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## **Long-Term Care Insurance: A Consumer's Primer**

by  
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The risk of needing nursing home and related health care and its ever-increasing expense have fueled an interest in long-term care insurance. While long-term care (LTC) coverage has expanded significantly in recent years, its rising cost and daunting complexity have discouraged potential consumers from buying it or led them to postpone a purchase decision.

The advice that one might hear from an agent or read in occasional articles about long-term care insurance tends to be confusing and conflicting. This article is intended to sort it out – outlining the need, summarizing the various policy provisions, and, in the process, raising the questions that require answers in an independent review of whether to buy LTC coverage and, if so, what to buy.

**The Need – Whether to Buy:** Long-term care is expensive, and its cost, like that for health care generally, has risen faster than the rate of inflation. Currently, the *average* expense for a nursing home stay runs around \$65,000 annually and \$18 hour for at-home assistance. Around-the-clock care at home can therefore cost twice as much as a nursing home. All of these costs are substantially higher in affluent urban areas. It is easy to imagine an extended affliction like President Reagan's costing \$1.5 million or more in today's dollars.

Public and private insurance provides little or no coverage for long-term care. Medicare covers few, if any, of these expenses, and virtually none are picked up by private health insurance. Medicare pays for a period of skilled (as opposed to custodial) nursing care but only if required after a hospital stay of at least three days. Then, after 20 days of such skilled nursing home care, it continues for an additional 80 days if the insured first pays a co-insurance amount of \$109 per day.

Medicaid accounts for almost half of all nursing home expenditures, but only helps those who have very little means or have run through almost all of their assets before falling back on government assistance. Those with modest estates sometimes attempt, or are advised, to impoverish themselves to qualify for Medicaid by shifting assets to spouses and heirs. But the laws to combat this practice have been toughened, placing Medicaid off limits for all but the truly needy. Even so, those without insurance who have only limited assets will soon qualify for Medicaid if they need long-term care for any extended period. In some parts of the country, however, they may have trouble finding facilities to take them.

Realistically, there is a net worth and income level below which LTC insurance is unaffordable. Those who face or anticipate difficulty in covering essential expenses will be hard put to come up with another \$2,500 to \$15,000 annually (the latter for higher priced coverage for two purchased at older ages) for these insurance premiums. To consider this insurance seriously,

income must be sufficient to pay for coverage that will provide a meaningful benefit – and to absorb possible premium increases as experienced in the recent past. Those without these resources will have to consume their assets, and ultimately seek help from the government, should they face the need for expensive care.

At the higher end of the net worth scale, it is possible to bear the risk and absorb (“self-insure”) the potential expense of long-term care. However, those who can clearly afford the financial cost might choose to insure against it instead for the same reason that they secure coverage for other economic losses that they could readily sustain. It is simply a comfort to know one can readily obtain help with all kinds of long-term care assistance without relying on family and that most of the expense will be covered.

An additional emotional reason that the affluent should consider long-term care insurance relates to family wealth preservation. Many wealthy people resist making lifetime gifts to family members that reduce their eventual estate tax exposure for fear that a prolonged and very expensive illness, particularly nursing home care, could force them to run through their money. The fact that the worst-case expense would consume a relatively small fraction of their net worth does not occur to them. Their financial concerns are largely irrational and are exacerbated by advancing age. Covering this potential expense with a broad form of LTC insurance may relieve such worries and provide the comfort level needed to make lifetime gifts that will conserve more family wealth and leave less of it to the government.

The moderately affluent who could conceivably afford the self-insurance alternative might well prefer a more predictable level of old-age expenditures by securing LTC coverage that would pay for a substantial portion, if not all, of the potential expense. While a 2003 study by Consumer Reports suggested that those with a net worth of \$1.5 million or more could go without long-term care insurance,<sup>1</sup> it is easy to imagine going through that amount of money with a lengthy and debilitating condition. Besides, a net worth of \$1.5 million, even if it all consists of liquid assets, will not readily produce a cash flow that makes long-term care affordable. Insurance therefore makes financial planning sense at net worth levels far above \$1.5 million. Those with a net worth amounts of \$1 million (and perhaps at lower levels for those with pension income) to \$5 million have the most compelling financial reasons to obtain this coverage. It also deserves serious consideration by many of those worth \$5 million to \$20 million for the emotional and wealth transfer planning reasons mentioned above.

**Policy Features – What to Buy:** The variety of policy features can confuse and deter the most conscientious consumers with a possible need for this insurance and an interest in exploring the alternatives. Long-term care coverage resembles disability insurance in this respect, but poses even more choices of policy provisions. The key options, which we will review one at a time, consist of the following:

- the daily dollar benefit;
- the number of years the benefit will last, possibly extending for life;
- the rate at which the benefit will increase (“the inflation factor”);
- the waiting period before the benefit begins after eligibility is established;

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<sup>1</sup> “Consumers Are Likely to Get Squeezed,” [Wall Street Journal](#) Online Edition, August 12, 2004.

- the method and timing of benefit payments;
- the types of care the benefit covers (e.g., nursing home, at-home care, assisted living, etc.);
- and the criteria for determining eligibility for the benefits, referred to as “benefit triggers.”

**The Dollar Benefit:** The current annual cost of care in the area where you expect to live in retirement should primarily determine the dollar benefit. You might reduce this figure to lower the policy premium or because you are willing and able to absorb some of the cost of care yourself if you should need it. Benefit amounts can range from \$50 to \$500 a day to cover various forms of care.

**The Duration of the Benefit:** Benefit periods can extend from two years to lifetime. Ideally, benefits should last a lifetime, but they are most expensive. The average nursing home stay is about two and a half years, but that is, of course, an average and does not include the common initial need for in-home or assisted living care. A benefit period choice of five or six years is a popular compromise for those who flinch at the cost of lifetime benefits.

**A Shared Benefit and Benefit Period:** One way to extend a potential benefit beyond the limited period chosen is through a shared benefit with a spouse. Called “shared care,” it can take different forms. The most common ones allow spouses to share a certain benefit period or, more often, make one spouse’s benefit period amount that goes unused available as a resource to the other spouse. For example, if each spouse has a five-year benefit period, and one spouse needs just one year of coverage, the other spouse could make use of the remaining four years in addition to that spouse’s own 5-year period. This policy feature can be an economic alternative to lifetime benefit coverage and might increase the combined cost of the two separate 5-year policies by around 10 percent.

**Inflation Protection:** Most policies have initial benefit levels that increase with inflation. The main variations in inflation protection features are the inflation rates, whether the increase is compounded or simple, and whether the initial premium amount incorporates the cost of inflation protection or starts lower and increases with the inflation factor.

Benefit inflation rates are often 5% or 3%. Five percent, while more expensive, is most common because of the rate at which health care expenses have tended to rise.

A compounding inflation method increases the benefit level by the inflation factor over the prior year’s benefit. The simple method of calculation increases it by the inflation rate times the original benefit amount. These two calculation methods produce big differences over long time periods – for example, \$235,000 vs. \$161,000 yearly after 25 years for a benefit that starts at \$200 a day. A compounding method is therefore important, though more expensive, for policies taken out at younger ages, and less so for policies issued to older applicants.

Some policies, rather than building the cost of the inflation protection into a level policy premium, will start the premium at a lower level and give the policyholder the option to increase it annually or less frequently to buy the added inflation protection. The disadvantage of the initial

lower cost is that the higher premiums in subsequent years to buy the needed inflation protection may seem unaffordable. Also, the failure to exercise the option to buy inflation protection in a future year will generally forfeit the right to increase the benefit again in later years. In addition, the option to buy added inflation protection each year may only last for a period of years or until a certain age, such as 75.

**Waiting Period for Benefit after Eligibility:** It is uncommon for a policy to begin paying a benefit as soon as eligibility is established. Usually, there is a waiting period of from 30 days to 1 year, though some states limit the maximum wait to periods much shorter than a year.

A waiting period – often called an “elimination period” just to confuse consumers with jargon, it would seem - is similar to a deductible on other insurance policies. But, unlike other deductibles, the waiting period does not require self-insurance of a fixed dollar amount. The policyholder absorbs all of the costs of care, whatever they may be, before the waiting period ends and the coverage kicks in.

Accepting the potential cost of a longer period of initial care before receiving benefits by electing a longer waiting period can effectively lower a premium. This might appeal both to those looking for a more affordable policy and others able to pay the higher premiums but preferring to save money by self-insuring for a longer initial period. Since the essential purpose of insurance is to guard against the most financially catastrophic losses, trading the premium savings from a longer waiting period to help pay for a longer or even lifetime benefit period can make sense. Some people can afford “Cadillac” coverage and will want a short waiting period and lifetime benefits to know there is a ready source of help whenever it might be needed. Most, however, will need to make compromises between various policy features to structure an affordable policy that will cover essential care while guarding against the most ruinous financial consequences.

Determining how the waiting period is calculated requires attention to a policy’s fine print. One might assume a waiting period is measured in days after care is first required. Yet, some policies only count days in which services are actually provided and not all calendar days. Other policies may use one method to determine when coverage begins for nursing facilities and another for home care. Policies also vary in whether they have only one waiting period in a lifetime or whether they impose a separate waiting requirement for a renewed need for care. Still another variable is whether a portion of a waiting period that is followed by a recovery can be used to shorten a subsequent waiting period or whether the clock begins to run anew when care is needed again.

**The Method and Timing of Benefit Payments:** Policies pay benefits in different ways, depending mainly on the policy type. One version, a **reimbursement policy**, covers services as they are needed, up to the benefit limit, by paying the policyholder or the service providers. With many such policies, unused benefit amounts can extend the effective limit of the benefit payment period. An **indemnity policy** pays the full benefit amount once eligibility is established and it is determined that permitted providers (e.g., properly licensed) are furnishing the care. A third, more expensive, alternative is a **cash policy** that sets no conditions on the payment of full benefits once eligibility is proven.

The method of computing the expenses of care and determining whether they fall within the benefit limits needs attention with a reimbursement policy. Many forms of care, and some of the more expensive ones, are not administered every day but only every week or less frequently. Policies that measure expenses on a daily basis and fail to reimburse those that exceed a daily benefit limit are more restrictive than those that aggregate expenses and benefit limits over longer periods to determine how expenses compare to a benefit ceiling. Figuring expenses weekly or monthly will enable more of the periodic expenses, which are not incurred every day, to stay within benefit limits.

**The Types of Care Covered:** Mention of long-term care brings to mind nursing homes. Yet there are many other forms of care that fall within its definition. Whether and to what extent they are covered by an LTC policy depends on the policy's terms.

A nursing home-only policy is the cheapest, and many other policies have or offer lower daily benefit limits for home care than for nursing homes. However, home care can be more expensive than that provided in a nursing home, and it makes little sense to have less coverage for care in what is, after all, the preferable setting for one's final days – one's home - rather than a nursing home.

A broad definition of types of covered care –beyond nursing home and home care - is also desirable. Such additional forms of care or facilities should include assisted living facilities and adult day care centers.

An inclusive provision for covered forms of care does not make a policy as comprehensive as possible, however. Most policies have fairly strict licensing requirements, not only for the facilities and agencies providing care but also for the individuals directly administering it. These conditions can limit the practical value of many policies, especially in less populous parts of the country with fewer such facilities. Even in more urban areas, the most readily available form of assistance may not come from a licensed professional.

One answer to the licensing requirements for care providers is a cash benefit policy that pays the monthly benefit limit once eligibility is determined without regard to the qualifications of caregivers. But be aware that these policies can be 10 to 30 percent more expensive than the alternatives. Another option is a reimbursement or indemnity policy that offers a possible waiver of the licensing requirements for home care services and personnel, the area where licensing status can most likely present a coverage problem. This potential flexibility comes under the supervision of a care coordinator selected by the insurer who oversees the use of such non-licensed services. The use of the care coordinator can also result in a waiver of the benefit waiting period for home care.

**Determining Eligibility:** Most LTC policies have standard methods of determining eligibility depending on whether the need for care is primarily due to physical or mental limitations that render the policyholder "chronically ill." Physically determined eligibility stems from the inability to perform certain activities of daily living ("ADLs") without "substantial assistance." The most common ones are bathing, dressing, continence, eating, toileting, and mobility ("transferring"). The inability to perform two or more of these ADLs triggers eligibility and starts the waiting period.

Mentally-related chronic illness relates to “severe cognitive impairment” from Alzheimer’s or other types of dementia. In these cases eligibility is established by the need for “substantial supervision” to protect against threats to health and safety resulting from such disabilities. Both “substantial assistance” with ADLs and “substantial supervision” for cognitive impairment must be expected to last for 90 days.

These standard definitions of eligibility are tax-driven. Policies that have them enjoy a “tax-qualified” status that has several potential advantages, as discussed below. In spite of the benefits of tax-qualified policies, some consider their definitions of eligibility – the need for “substantial assistance” with ADLs or “substantial supervision” because of dementia and expected to last for at least 90 days – overly restrictive and recommend non-qualified policies instead. However, premiums with more liberal eligibility definitions are more expensive, their benefits could be taxed, and it is not clear that the eligibility criteria of tax-qualified policies are difficult to satisfy for those who truly need long-term care. The debate between tax-qualified and non-qualified policies seems to be largely settled for now with tax-qualified policies representing about 95 percent of the market. With the possibility of future additional tax incentives for LTC policies, the case for tax-qualified products should grow even stronger.

**The Cost of Coverage – Potential Premium Increases:** The cost of LTC coverage has increased significantly recently. Current premiums for certain policy types and features are reflected in the table in Appendix A for policies issued in the Chicago metropolitan area. These quotes are for “standard” risks, which is one underwriting gradation below “preferred” risks. Couples applying together will generally qualify for discounts of 15 to 30 percent because the insurance companies reason that a healthy spouse will care for an infirm one and delay the point that a claim is made, reduce the need for certain forms of in-home care, or avoid a claim altogether in many cases.

Since this form of insurance is still relatively new, companies have had no solid base of claims data to use in pricing their products. Price increases over the last several years reflect several factors. Some carriers courted trouble with loose medical underwriting standards. The industry in general may have underestimated the use of outside care, rather than family assistance, when policyholders are able to pass the bills on to an insurance company. Actuaries have reportedly overestimated the rates of policy lapses – the tendency of a certain percentage of policyholders to drop their policies after paying premiums for a number of years and before collecting any benefits. In addition, the decline in interest rates in recent years, reducing the income from invested premiums, has contributed to upward pressure on premium pricing.

In any case, it is important to understand that premiums on new or existing policies could increase further – provided the rate hike is approved by state insurance regulators reviewing an insurer’s financial results for that product and it applies to all policies of a similar type. These policies are “guaranteed renewable,” which means they cannot be cancelled if premiums are paid. But the premiums can go up. For this reason, choosing a policy based solely on price is likely a mistake. The lowest-priced policies of the past have experienced some of the largest premium increases. No one really knows the potential for additional future premium increases or their extent. With the additional accumulated claims experience today, one can hope that a period of premium

stability will take hold. However, consumers exploring long-term care insurance should be prepared to absorb some increase in their premiums over the duration of their policies.

The history of past premium increases and the possibility of additional hikes in the future have led some insurers to offer “short-pay” premium payment plans over a reduced period of years. Ten years is one common short-pay period, and shorter payment periods may be available. Short-pay premiums must necessarily be much higher for a company to receive a value of premium dollars in a limited period of years equal to an ongoing annual stream of payments. But those who can afford this alternative may want to consider it. Once past the premium payment period, there is no future exposure to premium increases.

**Potential Tax Advantages:** An additional premium payment consideration relates to a possible tax deduction for this expense. For individuals paying their own premium, the cost of all medical expenses and insurance premiums exceeding 7.5 percent of adjusted gross income is deductible. The deductible portion of an LTC insurance premium is limited to certain dollar amounts that increase with age. At the same time, 22 states currently grant some form of tax deduction or credit for LTC premiums that may provide an added incentive for a policy purchase.

Federal tax provisions are most favorable for employer-paid premiums. As with health insurance, premiums are fully deductible for all employers, and they are excluded from the employee’s income. This is also true for policies on employee-owners of C corporations. Employer-paid premiums are includable in the taxable income of self-employed business owners (including partners, 10% or more LLC members, and 2% or more S corporation owners). But they are then partially deductible, subject to age-based dollar limits, if such owners do not participate in a subsidized plan maintained by an employer of the policyholder or spouse. It is really C corporation owners for whom LTC premium tax treatment offers the greatest advantages, as well as employees (most likely executives) of the generous employer that picks up all or part of the tab for this coverage. Employers can extend this benefit on a selective basis free of the non-discrimination requirements applicable to qualified retirement plans.

**Group vs. Individual Coverage:** Mention of employer-paid insurance raises the possibility that one might participate in a group policy through work. The potential advantages are somewhat simplified or more lenient underwriting for individuals who might have difficulty obtaining coverage on equally favorable terms and some possible break in premium pricing. However, those who are healthy and might apply for coverage together with a spouse may do better on their own, especially after the common discounts for two policies purchased by spouses are applied. The trade-offs need to be evaluated on a case-by-case basis.

**Choice of Insurer:** The choice of the company issuing the policy is as important as the policy’s features and more important than the policy’s price. Remember, premiums can increase as they have in the past.

The financial strength and size of the various carriers deserve special attention. Financial ratings can be obtained from the five ratings agencies that follow insurance carriers – A.M. Best, Moody’s, Standard & Poor’s, Fitch, and Weiss Research. Companies need to remain in this

business for the long haul. Many of the policies issued today will not pay benefits until 30 or more years from now.

A company's reputation for treating policyholders fairly and equally is a strong point in its favor. A record of paying claims in a timely way and upgrading existing policies with features incorporated in newly marketed products are two marks of a company with which you might want to do business.

**Medical Underwriting:** As with other forms of life and health insurance, willingness to pay for LTC coverage does not assure its availability or the most favorable premium rates quoted for "preferred" risks. The factors that cause LTC insurers to deny coverage or increase premium rates for certain applicants are both similar to and distinct from those that affect life insurance underwriting. Health symptoms that indicate a special risk of degenerative ailments or signs of memory loss are special red flags. But other conditions that may not shorten life and raise the cost of life insurance, such as joint problems that restrict mobility, may lead to increased premium prices for long-term care policies. For this reason, it is best to apply for LTC coverage, if possible, while health is still fully intact and before the minor aches and pains of advancing age are aggravated. The additional and more obvious advantage of doing so is that the annual premium cost is lower and perhaps more manageable at younger ages. Having LTC insurance at an earlier age will also cover the expense of a premature disability that requires long-term care.

**Conclusion:** Even in the space of a lengthy article, it is impossible to cover all the variables and considerations to weigh in evaluating whether to purchase long-term care insurance and, if so, from which company and with what policy features. The permutations and combinations are so numerous as to seem kaleidoscopic and, therefore, hopelessly perplexing. At least by discussing the key questions to be answered in an independent and objective analysis of LTC insurance, this article aims to make the decision-making process less confusing, more comprehensive, and, ultimately, more productive.

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### Appendix A

#### Sample Costs for Long-Term Care Insurance Policies - \$90,000 year (\$7,500 month)

These sample policy quotes vary by age, length of benefit period, length of waiting period ("W.P.") and whether there is an annual increase in the benefit amount. These are rates for standard risks, which is one rating lower than the preferred classification. Note that a couple applying together will qualify for individual premium discounts of 15 to 30 percent. Also, benefit durations are limited at age 80 or sooner.

	<u>W.P. (days)</u>	<u>3 Years</u>	<u>5 Years</u>	<u>Lifetime</u>		<u>W.P. (days)</u>	<u>3 Years</u>	<u>5 Years</u>	<u>Lifetime</u>
Age 55	30	3,801	4,953	8,370	Age 70	30	8,691	11,389	16,470
5%	90	3,168	4,128	6,975	5%	90	7,243	9,491	13,725
inflation	180	2,851	3,715	6,277	inflation	180	6,518	8,541	12,353
	365	2,534	3,302	5,580		365	5,794	7,592	10,980
Age 60	30	4,644	6,048	9,990	Age 75	30	9,450	11,700	15,480
5%	90	3,870	5,040	8,325	no	90	7,875	9,750	12,900
inflation	180	3,483	4,536	7,493	inflation	180	7,088	8,775	11,610
	365	3,096	4,032	6,660		365	6,300	7,800	10,320
Age 65	30	5,848	7,592	12,240			<u>2 years</u>	<u>3 years</u>	
5%	90	4,878	6,327	10,200	Age 80	90	10,575	13,575	
inflation	180	4,386	5,694	9,180	no	180	9,518	12,218	
	365	3,899	5,062	8,160	inflation	365	8,460	10,860	