Chapter 2

Features of a Good Long-Term Care Insurance Policy

Long-term care insurance policies today operate under legislation that was effective January 1, 1997, which required insurance companies to offer “tax-qualified” policies that contain certain standardized benefits that were recommended by the National Association of Insurance Commissioners (NAIC), the regulatory body composed of all of the state insurance commissioners. Most of these guidelines were already being followed by the insurance companies and simply provide extra protection for the consumer to ensure high value for premium dollars.

Congress ruled that long-term care insurance policies issued prior to 1/1/97 will count as qualified policies and do not have to be exchanged for a new policy. This includes employer-sponsored plans that were set up prior to 1/1/97, so that new enrollees after 1/1/97 have a “grandfathered” plan. However, if you materially change a
policy that you purchased prior to 1/1/97, the policy will lose this “grandfathered” status and will no longer be considered tax-qualified by the IRS. An example of a “material change” would be adding an inflation rider, which is a benefit increase for additional premium. A partial list of changes that are not considered a material change and therefore would not affect the grandfathered status are:

▲ Premium modal changes; for example, changing an annual payment to monthly payments.

▲ A class rate increase or decrease, which means a rate increase or decrease that applies to an entire segment of policyholders.

▲ Discounts that you receive after the original issue date of your policy due to other family members purchasing a policy; for example, if your spouse purchases a policy at a later date than you do.

▲ Premium decreases due to a reduction in coverage.

▲ Provision of alternate forms of benefits that do not increase the premium for example, companies sometimes add coverage for new forms of care, like assisted living, without increasing your premium.

▲ Allowing policyholders to continue group coverage if the policyholder is no longer part of the group; for example, because he or she terminates employment with an employer who offered a group long-term care insurance plan.
(Caution: Some insurance companies are still marketing non-qualified policies. Please be aware that if you purchased a non-qualified policy in 1997 or later, there is a chance that the IRS will say that benefits received from the non-qualified policy will be taxable income to you. A quick way to see if your policy is tax-qualified is to check the first page of your policy. All tax-qualified policies issued after 1/1/97 have a sentence that says the policy is intended to satisfy the requirements for a tax-qualified policy. As you read this chapter, you also will learn how to check the benefits to ensure that you have a tax-qualified policy.)

To provide you with a measuring stick for value if you already have a long-term care insurance policy or if you are currently shopping for a policy, this section will explain each feature of a long-term care insurance policy in detail to give you an in-depth understanding of how long-term care insurance works. If you are shopping for a policy, you will find helpful recommendations for appropriate benefit selections that you can apply to your situation. An insurance professional who sells long-term care insurance can help you finalize your choices.

**Level of Care**

Make sure the policy pays all levels of care—skilled or non-skilled—in any setting: the home, in an assisted living facility, in an adult day care center, or in a nursing home. (Sometimes you will hear non-skilled referred to as intermediate or custodial care. “Intermediate” means some skilled care but not every day, and “custodial” means no skilled care at all. These terms are old and just refer to non-skilled care.) Benefits should not be reduced because the level of care is less than skilled. Also, the policy should not require skilled care before non-skilled benefits are paid.
Home Health Care

More than ten million Americans need some type of long-term care and only about 1.5 million are in nursing homes. This means that most people are being cared for at home or in a community setting like assisted living or adult day care and that only about 15 percent of long-term care is in a nursing home. The number of nursing home patients has actually declined in recent years due to an increased availability of home health and other community services, especially assisted living facilities. Understandably, coverage for home health is a popular addition to long-term care insurance policies. Here are some points to keep in mind when choosing a policy:

▲ The home health care benefit is not intended to provide benefits for 24-hour care because around-the-clock care at home is more expensive than nursing home care. The home care benefit is most helpful when you have someone to live with; i.e. a “primary caregiver,” such as a spouse, son, daughter, or other family member or friend. If you qualify for benefits under the policy, a home health aide can stay with you for an eight- to ten-hour shift while your primary caregiver is at work, for example. The aide can do the heavy caregiving, such as giving you a bath (something you may not want a family member to do), washing your hair, changing your bed, preparing meals, supervising your medicine, and maybe light housework and laundry. Then perhaps your family can take care of you at night. Even if you have a primary caregiver who doesn’t work, no one can provide 24-hour care, so home health care can make it possible for your primary caregiver to get adequate rest.
Here’s a story that illustrates how consuming home care can become for the caregiver:

Judy Geck, Chattanooga, Tennessee, has seen both of her parents in long-term care. Her father had a major stroke late in life, which was magnified by complications from the diabetes he had suffered with since his early 40’s. After almost two years of caregiving, he passed away within weeks prior to being admitted to a nursing home. Her mother had a severe stroke three months after his death which, coupled with dementia, made it necessary for her to move in with Judy and her husband, Richard. Having a solid position with the same company over fifteen years, Judy was unable to give up her job for financial reasons, especially since she had a new grandchild to buy for! In order to keep her demanding job and get adequate rest at night, it was necessary to have home health aides 16 hours a day, from 7 a.m. till 11 p.m. Judy slept in a chair four nights a week next to her mother and had an additional home health aide the other three nights.

Judy had to be home every evening, because her mother could not be left alone. In addition to the dementia, she was unable to speak and could not respond to verbal commands to move her body due to damaged motor skills from the stroke. Activities or even vacation ideas that would take Judy away from home were out of the question. This went on for four years after her mother’s stroke. In the fifth year, her mother’s savings began running out and the paid home care had to be cut back. The home aides had to leave at 7 p.m. Judy took over after that and slept in a chair next to her mother for seven nights as there was no money for home health aides to come at night. When her mother died after five years of care, Judy had just refinanced her home to find more money for caregiving. Judy and Richard have purchased long-term care insurance on themselves.
A common statement is “I’m not buying long-term care insurance because I’m never going to a nursing home.” The irony is that a long-term care insurance policy with great home health benefits may be the only thing that keeps you out of a nursing home by providing financial and emotional support to the people who care about you so they can keep you at home. I don’t believe most caregivers would have been able to maintain the exhausting schedule that Judy kept in the above story for five years. Long-term care insurance could be the only thing that makes it possible for a family to keep a patient at home in a similar situation.

If you want to design your policy to pay 24-hour home care, work with your insurance professional to determine the cost for that service in your community so you can select a daily or monthly benefit that is high enough to accomplish your goal in combination with your savings. This selection will substantially increase the premium. But understand – there are still some situations that make staying at home impossible.

At almost 250 pounds, it takes four people to lift my Aunt Jeannette who can’t walk due to crumbling cartilage in both knees. At age 84, she is not a candidate for knee surgery. One or even two caregivers at home wouldn’t be enough to provide adequate care for her and certainly, my uncle at 160 pounds dripping wet, couldn’t lift her. She was admitted to a nursing home three months before he passed away. Now the staff at the nursing home use a Hoyer lift, a hydraulic device manufactured that will lift up to 400 pounds. She cheerfully hangs on with her arms while they swing her in and out of bed and her nurses tease her for being such a “swinger”.

▲ Home health coverage is automatically included in some policies—these policies are called “comprehensive” policies—
and optional in other policies. If the coverage is optional and you have no one to live with when you need care, you might consider putting your premium dollars toward a policy that covers just assisted living and nursing home benefits. This is called a “facilities-only” policy. You can use the additional premium of 30%-40% that you would have spent on home health benefits to buy a higher daily or monthly benefit to help you afford a really nice assisted living facility or a private room if you ever need nursing home care. Or, you could use the additional premium for a longer benefit period such as five years or even a lifetime (unlimited) benefit period. Probably the best use of the premium difference would be to purchase the best inflation option if you haven’t included it in your benefit selection already (see Inflation Protection on p. 62).

▲ There are a handful of policies that pay only for home health care with no coverage for assisted living or nursing home care. No policy can guarantee that you will never need nursing home care, so a policy that focuses 100 percent on home care may not be a wise choice. (It’s doubtful that very many of the 1.5 million Americans in nursing homes today “planned” to be there!)

▲ The most valuable home health benefit pays the same level of benefit for home care as for nursing home care, or at least 75%-80%, instead of paying home care at a lower amount such as 50 percent of the nursing home benefit, as many policies offer. Why? Because an eight-hour shift of home health care costs almost the same as a semi-private day in a nursing home, and a ten-hour shift can cost more.
If the policy allows family and friends to provide the care, a lower benefit can work since these people may charge less. A policy like this has a higher premium which buys you additional flexibility. The policy will pay a monthly benefit to you, and you can hire anyone you like, or use the money for other needs because you don’t have to provide proof of services or file claims in any way as long as you qualify for benefits. No surprise, additional flexibility usually brings additional responsibility. There are two cautions to this type of policy, which some refer to as a “disability-based” or “cash” policy:

1) Since this is a cash benefit, the temptation can arise in a family to use the money for a purpose other than for which it was intended; so why not buy a big screen TV for the whole family or a trip to Disney World?

2) If you hire caregivers and pay them yourself, the IRS probably will view you as an employer, which normally means you are responsible for the employer’s contribution for the caregiver’s Social Security, Medicare and state employment taxes. The good news is these expenses are deductible medical expenses for you. Your accountant can help you understand any employer responsibilities you may have in this capacity.

A few policies will allow immediate family members to care for you – even your spouse – but you still have to document their services and submit bills to the insurance company. (Your spouse will enjoy finally getting paid for your care!) Check the policy carefully to understand any limits on the percentage of payment or the amount of time paid for immediate family members.
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▲ Most new policies do not require that the care be provided through a home health agency. A policy like this will pay “professionals operating within the scope of their license,” such as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is freelancing his or her services. It is possible to find a policy that will pay for a family member, friend, or other person of your choice, except for an immediate family member, to obtain the necessary license or certification in your state to be paid as a freelancer. This can be helpful if you live in a rural area without a strong network of home health care agencies. (To find out more about your state’s home care licensing and certification training program, call your state’s Agency on Aging in Appendix B of this book and ask for the telephone number of your state’s association for home health professionals.)

▲ To help family members who are willing to be free caregivers, most policies pay for caregiver training to teach a family member how to provide care in the most effective and safest way for both patient and caregiver. This can include skills such as lifting techniques, patient positioning to avoid pressure sores, insulin injections, changing bandages, and so forth. The benefit amount for this feature is usually five times the daily benefit.

▲ On the other end of the spectrum, some policies require care to be provided by a licensed home health care agency and do not pay for family and friends (unless the family member is a licensed health care professional and services are billed through a third party, such as a home health agency).
The policy should not require a nursing home stay prior to providing coverage for home health care.

The policy should pay for non-skilled care at home (bathing, dressing, helping the patient get in and out of bed, etc.) with no requirement for skilled care (care performed by nurses, physical therapists, speech therapists, etc.) Many policies also pay for companion care and homemaker services like cooking, cleaning and laundry.

### Adult Day Care

If the policy covers home care, it will also cover adult day care. Aging adults who might otherwise succumb to isolation and depression if kept at home with an aide, sitter or companion can blossom in the socially more active setting provided by adult day care. Throughout the United States, more than 3,500 adult day care centers are in operation. That is well under the 8,520 that are needed, according to a report funded by The Robert Wood Johnson Foundation, but the industry is growing. Dollars from long-term care insurance policies will stimulate this growth as more families have funds to pay for adult day care.

The average cost of adult day care is about $62 per day, which is much less than assisted living at $621/week or home care or nursing home care, which can easily reach $1,360 a week.

To locate adult day care centers, an eldercare locator can be reached at 800-677-1116 or www.eldercare.gov. Other resources are the National Adult Day Services Association (www.nadsa.org) local senior centers, Area Agency on Aging, and of course, the Yellow Pages.
Assisted Living

Sometimes people may need help with one or two Activities of Daily Living (ADL), such as bathing or dressing, but may not need total 24-hour care in a nursing home. Retirement centers and nursing homes often have special sections for people who need just slight assistance. This type of assistance is called “assisted living.” This type of care also is available in some independent facilities such as personal care homes or bed and board homes. Assisted living is a popular form of long-term care because the setting is more like a home setting and costs less than nursing home care. (Compare the cost of about $88 a day for assisted living vs. $171 day for semi-private nursing home care.)

Assisted living is a wonderful alternative to nursing home care and consequently may be the fastest growing form of long-term care. To further explain the difference, nursing home residents typically need help with three or more Activities of Daily Living, while assisted living residents only need help with 1-2 ADLs and are certainly not bed bound. Although many assisted living residents would not qualify for benefits under long-term care insurance policies because they don’t need very much help, the National Center for Assisted Living reports that about 60 percent of assisted living residents need help with two or more Activities of Daily Living and probably would qualify. Others may qualify under the cognitive impairment benefit trigger as half of the residents have significant cognitive impairment.

The real attraction is that assisted living provides a place that looks like independent living to many people who can’t stay home anymore because they need extra help. Also, assisted living facilities make it possible for spouses to remain together, whereas nursing homes usually do not, at least not in the same room.
Older policies commonly provided assisted living benefits at a percentage of the nursing home benefit, but most policies today provide equal benefits. If you want the assisted living coverage and can do without home care benefits, you can save about 30%-40% in premium by considering a “facilities-only” policy that covers only assisted living facilities and nursing homes, as we discussed in the previous section.

**Guaranteed Renewable**

Policies today are “guaranteed renewable”, which means the policy cannot be cancelled as long as premiums are paid, even if the insurance company stops selling long-term care insurance. However, if the insurance company you bought your policy from goes out of business you can still lose your coverage, so it pays to consider large, reputable companies (see **Rates vs. Ratings** on p. 75).

Beware of anyone who tells you not to worry about the stability of the insurance company because the state guaranty fund will bail you out. This is a special pool of money that assumes responsibility for claims of policyholders from failed insurance companies. Generally, you have to be “on claim”, which means receiving benefits, on the date the company becomes insolvent to receive help from the guaranty fund. The guaranty fund is funded from assessments made by the insurance department on the other insurance companies in the state that sell similar insurance policies, and its liability does not extend to claims past the date of insolvency, so it doesn’t pay for future claims.

In addition to meaning the policy can never be cancelled, “guaranteed renewable” also means the rates can increase only if they go up on a “class” basis, not just on your policy. A class is usually defined as a specific
policy form number, perhaps in a specific geographical area. Rates won’t be increased by age groups or benefit features, such as “all 75+ policyholders who purchased a five-year benefit period”. Rather, a rate increase could be imposed on everyone who bought policy form #XYZ in the southeast or in a particular state, if the insurance department agrees that the rate increase is justified for that block of policies. Some policies offer rate guarantees from three to 20 years. Additional premium is normally required for rate guarantees longer than three years.

If the idea of a rate increase is particularly worrisome to you, you might want to consider a limited pay plan. This means that you pay additional premium for a specific number of years; then you never pay premium again. Your plan is subject to a rate increase during the years you are paying premium but not after your premium is paid up (see Lowering or Eliminating Long-Term Care Insurance Premiums in Retirement on p. 80).

Prior Hospitalization

It is illegal today to sell a policy that won’t pay nursing home benefits without a prior hospital stay. Many older policies were sold with this restriction, and their premiums are lower because these policies screen out a large number of claims. With strict hospital admission guidelines set forth by private insurance and Medicare, doctors can no longer admit patients just to satisfy an insurance requirement such as this. For example, Alzheimer’s patients or the frail elderly usually do not need hospitalization. Less than half of the nursing home patients in the last major survey came directly from a hospital.
Daily or Monthly Benefit

Some long-term care insurance policies pay a flat amount per day or per month for nursing home care with selections ranging from $40–$500 per day, or $1,000–$15,000 per month. These are called indemnity policies. Other policies will not pay more than the actual charge, regardless of the daily benefit you select. These are called reimbursement policies. Most reimbursement policies will allow the amount of daily benefit not used to carry over, thus extending your benefit period. Knowledge of local nursing home costs is helpful in making this selection. Costs nationwide average $171 per day for semi-private nursing home care. If home health care benefits are offered, the benefit ideally will equal the nursing home benefit but could be a percentage of the nursing home benefit, if it’s at least 75%-80%.

A policy with a monthly benefit will pay if home care for a particular day exceeds a normal daily benefit. For example, a therapist and an aide could come on the same day, and charges for both might total $250. A $150 daily benefit would pay no more than $150 for that day, but a $4,500 monthly benefit would pay the entire $250 or whatever the daily charges are until the $4,500 is used up for that month. Some policies provide a weekly benefit instead of a monthly benefit for home care. This can be helpful because there is less risk of using up all of your home care benefit in the early part of the month. Some newer policies give you a weekly or monthly benefit if you use a care coordinator at claim time (see Care Coordination on p. 73).

Note: Some applicants intentionally select a benefit lower than area charges to merely supplement their assets and income. For example, someone with $2,100 in monthly income may figure that he would use $1,000 of his income to pay toward his care, which is the equivalent of $30 per day. He then might purchase a policy that will pay $150 per
day, which results in a potential $180 per day available for an eight- to ten-hour shift of home health care or for semi-private nursing home care. Just be careful when you do this calculation to consider how much of your income you will need to pay your living expenses, which will be higher if you are receiving home care vs. nursing home care.

Some people prefer a private room and purchase a daily or monthly benefit to accommodate private room costs (i.e. $200+ daily benefit or $6,000+ monthly benefit). The daily benefit usually applies just to room and board. Personal items such as laundry, television, hairdresser, etc. aren’t covered. Care-related supplies like adult diapers or support stockings are usually not covered if they are billed separately. Selecting a benefit fairly close to the average cost in your area probably means you will still be self-insuring some of the costs. Make sure the policy will pay the percentage of costs you expect so you won’t be surprised when the bills start coming in.

The advantage of an indemnity policy that pays the daily benefit regardless of charge is to provide extra money to pay for these extra charges. The advantage of a reimbursement policy that pays no more than the actual room and board charge is to hold claim payments down and avoid rate increases for as long as possible. Since benefits above $260 per day (indexed annually) that exceed actual costs are taxable income, most newer policies are reimbursement; however, a new trend is to offer an option to change a reimbursement policy into an indemnity policy for additional premium, or at least the nursing home portion of the policy. A hybrid policy (indemnity nursing home benefits and reimbursement home care benefits) can make it easier for a company to keep rates the same, more so than a policy that is a total indemnity policy.
Note: A few reimbursement policies allow any difference between the daily benefit you select and the room and board charge to be used to pay miscellaneous charges that are not personal items, such as care-related supplies.

**Benefit Period/Benefit Maximum**

This is the amount of time (benefit period) or money (benefit maximum) the insurance company is obligated to pay benefits. This doesn’t mean how long you can be covered. You might have your policy 15 years before you need to file a claim for benefits. After you file a claim, the benefit period is how long the insurance company is responsible to pay benefits. Benefit periods from one year to unlimited are on the market, although some states require benefit periods of at least two years to be offered. Common choices are three years, four years, five years, six years, or unlimited.

Most insurance companies express the maximum benefit in dollars instead of time. Benefit maximum usually means a specific number of days multiplied by the daily benefit you select. For example, a benefit maximum of 1,095 days multiplied by a $200 daily benefit would be $219,000. This type of policy is usually a reimbursement policy. (See **Daily or Monthly Benefit** in the previous section.) If the charge happens to be less than your daily benefit, the remainder stays in this “pool of money” and extends your benefits. Instead of having the equivalent of a three-year benefit period with the pool of $219,000, your benefits may last 3 1/2 years or even longer. The insurance company won’t stop paying benefits until all of the dollars are used. If you purchase inflation coverage, the daily or monthly benefit you purchased will grow each year. The overall benefit maximum usually grows as well. A few policies will allow it to grow without deducting
any claim payments that were made that year. On the other hand, newer policies may sell you a dollar maximum, say $1 million, and allow you to access a specific percentage each month, usually 1% – 3%. Companies that do not offer an unlimited benefit period are concerned about future rate increases and want to be able to plan on a maximum payout for each policyholder.

After you have collected the maximum in benefits, the policy is over and you start paying out of your assets until you spend down to the qualifying level for Medicaid in your state (Medi-Cal in California and MassHealth in Massachusetts). A few states have a special program called The Partnership for Long-Term Care that allows you to shelter some of your assets and still qualify for Medicaid as a reward for purchasing a long-term care insurance policy (see Chapter Four, The Partnership for Long-Term Care).

To give you an idea of the nursing home usage, the chart in this section illustrates the length of stay information for patients in 2004 for all patients and also for those who stayed longer than three months. The average nursing home stay is 2.3 years. Three-fourths of nursing home patients stayed less than three years and 44 percent of the patients stayed less than one year. However, 12 percent of the patients stayed longer than five years. However, if you subtract the short stays of less than three months which are typically for short-term recovery care such as accidents, mild strokes, broken hips and the like, the five or more year percentage becomes almost 16 percent. Since women live longer than men, the majority of patients who need longer periods of care are women. Accordingly, most insurance companies will allow couples to choose different benefit periods as a way of reducing premium; i.e. a husband might choose a three-year benefit period and a wife might choose a lifetime (unlimited) benefit period.
Most caregivers are women, so men typically are taken care of at home by a wife or daughter as long as possible before entering a nursing home.  When a husband buys a long-term care insurance policy for himself, it may be the wife who realizes the greatest benefit from his policy because it pays for the support she needs to keep her husband at home as long as possible.

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<tr>
<th>Length of Stay for All Patients</th>
<th>Percentage of Nursing Home Patients</th>
<th>Length of Stay for Patients Who Stayed Longer Than 3 Months</th>
<th>Percentage of Nursing Home Patients</th>
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<td>Less than 3 months</td>
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<td>3-6 months</td>
<td>10.0%</td>
<td>3-6 months</td>
<td>11.0%</td>
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Cynthia Coe, an insurance professional in Massachusetts, relates what she describes as “a career transforming experience”:

I received a phone call from a local life insurance professional asking me to explain the benefits of a long-term care insurance policy his client had purchased from my insurance company when he lived in another state. He had recently suffered a debilitating stroke and moved back to our town to be closer to his children.

After setting an appointment with his wife, I arrived the next day to find one of the sweetest women I have ever met in tears, absolutely distraught and exhausted. The poor woman had lost 50 pounds and was absolutely frantic because Medicare was cutting back on home care for her completely disabled husband because his condition was “not improving.” Her poor husband was confined to a wheel chair or hospital bed, could not take a step, and was unable to communicate with anyone, except in a strange, garbled speech that only his wife understood. She was adamant about caring for him at home, but it was patently clear that she needed more help. I contacted the company, which immediately sent out a really nice social worker who assessed the situation and authorized benefits on the spot. We were able to arrange increased care within the week.

Three or four weeks after all this, I was having a particularly horrible day. My company was insisting I do telephone solicitation. I would rather have walked over hot coals, been caged with hungry lions or jumped out of a plane without a parachute—and I had encountered several really nasty individuals who had sworn at me and likened me to an unethical used car salesman. In other words, despite all my belief and conviction in the importance of long-term care insurance, I HAD HAD IT! I have the heart of a social worker, not a salesperson, and my fragile little ego was quivering. But, on the way home to tell my
husband that I absolutely had to find another line of work, I stopped at the bank to make a deposit, and who should be there but the wife of the client who was so disabled by the stroke. She spotted me, came rushing over, and HUGGED me with tears in her eyes and just gushed. “Thank God for you and your company, I don’t know what I would have done without you.” The new home care workers had given her back some semblance of a life, and she now felt she could cope with her life situation as a result of having such insurance.

Needless to say, I felt as if the Lord had given me a very strong message about the importance of the work I do. So, in spite of very regular set-backs, I still spend my days trying to spread the message about the emotional, physical, psychological and financial importance of this type of insurance—and I usually list “financial” last in this order, as the other three can eclipse everything else.

On the other hand, the wife or daughter may not have a similar caregiver and may access benefits on a long-term care insurance policy relatively soon. The more help a family has to provide home care, the easier it is to keep a family member at home who needs long-term care. The money from a long-term care insurance policy may be the only thing that makes it possible to provide extended home health care for a loved one. In fact, a recent claims study said that in the absence of their long-term care insurance benefits, half of the people receiving home care benefits would be in a facility because they wouldn’t have the support to stay home.¹⁷

Many older policies had separate benefit periods for home care, i.e. you could have three years for nursing home care and three years for home care, for a total of six years of coverage. If either side is used up, however, you can’t tap into the other side to continue the benefits in the same location. In this example, if you use up the three years of
home care benefits, and you still want to stay home, your remaining benefits will only be paid if you move to a nursing home.

Because of this problem, most policies today have “integrated” benefit periods. “Integrated” means that if you buy a six-year benefit period, for example, benefits will be paid however you need them—at home, in assisted living, adult day care, or in a nursing home.

How long a benefit period should you purchase? The answer is, as long as you can afford, without being uncomfortable with the premium. A recent study said that less than 10 percent of claimants are using more than four years of benefits. Who is at risk for longer periods? Four major categories:

1) People who take really good care of themselves may be the very people who need long episodes of long-term care. They are less likely to suffer a major heart attack or massive stroke, and instead, they just wear out! The healthier they are, the longer that can take—four years, six years, ten years!

2) Alzheimer’s patients – the average caregiving time is eight years, but the Alzheimer’s Association says it can be three to 20 years.

3) A younger person with a head or spinal cord injury (see Inflation Protection for an idea on how to manage this risk).

4) People with longevity in the family – is it common for relatives to live past age 90?

Here’s a comforting thought for you if you are concerned about how long you could need care and want to buy a long benefit period: If
you purchase a longer benefit period, such as lifetime (unlimited), and you decide later that it’s too much premium, you can always reduce your premium by reducing your benefit period, and that’s fine with the insurance company. If you start out with a shorter benefit period and decide later you want to increase it, the insurance company will require you to start over with new medical questions, and you will have to pay premium for the longer benefit period at your new age. It’s in your best interest to start out with the maximum benefit period you think you might want, because you can always come down. Increasing benefits later is more expensive, and if you have developed a health problem, you may be ineligible for a benefit increase.

As the average purchasing age for long-term care insurance declines, insurance companies are becoming uncomfortable with the risk of younger people incurring injuries or health conditions that cause them to need many years of long-term care. Consequently, some of the newest products no longer have an unlimited benefit period option. If this is really important to you (e.g. if you have a family history of Alzheimer’s), my advice is to buy a policy with an unlimited benefit period now while it’s still available. Once you have it, no one can take it away from you as long as the insurance company is in business. The best premiums on the unlimited benefit period seem to be with policies that sell joint policies that price the younger spouse at a percentage of the older spouse.

Restoration of Benefits

Some policies have benefit restoration periods that depend on being able to go a certain amount of time without using the policy (i.e., a five year benefit period is reinstated if a patient is in a nursing home and goes home for six months at the end of four years and no claims
are filed for the six-month period). The practicality of this feature is questionable as the policyholder must depend on someone else to provide care during the required period out of the nursing home.

Most restoration provisions, however, require that the patient be really better, which means that no care is needed for a six-month period, or at least that no expenses be incurred for six months that would be eligible under the policy for benefits. A benefit like this is good for people who have short-term problems, like mild strokes, and fully recover. Someone who needs care for an extended period of time is unlikely to get better and will not benefit from this feature.

I was enjoying a lovely dinner at the annual board meeting of the university I attended until the gentleman on my right asked me to divulge my line of work. He recoiled when he heard the words “long-term care insurance” fall from my lips. I was soon to find out why. His wife was just coming up on her fourth year in a nursing home with Alzheimer’s disease. Simultaneously, the benefits of her long-term care insurance were coming to an end. The professional who sold the policy had told him a four-year benefit period would be enough, because the policy had this great restoration feature and if she used up the four years, she could get her benefits restored. Since she will never recover, this has turned out to be very bad advice.

I have, however, advised younger people to consider this provision, especially if they are buying a short benefit period such as two or three years. It doesn’t cost much and a younger person could sustain a serious injury such as a fractured pelvis in an automobile accident, yet recover after a year or so, in which case the restoration of benefits provision could prove to be very meaningful.
Shared Benefit Periods

A new feature is catching on to make long-term care insurance policies more practical and affordable for married couples and even families. Four versions of this idea exist in current policy selections:

1) One version allows spouses to share a benefit period at a lower premium than two separate benefit periods would cost. (You and the insurance company are betting that both spouses won’t need a lot of long-term care.) If one spouse dies without using all the benefits, the surviving spouse is entitled to the remainder of the benefit period at a reduced premium.

2) Another version has separate benefit periods, but for a little more premium it allows spouses to access each other’s benefit period. For example, each spouse has a six-year benefit period. If one spouse uses only one year of benefits then passes away, the other spouse would have eleven years of benefits left.

3) A third version provides separate benefit periods of the same length for each spouse, then allows the couple to purchase an additional benefit equal to the primary benefit period to share first come, first served. For example, if the spouses each purchased a three-year benefit period, the insurance company would allow them to purchase a third three-year benefit period that both could access as needed.

4) The fourth version is a family policy. The applicant can select up to three immediate family members (parents, grandparents, siblings, children, stepchildren, grandchildren and respective spouses) to be on the same policy. This means they all share one deductible and a single benefit pool (see Elimination Period...
Features of a Good Long-Term Care Insurance Policy

[Waiting Period] in the next section). The unlimited benefit period is not available. If the applicant dies or no longer pays the premium, ownership of the policy can be transferred to the next named family member on the policy. In this way, parents can pass any unused benefits on to children or other family members.

Elimination Period (Waiting Period)

This is the number of days you have to pay until the insurance company pays benefits (like a deductible). Examples of choices range from 0, 20, 30, 60, 90, 100, 180, 365 or even 730 days. Some states won’t allow waiting periods longer than 180 or even 100 days to be offered. Patients receiving skilled care may be able to avoid out-of-pocket costs during the elimination period because regular health insurance may pay some skilled care for people under 65, and Medicare can approve up to 100 days for skilled care for people over 65. The chances of qualifying for skilled care as long as 100 days are slim, however (see Why Doesn’t Medicare Pay More? on p. 15).

The longer the elimination period, the greater the potential out-of-pocket costs. For example, someone with a 100-day waiting period who receives 30 days of skilled care reimbursed by private health insurance or Medicare will be responsible for the 70 days of non-skilled care before the policy begins to pay. At a $180 charge per day, the out-of-pocket cost would be $12,600.

Caution: A few policies don’t count days paid by Medicare or health insurance toward your waiting period. If you have a policy like the above example, you will be responsible for the full 100 days after the 30 days paid by Medicare. Ask the insurance professional to show you the section that addresses this point in the sample policy so you will have a clear understanding of how it works.
Some policies require the satisfaction of additional elimination periods if episodes of care are separated by longer than a specified time period, usually six months. For example, a patient may have a four-month nursing home stay and need to be admitted again four years later. Both admissions would require an elimination period before benefits could be paid. Most new policies require only one elimination period in a lifetime, regardless of how long it takes for you to accumulate the days of care that equal the waiting period. However, a few policies require you to accumulate the days within a certain time frame, such as six months or two years, in order for you to never have to satisfy another waiting period.

It is wise to ask how the elimination period is calculated for home health/adult day care. Some policies count only the days actual services are provided, so if the patient does not have home health care every day, it would take longer than 100 calendar days to satisfy a 100-day elimination period. Some policies count all seven days in a week toward the waiting period even though home care was only received on one day of that week. Others start counting when the physician first certifies the need for long-term care (see Claims on p. 93). Policies of the latter type may not require charges to be incurred during the elimination period. In other words, family members could provide the care until the elimination period is satisfied. For additional premium, a few policies allow days of care for one spouse to count toward the waiting period for both spouses.

Beware of policies that have choices of only 0 or 100 days, with no choice in between, especially if the insurance professional is urging you to choose a 0-day waiting period, which means first day coverage and no deductible. This sounds great on the surface, but if that insurance company sells most of its policies without a deductible, it will likely
be paying out claims much faster than other insurance companies. Again, this sounds good, but it means the company will be much more apt to need rate increases to stay in business than other companies.

A new trend in long-term care insurance is to waive the elimination period for home care benefits or even for all benefits if you agree to use a care coordinator provided by the insurance company (see Care Coordination on p. 73). Or a policy may not have an elimination period at all for home care benefits, regardless of whether a care coordinator is used or not. This is another consumer-friendly benefit that can have an adverse impact on that company’s future rate stability as no deductible normally increases both the frequency and dollar payout of claims.

In addition to home care, many companies don’t require the waiting period to be met prior to receiving benefits such as hospice, respite care, caregiver training, Emergency Response System, and so forth (see Miscellaneous Benefits on p. 70).

**Mental Conditions**

If you qualify for a policy, many policies will cover mental conditions only of an organic nature, such as Alzheimer’s and other dementias. Look for a written statement about coverage for “cognitive impairment,” which includes Alzheimer’s disease. Tax-qualified policies will cover severe cognitive impairment that causes the patient to be a threat to himself or others. For example, if you have high blood pressure and you can’t remember to take your medicine when you are supposed to, this could certainly make you a threat to yourself, because you could cause yourself to have a stroke. Many policies will not cover mental conditions of a non-organic nature such as schizophrenia, manic-
depressive disorders, etc. Some cover all types of mental conditions. Why is this important? Sometimes at older ages, the lines can blur between dementia and depression, for example. A company that covers all types of mental disorders may be more likely to pay the claim without a problem.

Waiver of Premium

In most policies, premiums are waived after a specified time, usually expressed in days of benefit payments. For example, older policies typically waived premiums after 90 days of nursing home benefits. Some policies do not require these days to be consecutive. Newer policies also waive premiums when you receive assisted living, home care or adult day care, and most policies waive premiums on the first day of benefits. The premium only comes back in most policies, if you get truly better, which means you don’t incur any eligible expenses, for six months. A new trend is the “dual waiver”, which means the premium is waived for both spouses when one spouse starts receiving benefits. This can be an optional benefit that requires additional premium, or it can be built into the policy at no additional charge.

Inflation Protection

The policy should have some provision to help the benefits keep pace with inflation because home care and nursing home costs are projected to grow 5%-6% compounded each year. At that rate, costs will triple in the next 20 years. Here are two common inflation options offered by insurance companies:

Future Purchase Option (also called Cost-of-Living, or CPI method)

This method allows policyholders to buy extra coverage at certain intervals (i.e. every one to three years) equal to the percent of increase
due to inflation. Typically, the amount of coverage offered is determined by changes in the Consumer Price Index and is offered as long as you haven’t filed a claim in a certain period of time. Some states and some policies require those offers to continue even if you have had a claim. Some policies discontinue the offers if you turn them down two or three times, or even one time.

The problems with this method of inflation protection are:

1) The amount of the offer is usually determined by the overall Consumer Price Index, which is lower than the medical component of the CPI, neither of which is keeping up with actual increases in long-term care costs. Since 1913, CPI for all items has averaged 3.5 percent, and medical CPI usually runs between 4%-5%, according to the Bureau of Labor Statistics. A few policies offer a minimum 5 percent compound annual offer.

2) One popular plan only offers 5 percent of the original daily benefit every three years, so it would take sixty years to double!!

3) The offers are priced at your attained age, which means the age you are when you accept each offer, not the age you were when you purchased the policy.

**Guaranteed Annual Increases**

Other policies allow the policyholder to purchase a rider that automatically increases the daily or monthly benefit by 5 percent—compounded or simple—for life. A few charge a lower premium and allow the daily benefit to compound annually just until the benefit has doubled or allow it to compound for 20 years before it stops. A
few policies offer other percentages besides 5 percent, such as 3%-4%. (Remember that long-term care inflation is projected to average between 5%-6% a year.) Whichever factor is used, only the benefit increases annually, not the premium, with one exception: a few policies have a “step-rated compound benefit increase” which means both the benefit and the premium increase at a compounded rate of 5 percent annually.

Proponents of the future purchase option method argue that since medical costs can increase faster than 5 percent per year, policyholders with the inflation rider may experience a shortfall at the time of a claim, which would result in increased out-of-pocket costs. However, when the cost-of-living offers are determined by the overall Consumer Price Index, these offers are even more inadequate since CPI for all items normally grows only about 3.5% each year.

People who like the 5 percent guaranteed annual increases method best say that the periodic premium increases under the cost-of-living method are unmanageable for most budgets, and the extra benefit usually can’t be purchased if there is a claim. Someone who has a five-year claim has a frozen daily benefit throughout the claim. (As noted above, some states and some policies require the future purchase offers to be made during a claim, but that’s rare.) The 5 percent guaranteed annual increases occur even if there is a claim and - a pleasant surprise - the premium is usually waived (see Waiver of Premium, p. 62).

Even if the future purchase offers are at 5 percent compounded so that the benefit will wind up in the same place as the guaranteed annual increase method, the biggest problem with the future purchase option method is that it has a lower premium when the policy is first purchased, but over the long run can cost much more. For example, let’s compare both types of inflation coverage for a married 54-year-old purchasing this plan:
Features of a Good Long-Term Care Insurance Policy

- $100 daily benefit for all types of care
- 20 day waiting period
- unlimited benefit period

One popular company illustrates that the annual premium for the Future Purchase Offers (FPO) method starts out at only $818 but would grow to $25,462 annual premium at age 86 if she accepted the 5 percent benefit offer every year. By comparison, she could have purchased the policy with a level premium and the 5% benefit increases are guaranteed for the rest of her life at an annual premium of $1,919. By age 86, she would only have paid $63,330 in premium vs. $203,051 with the FPO method! In both cases, the daily benefit would have grown from $100 per day to about $500 per day.

If you are considering the future purchase offer method, be sure and ask the insurance professional to show you a printout of the projected premium increases over your lifetime. The insurance companies who offer this method of inflation protection are required to include that information in the proposal. If the proposal shows significantly lower premiums at older ages than I have just illustrated in this section, check to see what the benefit has grown to under the FPO method. For example, the plan cited in #2 in the “problems with the FPO method” on the preceding page allows the daily benefit to increase by 5 percent of the original amount every three years. So a $100 daily benefit would grow $5 every three years. By age 87, the benefit would be only $155 vs. $502 with the 5 percent compound rider. Premiums at age 87 are substantially lower with this version but the obvious tradeoff is that the benefit is only 30 percent of what it would have been with the compound rider.

If you elect the 5 percent guaranteed increase rider instead of the future purchase offer method, you may be wondering if you should
choose the 5 percent simple (if your state allows that option) or the 5 percent compounded rate of growth. “Simple” means the benefit grows 5 percent of the original amount and doubles in 20 years. “Compounded” increases grow faster, doubling in 15 years, because the 5 percent increase is based on the previous year. Walter Newman, a North Carolina insurance professional, tells how this benefit really paid off at claim time:

In 1992, a locally prominent man bought a policy from me with a $100 daily benefit. After some persuasion, he agreed to add the 5 percent compound inflation rider. He was a wealthy individual and wanted to buy a plan without inflation coverage, intending to self-insure the difference.

Three years later he was diagnosed with Alzheimer’s and was cared for at home for the next two years. When his family could no longer manage him, he was admitted to a skilled nursing facility. Thanks to the inflation coverage, he is currently receiving benefits of $141 per day, instead of the original benefit of $100 per day. The cost of his care is $5,500 a month, leaving a difference of $1,138. His family tells me his Social Security check just about makes up the difference, so all his other income and assets are available to his family. If he hadn’t bought the inflation rider, the difference would have been almost $2,500!

Obviously, the younger the applicant, the better sense the 5% compounded makes, since long-term care costs are projected to triple in the next 20 years. Anyone 70 and younger is well advised to consider the 5 percent compounded inflation method because people are living so long today. People in their 70s may want to choose 5 percent simple to get a lower premium. The example on the next page shows that the growth for the first 10 years is very close to the 5 percent compounded rate.
Another way people age 75 or older can protect against inflation is to buy a higher benefit than the average cost of care (i.e. $250+ per day at age 78, or $400+ per day for high cost areas like New York, Massachusetts, Alaska, etc.) to build in extra benefit to accommodate future costs.

An interesting question for a 75-year-old is should she buy what the benefit will grow to in ten years or opt for a benefit that reflects current costs with a simple or compound inflation rider? The majority of purchasers in this age range don’t buy the inflation riders. At age 75, the premium is about the same for a lower benefit with the 5 percent compound rider vs. a benefit that reflects what the lower benefit will grow to in ten years —say $150 with 5 percent compound inflation vs. $240 without the rider. (Simple inflation is about 10 percent less premium at age 75.) The benefits will be close between simple and compound by the 10th year of the policy. If the person lives longer than age 85, the benefit gap widens — $30 a day apart by age 87, $40 apart by age 90, and so on.

But listen carefully. What about the person who bought $240 with no inflation coverage? What happens if that person lives longer than 85 years old? The benefit is stuck at $240 and does not grow at all.

At age 79, Spencer Jones had his foot in a cast when he bought his long-term care insurance policy from me in 1989 due to a fall in the yard. I looked at the twinkle in his eye and listened as he, his daughter and son-in-law (who were also purchasing policies in their early 50s) told me how active Mr. Jones normally was. My gut-level instinct said to me, “This man is not old.” I sold him the 5% compound inflation rider.

I got a call that Mr. Jones is ready to file a claim for assisted living benefits at age 92! He was walking a mile a day until a few
The following chart shows a comparison of a $100 daily benefit with a 5% simple growth vs. a 5% compounded growth.

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<th>Year</th>
<th>5% Simple</th>
<th>5% Compounded</th>
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### Pay Now or Pay Later

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<td>Waiting Period:</td>
<td>20 days</td>
</tr>
<tr>
<td>Benefit Period:</td>
<td>Lifetime (Unlimited)</td>
</tr>
<tr>
<td>Home Health:</td>
<td>Same benefits as nursing home</td>
</tr>
</tbody>
</table>

#### Client #1: Daily benefit grows 5% compounded annually for life

**Annual Premium:**

\[ \text{Annual Premium} = \text{Premium}_0 \times (1 + r)^t \]

\[ \text{Annual Premium} = \$4,286.52 \times 20 \text{ years} = \$85,730 \]

#### Client #2: Either no inflation or policy has future purchase offers, but client doesn’t purchase future amounts

**Annual Premium:**

\[ \text{Annual Premium} = \$2,313.36 \times 20 \text{ years} = \$46,267 \]

#### ASSUMPTION: Client #2 has a long-term care need in 20 years at age 85. Daily cost in 20 years: $450/day or $165,000

Client #2’s deficit = $300 per day ($450 cost - $150 daily benefit purchased) X 365 days = $109,500 shortfall first year. (Shortfall grows each year as cost continues to grow with inflation.)

Client #2 “saved” $39,463 in premium over the twenty-year period which grew to $97,511 at 8% annual return before taxes and investment fees. But applying the entire savings and investment earnings to the first year shortfall still leaves, $11,989 coming out of Client #2’s pocket and the shortfall will continue to grow with inflation for years two and forward.

#### QUESTION: Did Client #2 Really Save!

* Annual growth rate of 5.8% according to the Centers for Medicare and Medicaid Services 2006.
months before he suffered a heart attack. My instinct had served me well. He was a young 79-year-old and didn’t need his policy for 14 years. Was that compound inflation rider a wise decision for him? You decide.

It’s the old “pay now or pay later” problem if you are thinking about not buying inflation coverage because it increases the premium so much. You can wind up on Medicaid with limited care choices quickly if your benefit is far below the cost of care when you have a claim and you can’t make up the difference out of your pocket. Look at the example on p. 69 before making your decision.

**Miscellaneous Benefits**

The better policies today offer a variety of benefits in addition to those already described.

**Alternate Plan of Care**—If your doctor and the insurance company agree that you can be taken care of at home adequately, most policies allow money taken from your benefits to provide enhancements to your home, such as handrails, wheelchair ramps, shower stall improvements, etc., or even an emergency response system to make it easier for you to stay home. This benefit is also used to pay for new long-term care services as they are developed. This is a great feature, because without it, the insurance company would have to amend your policy to pay for new services, a process that can take a long time.

*Caution:* Beware of anyone who tells you the alternate plan of care benefit means it is not necessary to purchase home health coverage when you buy your policy. You may be able to get some home care assistance under the alternate plan of care provision, but it is by no
means a defined benefit for home care, assisted living or adult day care. If you want home care benefits, make sure that the “home care” or “community care” block is checked on the application, and that your policy specifically states that you have benefits for home care, assisted living and adult day care. (The real intent of the alternate plan of care provision is to find ways to provide care that is less expensive than nursing home care.)

**Hospice**—Most long-term care insurance policies cover hospice, which is care for terminally ill people to keep them as comfortable as possible and provide respite care to family members. Most health insurance policies also cover hospice and Medicare has a virtually unlimited benefit for hospice. Tax-qualified policies are not allowed to duplicate Medicare payments, so when would the long-term care insurance policy pay? Medicare’s inpatient respite care benefit for hospice is only five days per stay and the family may need a longer period of respite care. Medicare’s home care benefit for hospice won’t pay eight-hour shifts or longer except in a crisis situation. Long-term care insurance will pay eight-hour shifts indefinitely as long as benefit triggers are met and benefit maximums are not exhausted.

**Respite Care**—a specific benefit to give the primary caregiver a break. The break could be a few hours off to go shopping or a week or two for a vacation. This benefit is usually paid at home but the better policies pay also in a nursing home or assisted living facility to cover the 24-hour care that will be needed if the caregiver needs to be away several days. Benefit triggers (Activities of Daily Living or cognitive impairment) usually must be met to access the respite care benefit, but the elimination period often does not have to be satisfied.

**Homemaker Services**—a benefit that pays for personal caregiving services such as cooking, cleaning, laundry, shopping, telephoning
and transportation when a benefit trigger is met. Some policies will pay homemaker services only when you are receiving other home care services, such as care provided by a home health aide, nurse or therapist.

Alternate Payer Designation (Third Party Notification)—The policyholder has the opportunity to designate someone else to get a copy of a lapse notice in case the policyholder doesn’t pay the premium. Take advantage of this opportunity because this feature protects against policies lapsing if policyholders develop a mental or physical problem that makes them unable to pay the premium.

Impairment Reinstatement—If the policyholder allows the policy to lapse due to a cognitive or physical impairment, the insurance company will reinstate the policy with appropriate premium payment within a specific time period, such as five, six, or nine months. Without this provision in the policy, an insurance company is under no obligation to reinstate your policy if you miss the grace period by even one day. Tax-qualified policies are required to have a minimum reinstatement period of five months.

Bed Reservation—If you have to go to a hospital during a nursing home stay, this benefit will pay to hold your bed at the nursing home. Without this benefit, your family would have to pay or the nursing home could give the bed to someone else. Since nursing homes are 86 percent full nationwide, many nursing homes have waiting lists. Without a bed hold payment, you would have to find another nursing home if you lost your bed to someone else and the nursing home was full. Newer policies provide the bedreservation benefit when the patient leaves the nursing home for any reason, such as for short visits with family and friends, and policies also pay to hold your bed if you have to go to the hospital while you are in an assisted living facility.
Care Coordination—This benefit pays a third party who ideally doesn’t work for the insurance company or the provider of care to manage your care and report regularly to your family, although some companies require you to use care coordinators affiliated with the insurance company and even raise or lower the benefit level by whether or not you use the recommended care coordinator. The care coordinator would perform services like helping to determine the best place for you to receive care, i.e., at home, in an assisted living facility, adult day care or a nursing home and making sure you are getting the best care possible.

A care coordinator is especially helpful when children or other family members don’t live nearby, because the care coordinator can give care reports regularly to the family members. Some companies want policyholders to use this benefit so much that they don’t reduce the benefit maximum whenever you use it, which makes it a free benefit. They feel this way because they know a care coordinator will help you get the most out of your long-term care insurance policy by using your benefits most effectively and efficiently. Some companies require the use of care coordinators before paying benefits at all, but you may have the option to hire a private care coordinator if for whatever reason you don’t wish to use the free care coordinator provided by the insurance company. For example, a separate benefit for a private coordinator might be 25 times the daily benefit per year. This benefit payment would be subtracted from your lifetime maximum.

Survivor Benefit—Some policies will not require a surviving spouse to pay premiums after the death of a spouse if the death occurs after the policy has been held a specified period of time with no claims on either spouse, usually 10 years, but it could be less. For example, if the death occurs prior to the 10th year, the surviving spouse would not have a premium waiver. A few policies have a more liberal provision,
however, and will waive the premium on the 10th policy anniversary of the surviving spouse. This feature is rarely part of the basic policy; it is typically an option which requires additional premium, and a few companies offer both types of survivorship waivers.

**Worldwide Coverage**—Most long-term care insurance policies will not pay outside the United States and Canada, but a few will pay worldwide, or in a list of specified countries, especially if you live in the U.S. at least six months of the year. Payment is usually made to you in U.S. currency and benefits may be reduced to compensate for the additional administration required to process claims with international complexities. If this is important to you, ask if there are any benefit reductions for worldwide coverage. If this is really important to you, you might want to consider a cash plan that gives a monthly benefit check that you can use anyway you like without proving services. That way you will have total freedom to purchase whatever services are available in the other country.

**Coordination with Medicare and Other Insurance**—Tax-qualified policies are not allowed to make a payment if Medicare pays or if Medicare would pay in the absence of a deductible or coinsurance. Some companies interpret this provision in its strictest sense, i.e., if Medicare makes a payment on days 21-100 for nursing home care, the long-term care insurance policy will not make a payment, even though you are responsible for a daily co-payment for those days. Most people, however, have coverage to supplement Medicare for the first 100 days—either a Medicare supplement, retiree plan or a Medicare Advantage plan. (This is further evidence that Congress intends long-term care insurance to pay for long-term conditions beyond three months, not short-term recovery conditions.)

A few policies won't duplicate benefits paid by any other health insurance, which could include another long-term care insurance
policy but rarely does. Some companies police it another way: They won't sell you a daily or monthly benefit that, together with the policy you already have, would exceed the maximum daily or monthly benefit they offer.

Additional Benefits—Long-term care insurance policies commonly include payment for a medical alert/emergency response system (usually $25-$50 a month), ambulance (four trips per year) and medical equipment (30-50 times the daily benefit). Some of these expenses are picked up by Medicare and most policies will not duplicate Medicare’s payment. These types of benefits are nice to have, but they shouldn’t be given equal weight in the buying decision with the other benefits discussed in this chapter.

Rates vs. Ratings

Virtually all policies today lock in the rate at the time of purchase based on the age of the applicant and cannot increase premiums unless all policyholders in a certain class receive the same increase. Very few policies are “noncancellable,” which means the premium can never increase. Some states will not approve a noncancellable policy because higher than anticipated demand for long-term care benefits could make it difficult for an insurance company to hold the rate. Initial pricing and the type of underwriting, liberal or conservative, play major roles in an insurance company’s rate stability. “Underwriting” refers to the type of health conditions that an insurance company will accept when a person applies for coverage. Below-market rates, liberal underwriting (i.e., accepting a lot of people with major health problems), and a small asset base make future rate increases almost a certainty.

Another cause for rate increases is when an insurance company sets rates based on an assumption that a significant percentage of policies will lapse (cancel) before a claim is filed. For example, if a company
assumes that 15 percent of policies will terminate and only 3 percent do, you can see that many more claims will be payable than the company originally thought. Higher than projected claims can make a rate increase necessary. This has happened to a number of companies because long-term care insurance policyholders typically hang onto their policies. Why? Because the premium is determined by age and sometimes by health status. So it’s expensive to buy a new policy at an older age, and the policyholder may be charged more or declined due to health conditions. This is why some policyholders who wish they had purchased a higher benefit just buy an additional policy to go with what they already have instead of replacing their original policy with a brand-new policy at an older age. If you think you need additional coverage or if you’re just not sure, ask a long-term care insurance professional to help you make the best decision for your situation.

Do not even think of shopping for the cheapest long-term care insurance policy you can find. Some companies that started out with extremely low premium (i.e., half to two-thirds of other companies’ rates) have already experienced terrific rate increases, whereas most companies have not experienced a rate increase for policies issued in the past decade, if ever. If a company is having rate increases now, what will happen to it when the baby boomers begin needing long-term care? This point can’t be overemphasized. There have been cases of premiums not just doubling, but increasing 800%! If the premium is significantly less than other policies, run, don’t walk, away from it.

Landmark legislation in Florida passed in 2006 [SB2290/HB1329] that is supposed to address the issue of rates increases. Just in Florida, insurance companies are no longer allowed to:

1) raise rates on existing policies higher than new policyholders are being asked to pay for the same benefits; or
2) deny a claim based on fraud unless the fraud was discovered in the first two years after the policy was purchased.
Policies will cost more in Florida to absorb these requirements, especially #2. If someone applies for long-term care insurance, knowing he or she has early signs of dementia, it can be years before the dementia is obvious enough to be detected in the underwriting process.

**Legitimate Premium Savings**

Some legitimate premium savings can be had by paying annual premium vs. a monthly bank draft. A few policies don’t charge extra or may even reward you with a small discount for bank draft, but annual premium is the least expensive payment with most companies. Adding additional premium of 9% for monthly and 5.5% for semi-annual is a common practice. Rather than pay the additional premium, many people pay annual premium out of their investments. A common strategy to find the money to pay a long-term care premium without taking it out of monthly living expenses is to convert a low interest-bearing fund such as a CD or money market account to a deferred annuity that will earn a higher interest rate tax-deferred. Most annuities allow you to withdraw 10 percent or so annually with no penalty or surrender charge and that makes a great funding vehicle for the annual long-term care insurance premium. Check with your accountant when you are setting up the amount to ensure that the withdrawals accommodate your tax needs as well as the long-term care insurance policy premium.

**Spouse/Partner Discounts**

Married people get a break with spouse discounts ranging from as low as 7.5 percent to as high as 40 percent. Some companies even give a spouse discount if one spouse is declined for coverage due to a health problem or just doesn’t apply for coverage in the first place. The insurance companies are betting that most married people will try to take care of each other as long as possible and not use as many claims dollars as single people...
without the live-in support system of a spouse. Most companies offer the spouse discount to domestic partners as well.

Some of the spouse discounts extend to live-in siblings and a few are really a household discount that could include anyone living with you in a long-term situation. There are even policies that grant a 40%-50% discount, but don’t get fooled by the size of the discount. Compare with a few other policies to decide if the premium is either too low or too high.

Company Ratings

In addition to avoiding bargain basement premiums, it is not wise to consider a carrier with less than an A- rating by A. M. Best, the most well-known third-party rating service for insurance companies. Carriers with lower ratings may not have the financial strength to sustain long-term care coverage. It is also wise to ask if the carrier has assets in the billions, or if it is owned or reinsured by a company with assets that large.

“Reinsured” means that a larger company will pay claims after they reach a certain size. Some smaller companies are subsidiaries of billion-dollar companies; however, subsidiaries can be sold. A major reason some insurance companies have withdrawn from the long-term care insurance market is because they could not keep up with product design required by regulatory changes. Many smaller companies just don’t have the financial flexibility to make these changes in a timely manner necessary to be competitive in the market. The chart on the next page may help you examine ratings of companies.

- A.M. Best provides a financial and operating performance rating on virtually all life and health insurance companies.
# Financial Quality Ratings of Major Rating Agencies

<table>
<thead>
<tr>
<th>Ranking</th>
<th>A.M. Best</th>
<th>Standard Poor’s*</th>
<th>Moody’s**</th>
<th>Fitch</th>
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<tr>
<td>#1</td>
<td>A++, A+</td>
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<td>#8</td>
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* “pi” following a rating indicates that it is based on quantitative analysis of public financial data vs. data provided by the insurance company.

A “w” following a rating means the rating is under watch and subject to change. Ratings from “AA” to “CCC” may be modified by the addition of a plus or minus sign to show relative standing within the major rating categories.

** Ratings from “Aa” to “Caa” may be modified by the addition of a 1, 2, or 3 to show relative standing within that rating category.
• Standard & Poor’s provides financial strength ratings for those insurers who request a rating. S&P also provides financial strength ratings from public information for other insurers.
• Moody’s and Fitch provide ratings for those insurers who request a rating. Therefore, ratings from these two services are not available for all insurance companies. The chart on the following page outlines the rating scales used by the four primary rating services.

To get ratings on selected companies over the telephone at no cost, you can call Standard & Poor’s at 212-438-7280, Moody’s at 212-553-1658, and Fitch (formerly Duff & Phelps) at 800-853-4824 or 212-908-0500. The A. M. Best rating can be obtained by visiting the reference section of your local library. Ask for the most recent Best’s book, because it is published annually. Ratings are updated more frequently in the monthly magazine, Best’s Review. You can also call A.M. Best at 908-439-2200.

*Lowering or Eliminating Long-Term Care Insurance Premium in Retirement*

A few policies allow you to pay two years’ annual premium when you purchase the policy in exchange for a lower lifetime rate; e.g. a 10%-25% discount for the second year forward. Or, a policy may allow you to pay enough extra premium each year so that at age 65, your premium drops to half the original premium. These types of options can be meaningful for people who are trying to reduce expenses in their retirement years.

For people who don’t want to pay long-term care insurance premium at all in their retirement years, there are “limited pay”
policies that allow you to stop paying after 5, 10, 15 or 20 years or at age 65. A few companies even offer a single premium. States vary greatly on whether limited pay policies are allowed to be sold, as some insurance departments worry about limited pay policies having a potential adverse affect on rate stability. A long-term care insurance professional can tell you what is available in your state.

Rates (premiums) are the same for men and women, but are based on age. Policies are available for ages 18+, but most are sold in the 40-84 range. You’re never too young to think about long-term care insurance—a 25-year-old can wind up in a coma after a car accident! If you haven’t bought a policy by the time you are 40, pre-retirement ages (40s and 50s) are the best time to consider long-term care coverage, because premiums are lower and health is better at younger ages. Some people worry about buying at younger ages and experiencing rate increases that could make a policy unaffordable as they get older.

### The True Cost of Waiting!

<table>
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<tr>
<th>Age</th>
<th>Annual Premium</th>
<th>Premium paid by Age 80</th>
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<td>30</td>
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A really new trend in long-term care insurance policies is to offer a limited pay option with a corresponding rate guarantee. For example, some companies offer rate guarantees from three years up to 20 years. A possibility with a policy like this is to purchase a policy that would be paid up in ten years along with a corresponding 10-year rate guarantee, a combination which provides you with a guaranteed premium.

The True Cost of Waiting

There are three solid reasons why you should ignore advice to wait until you are in your 50s or 60s to purchase a long-term care insurance policy.

1. Anything could happen to you—see examples of younger people needing long-term care in *Long-Term Care Insurance is Not “Senior Citizen Insurance,”* on p. 127.

2. Because of Point #1, you may not be insurable. No amount of money will buy you a long-term care insurance policy after you develop a serious health condition.

*Kathy Halverson’s 41-year-old husband was diagnosed in 1986 with Parkinson’s disease. An insurance professional in Wisconsin, he and Kathy “had it all” when it came to insurance policies—except long-term care insurance. Kathy had to learn the insurance business and take over his practice to care for him and provide for their family, especially their children’s education. Her husband has since passed away, and Kathy has dedicated herself to getting the word out about how long-term care insurance can protect families. She repeatedly testifies, “We sold insurance for 31 years! We had it all . . . but not LTC . . . and after spending all our pensions, retirement, etc, to care for my*
husband and educate our children, we were 10 months away from seeking assistance [with Medicaid].”

3. You will pay longer, but you will pay less. The longer you wait, the more benefit you must purchase because long-term care costs are increasing so rapidly. Consider that a married 30-year-old in good health may wish to purchase a policy that will pay about 2/3 of the cost. He could consider a $120 daily benefit for a premium of $550. If that person waited until 40 to purchase, he would have to buy a $190 daily benefit for a premium of $1,080 to accomplish his goal because the cost of care in 10 years will be at least $265. At 50 years old, he is looking at a $300 daily benefit to pay 2/3 of the cost, for a premium of $2,015. Now multiply all three premium amounts to age 80 to see how much he would pay, depending on his purchase age. ($550 x 50 years = $27,500 vs. $1,080 x 40 years = $43,200 vs. $2,015 x 30 years = $60,450)

The difference is most dramatic from age 40 to age 50, but both of those ages become a moot point if he has a skiing accident at age 35 and becomes paralyzed for the rest of his life.

Consumer advocates advising you to wait until you’re older to buy may change their advice when a younger sister or son is paralyzed from a car accident or rendered almost lifeless from a stroke or aneurysm.

Saving vs. LTC Insurance

Consider the following example of purchasing a long-term care insurance policy versus investing in an IRA to fund long-term care. A man or woman invests $500 in an IRA at age 40 annually until age 70 ½, which is the mandatory IRA distribution age. That consumer will
have $47,500 ($500 each year compounded annually at 6 ½ percent). While that sounds like a tidy sum for a minimum investment, it will barely pay for nine months of long-term care at today’s annual cost of more than $62,000, much less the projected cost of $320,000 per year in 30 years. Suppose the man or woman had decided to purchase long-term care insurance at age 40. For a little more than this $500 IRA investment, he or she can get coverage of $120 per day* for all benefits (home care, assisted living, adult day care and nursing home care) with a total benefit period of three years and a waiting period of 100 calendar days. Since this plan includes a 5% compound inflation feature, at age 84 the daily benefit will grow to $805 per day. The annual married premium is only $730 per spouse. If neither spouse has a claim until age 84, the couple will have paid about $65,850 in premiums, and the total available benefit payout for one person will have grown to a whopping $1,125,068 or about $2.25 million for both spouses. And, don’t forget that the premium stops when you are using the policy!

On the other end of the age spectrum, a 70-year-old couple may decide to save $5,890 a year, instead of spending that amount to pay the premium for a rich plan with a $150 daily benefit. (The other elements are the same as the plan described above for the 40-year-old.) By age 84, the couple will have saved $181,250 at 10% before taxes and investment fees, which sounds like a lot until you realize that the cost of care at that time is projected to be at least $120,000 a year. Their savings at age 84 would pay for less than two years of care for only one person. Had the couple bought the long-term care insurance policies, the $150 daily benefit would have grown to $297 per day by age 84, and the couple would have had an available benefit of $108,405 a year for each of them, and a potential payout of $682,550 for the next three years for two people. (If you do this calculation yourself, don’t

*A good plan that pays about two-thirds of the cost in most parts of the country.
forget that the daily benefit continues to grow 5% compounded each year - $297, $311, $327 and so on.)

Underwriting

Applicants for individual policies must qualify medically for long-term care coverage. Progressive conditions such as Alzheimer’s, Parkinson’s disease, AIDS, multiple sclerosis, muscular dystrophy, and psychiatric disorders are uninsurable. Applicants must be ambulatory to qualify for coverage, and must not need help with activities of daily living, such as bathing, dressing, toileting, transferring from bed to chair, eating or continence. Heart disease, cancer or one mild stroke can be acceptable risks after recovery periods of usually between two and five years, depending on the insurance company. Conditions such as hypertension are acceptable if controlled. Diabetes (contracted later in life, not during childhood) can be insurable if it is well under control, especially non-insulin dependent. Some companies will accept insulin as long as height and weight are reasonable and the diabetes is under control. People who take antidepressants for “situational depression” (death of a spouse, for example) usually can get a policy if their health otherwise is good.

The standard basis for underwriting is medical records from your doctor, instead of a physical exam, although some insurance companies are utilizing paramedical or “face-to-face” exams. A paramedical exam means a home health nurse visits you to check your blood pressure, height, weight, and to do a quick assessment of your overall physical and mental health. A face-to-face exam means that someone personally interviews you to be sure you are in good mental health. Most companies require this for applicants in their 70s and older. Underwriting commonly includes a telephone interview. (Tip: This is not the time to joke about losing your car keys!)
Caution: A carrier with “loose” underwriting may need future rate increases sooner than a carrier with conservative underwriting. Also, there are horror stories about carriers who do “post-claim underwriting” (i.e. medical history is thoroughly investigated after a claim is filed, which naturally results in a large number of denied claims.) This practice is illegal today, but be wary of a “yes/no” application with a policy issued to you in a very short period of time. It usually takes about four to six weeks for a policy to be issued, because the company is doing a good job of checking your mental and physical health to see if you qualify for coverage.

Some carriers will accept health problems if you pay a higher premium or will make alternative benefit offers. For example, you may be offered a four- or five-year benefit period instead of an unlimited benefit period, or a 90- or 100-day waiting period instead of a 20- or 60-day waiting period.

The most important thing about underwriting is that the younger you are, the better chance you have to qualify for a policy. No amount of money will purchase long-term care insurance for you once you are uninsurable due to a significant physical or mental health problem. Industry statistics show that the average decline rate is 19 percent but this increases significantly when people apply at older ages. People are strongly encouraged to apply for long-term care insurance certainly by the time they reach their 40s and 50s (pre-retirement ages). A health care think tank found that the percentage of baby boomers with very good health drops from more than 80 percent for those under age 45, to 62 percent for those 65 and over. (Of course, premiums are lower at younger ages and are locked in at the younger age unless there is a rate increase for an entire classification of policyholders.) On the other hand, don’t assume you don’t qualify for a policy without checking with
Features of a Good Long-Term Care Insurance Policy

some reputable insurance companies. You have nothing to lose and everything to gain to see if you can get a long-term care insurance policy.

Pre-Existing Conditions

An ideal policy will cover the policyholder from the effective date of the policy for all conditions disclosed on the application. Most policies have no restrictions at all for pre-existing conditions. A few policies have a 90- to 180-day waiting period for pre-existing conditions.

“Free-Look” Period

Policies issued today must contain a 30-day period after policy delivery in which the policyholder may return the policy for a full return of premium if not satisfied for any reason.

Non-Forfeiture Options

For additional premium, some policies (more commonly non-tax qualified policies) may guarantee to return a specified percentage of premium to a beneficiary if the policy was not used after being in force a specified number of years. For example, a policy may guarantee to return a scheduled percentage of the premium if the policyholder terminates the policy or dies after the policy has been held at least five years. Some policies return all of the premiums if the policy is held at least 20 or more years. This feature usually costs about 30 percent or more in premium. The odds of using the policy and getting nothing back are very high, especially if you purchased home health care benefits. However, for even more premium, a few policies will return 100 percent of the premium to you, or your estate if you are deceased, after a specified number of years even if you have used the policy.
A partial daily or monthly benefit may stay in effect if the policyholder stops paying premium after five years or so. Known as a “reduced paid-up benefit,” this feature has not been popular. Because the benefit is so potentially small at claim time, the policyholder is at risk to make up large balances from the very first day of care.

The policyholder must decide if these money-back features are worth the additional premium, or if a greater return on investment can be achieved by putting the difference in premium in a mutual fund or other type of growth investment, such as annuities, individual stocks and bonds, or life insurance, which is frequently used in wealth preservation and estate tax planning strategies.

A few tax-qualified policies have a cash-back nonforfeiture benefit but any refunded premium that was used for a tax deduction creates a taxable event upon its return.

More commonly, tax-qualified policies contain an option for a nonforfeiture benefit called a “shortened benefit period.” You are not required to purchase it. If you do purchase it, the value will not be cash back as described above. Instead, the tax-qualified version of nonforfeiture guarantees that if you terminate your policy after three years, in most states the insurance company must pay benefits equal to the amount of premium you have paid for any claim you have in the future, even though your policy is no longer in force.

For example, you paid $15,000 in premium and then decided to cancel your policy. If you had purchased this feature and you had a claim the day after you cancelled your policy, the insurance company would have to pay benefits at the daily benefit in force on the day you cancelled your policy up to $15,000. If your daily benefit was $100, the company would pay 150 days of benefits, or five months. If you
Features of a Good Long-Term Care Insurance Policy

had a claim 10 or 15 years from now, the company would still pay benefits of $100 per day up to $15,000. However, at future prices, this would probably pay for only a few weeks of care. This feature will cost you about 30 percent more in premium with most policies. Many companies will give you the shortened benefit period nonforfeiture benefit, even though you didn’t pay extra for it if your premium goes up past a certain predetermined point based on the age you were when you purchased the policy. For example, if you purchased your policy at age 60, the predetermined point is 70 percent. So if you had a rate increase that took your premium to 71 percent more than your original premium, the insurance company would have to give you the shortened benefit period nonforfeiture benefit.

This is called “contingent nonforfeiture,” because your receiving the benefit is contingent upon your premium being raised to the predetermined point that triggers the benefit. This means you could stop paying your premium and the insurance company would have to pay a claim for you at any point in the future equal to the premium you had paid in. Or, if you wanted to keep your policy in force without the additional rate increase, you could do so by accepting a reduced benefit offer that the insurance company is required to extend to you. Your benefit would be lowered, but you could keep the same premium and you would not have to pay the additional rate increase.

The National Association of Insurance Commissioners passed a new Long-Term Care Insurance Model Act in 2000, which requires all insurance companies to provide contingent nonforfeiture, because they believe it will act as a deterrent to unnecessary rate increases. Since companies don’t want to give this benefit away without the additional premium it normally costs, this requirement serves as an incentive for the insurance companies to do everything possible to hold your premium down so it won’t increase to the

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point that makes the company give you the shortened benefit period nonforfeiture benefit free. Each state has to pass the new NAIC model act into law, and almost two-thirds have done so:

Arizona, California, Delaware, Florida, Iowa, Idaho, Illinois, Kansas, Kentucky, Maryland, Maine, Minnesota, Missouri, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin

The majority of states plan to pass it because it has additional features that are expected to create a powerful deterrent to widespread rate increases in the long-term care insurance industry. In addition to requiring contingent nonforfeiture in every policy at no additional cost, highlights of the NAIC Long-Term Care Insurance Model Act of 2000 are:

▲ The 60/40 loss ratio requirement for long-term care insurance, which means that at least 60 cents of every premium dollar must go for benefits, is eliminated. The NAIC thinks that’s an incentive for rate increases - the higher the rate, the more money the other 40% generates for administrative costs.

▲ Rates must be actuarially certified that they aren’t expected to increase.

▲ When a rate increase is approved by the state, 85 cents of each rate increase dollar must go to benefits and only 15 cents can go to administrative costs.

▲ The applicant must sign that he or she understands rates can increase.
Features of a Good Long-Term Care Insurance Policy

▲ The insurance company has to disclose at time of sale the rate increase history on similar policies for the last ten years.

▲ If a rate increase is approved by the state then turns out to be unjustified, the insurance company has to refund the money to the policyholders.

▲ If an insurance company exhibits a pattern of inappropriate rates, the insurance commissioner can prevent the company from doing business in that state for five years.

To find out if the NAIC LTC Insurance Act of 2000 has been passed in your state, contact your state’s insurance department (see Appendix B for contact information).

If your budget forces you to choose between nonforfeiture and inflation coverage, buy inflation coverage.

Suitability

Individuals without assets outside a home and/or car are usually not candidates for long-term care insurance as they will quickly qualify for Medicaid. The National Association of Insurance Commissioners believes you may not be a candidate for long-term care insurance if you have an income less than $20,000 and/or assets less than $30,000, not counting your house and car. The exception to this thinking occurs when a family member (such as a child for a parent) purchases a policy to provide a higher level of care than that offered by Medicaid reimbursement and to ensure an option for home health care and other community choices such as assisted living or adult day care. Or, if nursing home care is needed as a last resort, the adult son or daughter wants the parent to have a complete choice of nursing homes. Many
nursing homes have waiting lists and many admit only private-pay patients or patients with long-term care insurance as both types of patients can pay higher rates than the Medicaid reimbursement level. Since a number of nursing homes no longer accept Medicaid patients, people trying to enter a nursing home as a Medicaid patient sometimes have to go to a facility several hours away from the desired location.

Because of the poor choices on Medicaid, another exception to this rule occurs when people who are “house rich and cash poor” obtain a reverse mortgage on their home and use some of that money to purchase long-term care insurance to avoid being on Medicaid.

Some people with assets of $500,000 or more consider paying for their own long-term care. Sometimes the question is: How much of your asset base is liquid? Or will a long-term care need force you to sell property and/or investments at a loss because of poor market timing? **If you have less than $2 million in assets, it is very risky to try to self-insure your long-term care expenses.** Many financial planners advise clients with less than $5 million in assets to purchase LTC insurance. (See the chart in *The Private Sector Solution* on p. 27 in Chapter One that shows how quickly $500,000 can be wiped out when faced with a long-term care need of $60,000 a year.)

Another reason people with significant assets buy long-term care insurance is to avoid confrontations with children over how much money is spent for long-term care. Others will purchase long-term care insurance to preserve privacy of financial records. Without a policy, private-pay nursing home patients usually have to show financial records to prove long-term payment capability. Finally, people with significant assets sometimes purchase long-term care insurance because they want money that would be spent on long-term care to go to other causes such as charities, church, their university alumni association or their grandchildren, like the gentleman who owned several McDonald’s in *The Private Sector Solution* in Chapter One.
Prior to the tax-qualified policies that were introduced January 1, 1997, most policies required your doctor to tell the insurance company that you needed help with at least two Activities of Daily Living (ADLs) before a claim could be paid, although a few policies required help with only one ADL. These are generally dressing, eating, transferring from bed to chair, toileting and maintaining continence. Some policies included bathing in the list. These policies have the potential to pay sooner, as bathing is usually the first ADL that people need help with. Two states added a seventh ADL to the list: Texas required “mobility” and California required “ambulating”—both just a measurement of being able to move around well. Help with ADLs can be “hands on,” which means direct physical contact, but better policies also allow “stand-by” or supervisory assistance from the person who is helping you.

If you can physically perform the Activities of Daily Living but have to be told when and how to do them because you have a cognitive impairment, the better policies issued prior to January 1, 1997 will still pay your claim. Cognitive impairment is usually determined by a standardized test to determine deficiencies such as short-or long-term memory loss and general orientation (knowing one’s name, place of residence, current political leaders, date, time, etc.) or bizarre hygiene habits.

The new tax-qualified policies sold after January 1, 1997 changed the requirements somewhat to get a claim paid. Tax-qualified policies will pay a claim if you are expected to need help for at least 90 days with two or more of at least five Activities of Daily Living from this list:

- bathing
- dressing
- toileting
- transferring
- eating
- continence
This means that insurance companies can use a list of five or six ADLs, but almost all companies use the list of six. California requires insurance companies to use all six ADLs. The 90-day certification must be provided by a licensed health care practitioner (physician, registered nurse or licensed social worker). The **90-day certification is not a waiting period.** If you have a 20-day waiting period, for example, your policy will begin paying benefits on the 21st day you need care as long as your doctor (or nurse or social worker) says that you are expected to need help with at least two ADLs for longer than 90 days.

The 90-day certification assures that long-term care insurance will be preserved to pay for truly long-term conditions. Short-term conditions like fractures and mild strokes usually require skilled care such as physical, speech or occupational therapy. The previous sections *Why Doesn’t Private Insurance Pay More?* on p. 14 and *Why Doesn’t Medicare Pay More?* on p. 15, explain that health insurance and Medicare pay only for skilled care and will therefore cover most short-term conditions, also called “sub-acute” or “post-acute” care.

Tax-qualified policies also pay if you can do all of the Activities of Daily Living, but you need help due to a severe cognitive impairment. This means that you are cognitively impaired to the point of being a threat to yourself or others. For example, if you can’t remember how to take your medicine appropriately and you have high blood pressure, you are probably a threat to yourself since by not taking your medicine when you are supposed to could cause you to have a stroke.

Non-tax-qualified policies are still being offered by some insurance companies, even though 98 percent of individual long-term care insurance policies purchased in 2005 were tax-qualified policies. Non-tax-qualified policies do not require the 90-day certification,
and may require help with only one Activity of Daily Living to get a claim paid. Instead of needing help with Activities of Daily Living or being cognitively impaired, some non-tax-qualified policies will also pay a claim if your doctor says you need care that is medically necessary, which means that you need care for some type of illness or injury. Most policies like this allow only nursing home benefits to be paid if you need medically necessary care, but a few policies will allow home care to be paid as well. For example, you may be able to perform all of the Activities of Daily Living and you may not be cognitively impaired, but you can’t completely take care of yourself because you have crippling arthritis in your back. If your policy pays homemaker benefits such as cooking, cleaning, laundry, etc., and pays for medically necessary care under the home health benefit, it could pay for homemaker services because your arthritis makes it medically necessary for you to have help. The medically necessary benefit trigger is not in tax-qualified policies.

Needing help with Activities of Daily Living, cognitive impairment or needing help because it’s medically necessary are all called “benefit triggers,” because satisfying one of these requirements is necessary to get the policy to pay benefits.

Tax-Qualified or Non-Tax Qualified

Some people say that tax-qualified policies are more restrictive than policies sold before January 1, 1997 because of the required 90-day certification and because the medically necessary benefit trigger is no longer allowed. While this is true, there is a very good reason for the tightening up of the access to benefits.

A few years before this law was passed, long-term care insurance policies began growing more liberal. Some policies would pay for any
type of care at home or in a nursing home if help was needed with only one Activity of Daily Living, and the list included bathing. A growing number of policies also had the medical necessity benefit trigger. That made it easier to collect benefits, especially when it applied to home health care. A couple of policies were introduced that would pay nursing home care at the policyholder’s discretion, which means you say you want to go to a nursing home and the insurance company pays your claim! Another policy that became extremely popular paid benefits if you only needed help with two “Instrumental Activities of Daily Living,” such as cooking, cleaning, laundry, grocery shopping, telephoning for doctor’s appointments, and the like. This brings to mind the old phrase, “If it sounds too good to be true, it usually is.”

Why did this happen? The free enterprise system allows insurance companies the opportunity to sell more policies by offering policies with liberal benefit access. The combination of easy access to benefits, low premiums and liberal underwriting (which means that policies are issued commonly to people with significant health problems) means these companies could be more competitive in the marketplace and sell more policies. But these features that sound so good now mean bad news for the consumer in the long run in the form of future rate increases.

Congress saw this trend and stepped in. If the benefits are too easy to obtain, and if the policies are sold to people who have a high likelihood of using the coverage in a short period of time, the policies will pay out more than the collected premiums will support. This means that in the next 10–15 years when the claims activity is high, the long-term care insurance market could “crash” due to large rate increases that many consumers could not afford to pay. And, of course, smaller insurance companies can be hit harder and need bigger rate increases than larger, more financially solvent companies, and that’s if they are even able to stay in business.
The taxation issue often is presented as the center of the controversy on whether to purchase a tax-qualified or non-tax-qualified policy, i.e., will the IRS ever rule that benefits from a non-tax-qualified policy are taxable income?

Insurance companies are required to provide Form 1099-LTC to anyone who receives benefits from any type of long-term care insurance policy, tax-qualified or non-tax-qualified. The policyholder is required to report benefits paid from any type of long-term care insurance policy to the IRS on Form 8853, Medical Savings Accounts and Long-Term Care Insurance Contracts. The IRS matches up these 1099s with individual tax filings and sends letters requesting an explanation from people who failed to report benefits received from long-term care insurance policies.

Some insurance companies that actively promote non-tax-qualified policies promise to convert your policy to a tax-qualified policy if the IRS makes such a ruling. Read the fine print, as some will not allow you to switch if you are already receiving benefits.

Beware of advisors who explain nonchalantly that it’s no big deal because the cost of your care is a deductible medical expense that will offset the taxable income. Not so! IRS Form 1040: Schedule A—Itemized Deductions plainly states in the block marked “Medical and Dental Expenses”: Caution: Do not include expenses reimbursed or paid by others. This means any amount reimbursed by a non-tax-qualified policy cannot be deducted as a medical expense.

Is the tax question the real issue or was Congress trying to use the tax liability as a velvet hammer to swing the market to tax-qualified policies with more reasonable benefit triggers?
I believe that the measures Congress took in the 1996 health care reform legislation will function as consumer protection measures to ensure that long-term care insurance is there for us when we need it by restoring long-term care insurance to its original purpose, and that is to pay for long-term conditions. For this reason, there’s an excellent chance that improved tax deductions for long-term care insurance premiums will continue to apply only to tax-qualified policies.

Getting a Claim Paid

Regardless of which type of policy you buy, the better insurance companies have streamlined claims filing procedures. Most allow you to call an 800 number and notify the company that the need for long-term care has arisen. At that point the claims representative will assist you with the necessary paperwork and help you obtain the 90-day certification from the appropriate medical practitioner. Most companies will even pay for a care coordinator, which is someone to evaluate your needs on a local level to ensure that you get the appropriate level of care in the best setting for your condition, i.e., home care, adult day care, assisted living or nursing home care.

The cash plans provide a nice advantage when it comes to the claims process. The benefit qualification process is the same as any other type of policy as all tax-qualified policies require either the 2 or more ADL trigger expectation for at least 90 days or severe cognitive impairment, but once approved for benefits, the insured receives a check each month, without having to justify charges or services. The insured or responsible party signs a statement once a month that the patient still meets the benefit trigger criteria, and that’s all there is to it. If you do receive benefits above the Federal threshold of $260 per day in 2007 ($7900 per month), you will have to prove that the money is being spent for IRS-approved medical expenses, but anything less than that does not have to be accounted for. Of course you will need someone
whom you can trust to manage the money if you are unable to do so, and the IRS is likely to view you as an employer if you are hiring caregivers and controlling their times. See your tax advisor for further clarification on this point.

When claims are paid, the benefit checks are usually sent to you, but some insurance companies will pay the provider of care if you like, especially if the provider files the claim for you. If this is your choice, it’s a good idea to get a family member or someone else you trust to audit the bills and claim payments every month to be sure you are being billed correctly for the services you receive.

Ask the insurance professional or company for references from satisfied policyholders who have been through the claims filing process. You can also ask the department of insurance in your state if any complaints have been filed about the insurance company. (See Appendix B for the address and telephone number of your state’s insurance department.)

**Policy Improvements**

Policies purchased prior to 1991 may have benefit restrictions that need to be analyzed carefully to see if you need to upgrade or replace your policy with a new one. Some examples of restrictions in these older policies are:

- a prior hospitalization requirement before benefits for nursing home can be paid
- a prior nursing home requirement before benefits for home health care can be paid (if home care benefits are important to you)
- a requirement for skilled care before non-skilled care can be paid
△ a lower benefit for non-skilled nursing home care than skilled care
△ an exclusion for Alzheimer’s disease and other organic mental disorders
△ a 50 percent home health care benefit if care is required to be provided by a home health agency; home health care aides average $19 an hour when provided through a home health agency
△ no inflation coverage

Caution: Upgrading a policy that was issued before January 1, 1997 may cause you to lose the “grandfathered” status that allows it to be a tax-qualified policy. You may be better off keeping the old policy and purchasing a new one on top of it, especially if you are trying to add inflation coverage. Your insurance professional can advise you on the best thing to do. Whatever you do, never cancel an existing policy until a new one is in effect.

Your Customized Benefit Selection Process

To simplify the benefit selection process, you just need to remember that there are six major choices that impact a premium. Here is each choice and a recommendation.

1) Daily or Monthly Benefit—Look at the average cost in your area and buy a daily or monthly benefit as high as you can afford—even $20-$30 more than the average cost in your area if you can afford it. Inflation is strong, and you’ll probably need the extra benefit at claim time. (The national average cost for semi-private room and board is $171 per day. High cost areas like Alaska and New York City can easily cost $370 per day for semi-private room and board.) A private room usually costs $10-$20 more per day than a semi-private.
Features of a Good Long-Term Care Insurance Policy

Some insurance professionals may be able to provide you with a local cost survey, or you can call some providers listed in the Yellow Pages: assisted living facilities, home health agencies, adult day care centers and nursing homes. Your local Agency on Aging also may have this information. You can get that number by calling your state’s Agency on Aging office (see Appendix B for contact information). Another excellent resource for average cost information for home health care agencies, assisted living facilities and nursing homes is the Genworth Financial Cost of Care Survey at http://longtermcare.genworth.com. MetLife Mature Market Institute publishes surveys for assisted living costs as well as home health care and nursing home costs at www.maturemarketinstitute.com.

Cost surveys normally will reflect just the room and board rate for nursing home care. Most reimbursement policies will pay no more than the room and board charge and you are on your own for any miscellaneous charges like care-related supplies. An indemnity policy that pays the selected daily or monthly benefit regardless of charge makes it possible to build in extra benefit to cover the extra charges. Most policies are reimbursement, because the theory is that people will use insurance more wisely if there is some cost sharing, and a wiser use of benefits will help hold rates down in the future.

Here’s an example of how to calculate a daily or monthly benefit for yourself: if you are considering a reimbursement policy and you are willing to pay about 20 percent of the long-term care cost, you could consider a daily benefit of $130, if the average cost in your area for semi-private room and board is $150.

Some people purchase lower daily benefits, however, because they decide to put some of their income toward the cost of care, especially if they do not have a spouse and do not need their income to maintain
a home. For every $1,000 of income you are willing to contribute to the cost of your care, you could reduce the initial daily benefit you purchase by $30.

For an example of premium impact, the premium difference between a $140 daily benefit and a $100 daily benefit is, interestingly, about 40 percent.

2) Waiting Period (Elimination Period)—Most people will choose a waiting period (deductible) of 100 days or less. If you have over $1 million in assets (not counting your house and car), you can look at waiting periods of greater than 100 days. (Some states allow insurance companies to offer waiting periods as long as 180, 365 or even 730 days.) If you have assets less than $100,000, definitely choose a shorter waiting period like 20 or 30 days. If you have assets greater than $100,000 most companies offer waiting periods of 60 days, 90 days or 100 days. (The premium difference between 20 and 100 days with most companies is about 20 percent, so you have to contrast that with self-insuring the cost for an additional 80 days—not just at today’s costs but at future costs.) Look at policies that require only one waiting period in a lifetime.

A few policies do not require formal charges during the waiting period. If you are considering that type of policy, the question becomes “How long can I wait before benefits begin vs. how long can I pay”—in other words, how long could you manage with help from informal caregivers, like family and friends before benefits start?

3) Benefit Period/Benefit Maximum—Choose at least two years and longer if you can afford it, but don’t ever sacrifice inflation coverage for a longer benefit period. If you live in a “Partnership” state (Connecticut, New York, Indiana, California with many others coming on board),
See Chapter 4, *The Partnership for Long-Term Care* for guidance. The average benefit period purchased in 2005 was five years, and 20% of the policyholders purchased the lifetime (unlimited) benefit period. A recent claims study showed that less than 10% of claimants are using more than four years of benefits.

Average premium differences:

<table>
<thead>
<tr>
<th>Assets *</th>
<th>Suggested Waiting Period (in days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Does not include house and car</td>
<td>20-30</td>
</tr>
<tr>
<td>Less than $100,000</td>
<td>X</td>
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<tr>
<td>$100,000 - $500,000</td>
<td>X</td>
</tr>
<tr>
<td>More than $500,000</td>
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Unlimited vs. 5 years = +40%
Unlimited vs. 3 years = +82%
Five years vs. 3 years = +30%

4) **Inflation Protection**—The method that makes your benefit grow 5 percent compounded every year for the rest of your life is the most desirable if you are age 70 or under. If you are in your early 70s,
you can choose the method that makes your benefit grow 5 percent of the original amount, which is called “5 percent simple”, for the rest of your life, if your state allows that option. (Tip: At age 75, the premium difference between compound and simple is about 8%-10%.) If your state doesn’t allow a simple inflation option, purchase the 5 percent compound. If you are in the upper 70s or older, you can purchase an extra benefit—perhaps an extra $30-$50 per day—to build in immediate inflation protection. The exception? If you think you will live longer than ten years like my client, Mr. Jones, you should seriously consider either the simple or compound inflation option.

If the 5% compounded for life is out of your price range, try buying a greater benefit with either simple inflation or one of the newer inflation options like “5% compound two times”, which means your benefit will double in 15 years and stop growing. Sometimes, the premiums are reasonable if you take the time to explore new options. An insurance professional can help you ensure you make the best inflation choice for your situation. Here’s my formula:

1) Determine the average cost of care in your area
2) Decide how much of the cost you want the insurance policy to pay – 50%, 2/3, 80%, full coverage?
3) Project what the cost of care will be in your area by the time you are in your 80s
4) Construct your inflation benefit so the daily or monthly benefit will pay that percentage of the costs at that time in your life

With this formula, if you need care at any age, you’ll have a benefit that won’t disappoint you.
5) **Home Health and Community Coverage**—If you have someone to live with who can be a primary caregiver, you can select this coverage if it is optional on the policy you are considering. Some policies include it and it’s not an option. If you do not have a primary caregiver and home health care benefits are required, the policy may allow you to lower your premium by choosing a reduced percentage such as 50 percent. If you are younger (30s–50s) and you don’t know if you will have a primary caregiver, buy it if you can afford it so you will have maximum choice when you need care.

*Note:* If you have no one to live with, you may be better off buying a “facilities-only” policy with “Cadillac” benefit levels – a monthly benefit high enough to get into the nicest assisted living facility in your area, 5% compound inflation, a longer benefit period, and the like. Not everyone is a candidate for home health benefits. One of my clients was a retired schoolteacher with little family. She absolutely did not want to stay home if she needed extensive help. We used her premium dollars to purchase the best assisted living/nursing home policy she could afford. She was able to reside in a beautiful assisted living facility after suffering a severe stroke. Bill Comfort, Jr., a long-term care insurance specialist in St. Louis, had a similar story:

*After a lengthy discussion of all the wonderful long-term care insurance policy features that would allow for her to stay in her own home, a new client of mine looked at me and said, “If I ever need this kind of help, I don’t want to stay in my own home.”*

*I couldn’t believe it. Doesn’t everyone want to stay in their own home as long as possible? No. My client is a single woman with no family in town. She knew that if she needed on-going long-term care that it would be time to move—part of life. We found a policy with the best assisted living and nursing facility benefits she could get.*
The premium difference between a comprehensive policy with home care benefits and a facilities-only policy that covers assisted living and nursing home care is 30%-40%.

6) Non-Forfeiture—This benefit is something you can do without. It increases your premium significantly with very little value in return. The extra 30 percent or so you would spend for this option is better spent on purchasing the 5 percent inflation rider or if you are 75 or older, at least a higher daily benefit to combat inflation or a longer benefit period if you’ve already taken care of inflation.

The Bare-Bones/Best Value Policy for the Premium Conscious

Summary: If premium is your main consideration, the most “bare-bones” policy with the best premium value for the dollar is a policy that pays:

▲ assisted living and nursing home only, sometimes called a “facilities-only” policy

▲ a 20- or 30-day waiting period

▲ a two- or three-year benefit period

▲ the appropriate inflation choice for your age (see Inflation Protection on p. 62).

You can delete the home care as long as assisted living is covered. **Do not delete the inflation coverage.** If your benefit is too small at claim time and you can’t make up the difference, you could wind up on
Medicaid immediately (or whatever type of public assistance/welfare benefit is available at the time).

Some Parting Advice

Many companies are competing for your premium dollar, so don’t fall prey to marketing strategies that may cause unnecessary rate increases in the future. Companies that offer very low premiums compared to most of the other companies, sell policies to people with significant health problems, and make it very easy to obtain benefits (see Claims on p. 93) are at a higher than average risk for rate increases—particularly if the company is small. (There are companies selling long-term care insurance with $100 million in assets and there are companies with $100 billion and more in assets.)

You can also call your insurance department to ask about rate increase activity as well as any complaints that have been filed against the insurance company. (See Appendix B for the contact information for your state’s insurance department.)


Chapter 2:
Features of a Good Long-Term Care Insurance Policy


5. Ibid (Adult day care costs are trended forward from $56 per day in 2002)


7. Ibid


11. Ibid


19. “Costs are growing about 5.6 percent a year, according to estimates from the Centers for Medicare and Medicaid Services” – Mara, Janis. “Preparing for Illness in Old Age,” ContraCostaTimes, November 6, 2006.

20. Ibid


