language.

Assessment: A determination of physical and/or mental status by a health professional based on established medical guidelines. The assessment is a central component in home care coverage and the payment of home care claims. Upon the triggering of benefits, due either to the loss of some number or activities of daily living or a cognitive impairment, an assessment is performed by a multidisciplinary team. This "team" usually spearheaded by the insured's physician, determines the level of functional incapacity and develops a plan of care that will be followed in assisting the insured in the performing the ADLs and IADLs (instrumental activities of daily living). See Plan Of Care.

Assisted Living: A non-medical institution providing room, board, laundry, some forms of personal care and usually recreational and social services. Often times referred to as residential care facilities for those who tend to be older and frail and who need some assistance but are not so impaired as to need nursing home care. Licensed by state departments of social services, these facilities exist under several names including domiciliary care facility, sheltered house, board and care, community based residential care facilities and alternate care facilities.

B **Baby Boomers:** People who were born between 1945 and 1964.

Benefit: Amount payable by the insurance company when the insured suffers a loss covered by the policy.

Benefit Increase Options: Also known as automatic benefit increase option, automatic increase benefit, cost of living adjustment benefit. These are optional benefits that provide for annual increases in the benefit amount to offset the effects of inflation. Benefit increase options are paid for at the time of issue and either increase the daily policy benefits by a 5% compounded or simple interest factor. A key element to remember is that the increases begin at the second policy anniversary and continue for the duration of the policy, except where the insurance carrier "caps" the increase at some predetermined amount. These increase options are not to be mistaken with future insurability options.

Benefit Maximum: Amount of money or number of days of care beyond which a long term care policy will not pay benefits.

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Benefit Period: The maximum length of time for which benefits will be paid. Period of time that begins when the insured becomes eligible for benefits and ends when the insured has been out of claim status for a given period of time such as 90 days.

Benefit Trigger: Criteria used to determine eligibility for benefits. Triggers may be based upon limitations in ADLs and or degree of cognitive impairment.

Board & Care Homes: See Assisted Living Facilities.



California Public Employees Retirement System (Calpers): A retirement and benefit program available primarily to public employees and their immediate family members. Calpers offers a self-funded long term care insurance program to its members. Due to its self-funded nature, the Calpers program is exempt from many of the consumer protection provisions applicable to traditional and Partnership long term care insurance program.

Caregiver: Person providing care to someone with chronic illness or disability. The caregiver, who can be unpaid (family, friend, or volunteer) or paid, provides care in the home or community.

Care Plan: Written plan of care development after an assessment of a person with chronic disease or disability. The plan outlines a person's needs and the services and care options (both type and amount) to meet them. It is used to ensure that care and services are provided and coordinated.

Care Management: Also known as care coordination. It is a process of assessing and reassessing an insured's need for long term care (not specifically limited to policy benefits alone), developing a plan of care, coordinating services and monitoring the adequacy of the care received. Takes an all-inclusive look at an individual's total needs or resources and links the individual to a full range of appropriate services using available funding sources.

Case Management: Systematic process of assessment, planning, service coordination and or referral and monitoring through which the multiple service needs of people are met. Its dual goal is to contain costs and promote more effective intervention to meet patient needs.

Cash Surrender Benefit: A type of non-forfeiture benefit that returns to the policyholder a portion of the reserves when the policy lapses. The amount returned varies based on the individual's age, when the policy is issued and when the length of time the policy was in force. The amount is reduced by any benefits paid under the policy. Chore Services: Heavy housecleaning, minor home repairs, yard work, and other infrequent tasks related to home maintenance.

Chronic Care: Care for illness continuing over a long period of time or recurring frequently. Chronic conditions often begin inconspicuously and symptoms are less pronounced than acute conditions. Long term care insurance is designed to assist people who have a loss of capacity due to chronic illnesses.

Chronic Illness: Irreversible presence of disease or impairment requiring care, rehabilitation, or observation; may require long term care.

Cognitive Impairment/Loss: A deterioration or loss of intellectual capabilities (i.e. loss of short or long term memory; orientation to person, place or time; and/or abstract reasoning), sometimes resulting in the inability to remain in the current environment without assistance. Problems with attention, memory, or other loss of intellectual capacity that requires supervision to help or protect the impaired person. Impairment can be permanent or temporary. The loss of cognitive ability is a long term care insurance benefit trigger under California Senate Bill 1943.

Coinsurance: The portion of covered charges that a policyholder must pay. If the insurance company reimburses 80 percent of covered charges, the policyholder's coinsurance is 20 percent.

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Congregate Meals: Meals provided to older persons at a site such as a senior center, congregate housing complex, adult day care center, or community center. The intent is to offer a nutritious meal while reducing the isolation experienced by many older people. This program constitutes the single largest categorical program funded under the federal Older Americans Act of 1965, as amended.

Continuing Care Retirement Facility (CCRC): Originally called "life care" communities, these organizations provide living arrangements and services ranging from independent to assisted to institutional care. Often time, CCRC's require a large initial cash payment, on-going maintenance fees, assignment of assets or a combination of all three, in consideration for services rendered.

Continuum Of Care: The full range of interrelated services, from home and community-based programs to institutionalization, that may be needed by individuals at various stages of disability. Conversion: Policy provision that entitles an individual to elect to convert coverage to an individual policy when coverage under group terminates.

Coordination Of Benefits: Method of integrating benefits payable under more than one insurance policy so that the benefits paid from all sources do not exceed 100 percent of allowable expenses. Many private policies coordinate with Medicare so that the carrier is not responsible for benefits payable by Medicare. Under HIPAA, tax qualified policies must coordinate with other insurance.

Covered Expenses: Those expenses that an insurer will consider for payment under the terms of an insurance policy.

Custodial Care: Services that could be given safely and reasonably by a person not medically skilled, which are designed mainly to assist with ADL's or IADLs. The services provided under this level of care can be received in different settings, formally or informally. Most services can be described as personal care services.

Custodial Care Facilities: A licensed facility that provides personal assistance to persons who are unable to care for themselves due to age, illness, physical or mental infirmity, but who do not require daily nursing care.



Daily Benefit: The value of benefits a policy will pay each day until the total value of the policy is exhausted.

Death Benefit: A benefit payable in the event of the death of the insured to his or her beneficiary.

Deductible: Amount of covered expenses (or number of days of care) the insured must incur before benefits are payable under the policy.

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Dementia: The severe impairment of cognitive functions (thinking, memory and personality). Of our elderly population, 5 to 6 percent have dementia. Alzheimer's Disease causes approximately one-half of these cases, vascular disorders (multiple strokes) cause one-fourth and the other dementia are caused by alcoholism, heart disease, infections, toxic reactions to medications and other rarer conditions. While impairment from Alzheimer's Disease and vascular disorders is permanent, dementia caused by other conditions can usually be corrected.

Diagnostic-Related Groups (DRG's): Specific classifications of illnesses into which hospital inpatients are grouped. Under Medicare, medical providers are reimbursed at fixed amount, determined in advance, for each patient admitted for an illness in a given classification.

Divestment: In reference to eligibility for Medicaid, the disposal of resources at less than fair market value in order to qualify for benefits.

Disability Criteria: Measures of the extent of functional and or cognitive impairment to determine need for care (see benefit trigger).

Durable Medical Equipment: Mechanical devices, equipment and supplies which enable a person to maintain functional ability.

Durable Power of Attorney: An individual's appointment of a representative to act on his or her behalf via a legal document that remains in effect in the event of incapacity of the grantor.

Elimination Period: The number of days the insured must be in a nursing home before monthly benefits begin to accrue. In the case of home care, the number of home care visits that must be provided as per the plan of care prior to daily benefits being paid. Also known as a waiting period or deductible.

Entitlement Program: A government program under which individuals are eligible for benefits so long as they meet specific criteria.

Exclusion: Any condition or expense for which a policy will not pay.

Extended Term Insurance: A non-forfeiture option that provides that when premium payments cease, full benefits are continued, but only for a specific period of time. The duration of coverage depends upon the individual's age when the policy is issued, the length of time the policy was in effect and any benefits paid under the policy.

Formal Care: Long-term care that is paid for.

Free-Look Period: Period of time, usually 30 days after sale, during which the policyholder may return the policy for any reason and receive a full refund.

Functionally Dependent Elderly: Individuals who need assistance to perform self-care and household tasks in an independent manner.

Functional Impairment: Limitations of physical or mental functioning that may affect an individual's capacity for independent living (see activities of daily living).

Gatekeeper: Means of controlling access to services or benefits.

Geriatrics: The study of physical and mental changes in persons as they age -- including the diagnostic, treatment and prevention of disorders.

Guaranteed Renewable: A provision that precludes cancellation of a policy or change in its provisions as long as the policy stays in force by timely payment of premium. The insurance carrier, may however, adjust the premium of the policy by class of insured and or by state. Almost without exception, all long term care insurance in California is guaranteed renewable. See Non-cancelable/Guaranteed Renewable.

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H Hands-On Assistance: The physical assistance of another person without which an individual would not be able to complete an ADL (IRS Ruling 97-31, May 1997).

Health Care Financing Administration (HCFA): The federal agency that administers Medicare.

Health Insurance Portability & Accountability Act of 1996 (HIPAA – Public Law 7702(b)): Federal legislation that defines chronic illness and establishes deductibility of long term care expenses. Creates tax-qualified long term care insurance.

Health Maintenance Organization (HMO): Organization that provides for a wide range of comprehensive health care services for a specific group at a fixed periodic prepayment.

Home Care Aide Organization: An entity that provides a wide range of non-medical assistive services to adults and children, including environmental management such as housekeeping, chores and shopping, companionship and respite services, transportation and escort services as well as assistance with ADL's and IADL's.

Home Health Aide: A person who is hired and certified by a home health agency to help clients in the home with personal care such as light housekeeping, meal preparation, and or shopping.

Home Care: A broad range of services which include home health care, adult day care, personal care services, homemaker services, hospice and respite services. California Senate Bill 1943 stipulates that all levels of home care be covered under any long term care policy that purports to cover home care; this includes stand-alone home care and comprehensive long term care products.

Home Equity Conversion: A mechanism through which people are able to convert a portion of the equity in their homes to cash. Often referred to as a reverse mortgage.

Home Health Care: The skilled component of home care. Health services provided in the home or alternate living facilities, including skilled nursing care, physical, speech and occupational therapy.

Homemaker Services: Basic services provided at home to help a person with a chronic illness or disability to be as independent as possible. These services may include housekeeping, cooking, transportation, and shopping.

Hospice: Program of care provided to terminally ill patients and their families. It emphasizes emotional needs and coping with pain and death rather than cure.

Incontinence: Inability to voluntarily control bowel or bladder function.

Indemnity Benefit: This is a method of benefit payment in long term care insurance policies. An indemnity method pays the stated daily benefit regardless of actual incurred expenses. There are two types of indemnity methods of payment; per diem and cash. The former pays the stated daily benefit for a day that a long term care service is received. Cash method pays a monthly benefit once the insured is certified to be chronically ill. It is not necessary for them to receive care in order to receive the benefit. Similar to the reimbursement method of payment (see reimbursement) a per diem payment requires a plan of care. A cash method typical does not.

Informal Care: Unpaid care, usually provided by family or friends, to assist a person with a chronic illness or disability to be as independent as possible.

Institutionalization: Admission of an individual to an institution, such as a nursing home.

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Instrumental Activities of Daily Living (IADLs): The more complex tasks associated with independent living. California Senate Bill 1943 stipulates that any long term care insurance policy that purports to cover home care, must provide benefits for the IADLs. The IADLs include light house keeping, taking medications, using the telephone, meal preparation, moving about outside, and shopping for essentials. IADLs define the services covered by policies covering home care.

Intensive Care: The highest level of acute care. Monitoring is continual. Usually care involved with heart attack, stroke, serious accidents or any life threatening emergency.

Intermediate Care: Dressing changes, IV solutions, therapies such as physical, speech, occupational therapies. Occasional nursing and rehabilitative care performed by, or under the supervision of skilled medical personnel, generally in a nursing home. Care does not necessarily need to be delivered by a skilled professional.

Lapse Protection: Companies are required to allow a policyholder to reinstate his/her policy after a lapse if the policyholder can show that his/her failure to pay premiums was because of an impairment in cognitive or functional abilities. Reinstatement of the policy shall be available to the insured if requested six months after termination and shall allow for collection of past due premiums.

Lifetime Reserve: Under Medicare, the one-time 60 extra days of hospital coverage available to individuals who have a hospital stay that exceeds the 90-day limit during a benefit period.

Life Settlement: An arrangement whereby the owner of a life insurance policy "sells" the future value of the death benefit to an institutional buyer. These arrangements are different from Viaticals settlements in that terminal illness is not required (See Viatical Settlement)

Long Term Care: Medical, social, and or personal care services required over a long period of time by a person with a chronic illness or disability. Services are designed to help the person maintain as much independence as possible and may be provided at home, in the community or in an institutional setting.

Look-Back Period For Medi-Cal: The time (currently 30 months) during which a person may not transfer property to others or set up certain types of trusts, in order to qualify for Medi-Cal. When a person applies for Medi-Cal, any transfer made during this look-back period could be counted as part of the applicant's assets for purchase of Medi-Cal qualification. This may result in a period of ineligibility during which an individual will have to pay for his/her long term care costs even though they are receiving other Medi-Cal benefits.

Loss Ratio: The ratio of claims to premium (the dollar value of all claims divided by the total amount of premium dollars).

Meals On Wheels: A program designed to deliver meals to the homebound.

Means Test: A measure of income and assets used to determine eligibility for benefits under some government programs.

Medicaid (Title XIX Of The Social Security Act): A federally funded, state managed program of medical aid for person of any age who are unable to afford regular medical services. In California, Medicaid is referred to as Medi-Cal. Both are part of the national and state sponsored welfare program.

Medi-Cal Asset Protection: A current feature of California Partnership for Long Term Care policies. Provides dollar for dollar asset protection for each benefit dollar paid by the policy.

Medical Necessity: A benefit trigger used under traditional medical care policies to determine whether a charge can be accepted as a covered expense. Early long term care policies uses medical necessity as the primary benefit trigger. Today, some non-tax qualified use it as an optional trigger; under California law, it cannot be used as a criteria for benefit payment.

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M **Medicare (Title XVIII Of The Social Security Act):** A national health insurance plan for people over age 65 and for some people under 65 who are disabled. It includes two parts; Part A covers hospital costs and a limited amount of skilled nursing care; Part B is the supplemental portion for which the insured pays premiums covering a portion of the physician's fee as well as various types of therapy.

Medicare Risk Plan: A type of Medicare supplement coverage where the Medicare recipient "assigns" his/her benefits to an HMO. The HMO contracts with the Federal Government to provide medical services to the Medicare recipient at a discounted rate to the government.

Medicare Supplement (Medigap) Plan: A private insurance program designed to pay Medicare co-insurance amounts and other various benefits.

Morbidity: Frequency and severity of sickness and accidents in well-defined class of people.

Mortality: Measure of death from various causes in a well-defined class of people.

N **National Association Of Insurance Commissioners Model Law & Regulation:** Model insurance laws are developed by the National Association Of Insurance Commissioners (NAIC) to serve as a model or standard for adoption by individual states. Model laws are designed to promote both a level of minimum standards and standardization from state to state and to facilitate the ability of states to appropriately regulate new and evolving insurance products.

Ninety-Day Certification: HIPAA requirement in order for taxpayer to deduct expenses for chronic illnesses and/or receive benefits from a tax-qualified long term care insurance policy. In order to be considered chronically ill, a licensed health care practitioner must certify that the individual will need care for more than 90-days.

Non-cancelable/Guaranteed Renewable: A provision that precludes cancellation of a policy or a change of any of its terms by the insurance company, as long as the policy remains in force. The insured need only make timely payment of premiums. See Guaranteed Renewable.

Non-Forfeiture Benefits: A guarantee for a refund of all of the premiums paid in one of two ways; (1) to a named beneficiary at the death of the insured, or, (2) as an "extended term" type benefit for as long as all premiums accrued will last with the balance (if any) left to a named beneficiary. See Return Of Premium

O **Older Americans Act Of 1965, As Amended:** Federal law establishing a network of state and community based programs and services for older Americans. Primarily, it fosters provision of preventive services such as congregate and home delivered meals and certain supportive services. Priority is given to minorities and persons with the greatest economic and social needs.

Outline Of Coverage: Brief description of important features of a policy, including benefits and limitations, delivered at the time of solicitation.

P **Per-Diem Benefits:** Benefits that pay a flat dollar amount for each day of benefit eligibility. Use of licensed providers may not be required.

Personal Care Advocate: A representative of the nursing facility resident who reviews care, address concerns, and provides advocacy support for a patient and his or her family.

Personal Care Services: A component of home care, personal care services provide assistance with ADL's and IADLs. Under California Senate Bill 1943, long term care insurance policies that purport to cover home care must provide for reimbursement for personal care services.

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Physical Therapy: Rehabilitation for disease or impaired motion through the use of physical methods such as heat, hydrotherapy, massage, exercise or mechanical devices.

Physician Assistant: A person who works under the supervision of a physician and performs tasks such as taking medical histories and making routine examinations.

Plan Of Care: Also known as Home Care Plan. It is the result of an assessment; a program for providing home care services. In most policies, such a program will be prepared by a physician and the multi-disciplinary team. It will be appropriate for the level of care needed for the physicians diagnosis. All long term care policies qualifying under California Senate Bill 1943 require plans of care (see care plan).

Post-Claims Underwriting: The practice of being more diligent at obtaining information on health status or functional capacity when a claim is filed than during the underwriting of a policy in order to deny the claim or rescind the policy. Post-claims underwriting was outlawed in California as a result of the passage of California Senate Bill 1943 (Mello-1992).

Pre-Existing Condition: A medical condition that existed before the effective date of the policy. If the condition existed within a specific period (often six months) before the policy went into effect, charges for care relating to that condition are often not covered for a period of six months following the policy's effective date.

Professional Care: Care services that must be delivered or supervised by a health care professional such as a registered nurse, physical therapist or physician.

Protection: Policy provision that provides that benefits increase over time, either automatically or at the option of the policyholder, to help offset future increases in service costs. Various forms of inflation protection must be offered to policyholders in California.



Reduced Paid-Up: A non-forfeiture benefit that pays a percentage of daily benefits such as 30 percent after 10 years, increasing to 75 percent after 25 years. These types of non-forfeiture benefits are not available in California.

Reimbursement Benefit: This is a method of payment in long term care insurance policies. A reimbursement method pays for incurred expenses up to the daily limit of the policy. Often referred to as the medical model. (see indemnity benefit).

Rescission: Voiding of an insurance contract from date of issue by the insurer because of material misrepresentation on the application.

Residential Care Facility For The Elderly (RCFE): Facilities that provide room and board, assistance with personal care and any necessary supervision. They range in size from small, two – six bed “mom & pop” operations to facilities with over 200 living units. Often they are part of an overall campus that provides various different levels of care. RCFE's are licensed by the Department of Health Services.

Respite Care: Temporary, intermittent relief for the family member or other person providing the primary ongoing care for an individual who is functionally or cognitively impaired. Respite services are provided for in California Senate Bill 1943.

Restoration Of Benefits: This benefit will restore the original policy maximums if an insured is “off claim:” for a stated period of time (normally 90 or 180 days).

Return Of Premium Benefit: A guarantee for a refund of a percentage of all premiums paid, to the insured, after a stipulated period, subject to specified conditions. (see Non-Forfeiture Benefits).

Reverse Annuity Mortgage: An arrangement under which an individual exchanges the equity in a home for a lifetime annuity.

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S **Severe Cognitive Impairment:** Defined as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term or long-term memory, orientation to people, places or time and deductive or abstract reasoning (IRS Ruling 97-31, May 1997).

Shortened Benefit Period (SBP): A non-forfeiture benefit that provides full daily benefits, although for a shorter period than was initially purchased, if the person meets the criteria for payment of benefits after the policy has lapsed. The period of coverage will depend on the age of the individual when the policy is issued, the length of time the policy was in effect, and any benefits paid under the policy. SBP must be offered as an optional benefit in California products.

Skilled Care: The highest degree of medical care. The patient is under the supervision of a physician and or registered, care is provided twenty-four hours a day and the facility has a transfer arrangement with a hospital.

Skilled Nursing Facility: Institution that provides a planned program of observation, medical care, and treatment under the direction of a physician and continuous twenty-four hour nursing care under the regular supervision of a doctor and or registered nurse.

Spend Down: Depletion of assets for the purpose of qualifying for Medi-Cal (Medicaid). (see divestment).

Standby Assistance: The presence of another individual that is needed to prevent an individual from injury while performing an ADL (IRS Ruling 97-31, May 1997).

Substantial Assistance: Hands-on & Standby Assistance (IRS Ruling 97-32, May 1997)

Substantial Supervision: Defined as continual supervision by another person which is needed to protect the severely cognitively impaired person from threats to his health or safety (IRS Ruling 97-32, May 1997).

Sub-acute Care: Care provided to patients who need skilled care in settings other than a hospital; sub-acute care focuses on achieving measurable outcomes.

T **Twisting:** Un-warranted replacement of a policy. The unfair marketing practice of inducing a person to lapse or to convert an existing policy and to adopt a new 14 one without providing significant added value. California long term care laws expressly prohibit twisting and enforce safeguards and penalties against agents who engage in these practices.

U **Upgrade:** Formal process by which an insurer allows policyholders with an earlier generation of product to purchase a new policy, generally without meeting some of the standard requirements. For example, underwriting requirements may be waived and the premium for the enhancements may be based on the insured's age when the original policy was issued. As a result of laws passed in 1997, California has instituted upgrade criteria that carriers must follow. These will be discussed later in the course.

V **Viatical Settlement:** A contract that enables an individual who is terminally ill to receive a sum of money in exchange for the right to death benefits under a life insurance policy.

W **Waiver Of Premium:** Provision that ensures that insurance will remain in force under certain circumstances, when the insured stops paying premium while benefits are being received.