LTC Insurance

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In the preceding chapter we learned why personal savings and assets, Medicare, and Medicaid are for most people not good ways to fund long-term care. But there is another approach to funding these expenses: long-term care insurance. A person can buy an LTCI policy, pay premiums of a set amount, and when she needs care, she will receive benefits to help cover the cost.

All LTCI policies work in essentially the same way and have many of the same provisions. But there is also a great deal of variation, resulting from different product designs and optional features. We'll start with product design (the basic package of benefits offered by insurers) and then we will examine purchaser options -- the choices a consumer makes to tailor a particular LTCI product to meet his needs.

Long-Term Care Policy Design

A LTCI product's design addresses a number of basic questions: Is the policy federally tax-qualified? Does the policy qualify for a state long-term care partnership program? What conditions must be met for benefits to be paid? What long-term care settings and services does the policy cover? On what basis are benefits paid? What rights does the policyholder have regarding renewal of the policy and premium increases?

The answers to these questions directly affect the level of coverage the insured can rely on, and the cost of the premiums for that coverage.

Tax-Qualification of LTC Policies

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a class of LTCI policies: federally tax qualified (TQ) policies. To be tax-qualified, a policy must meet certain requirements, and owners of TQ policies enjoy certain tax advantages. Around 90 percent of all LTC policies in force today are tax-qualified -- the rest are referred to as nonqualified (NQ) policies.

It is important to note that all LTC Partnership programs (discussed later in this course) must be tax-qualified. But being a tax-qualified plan does not automatically make the policy a Partnership plan. Partnership plans must be tax qualified and meet certain other requirements. Those additional requirements are explored in later chapters.

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Benefit Triggers

To receive benefits under an LTCI policy, the insured must meet at least one of certain conditions stipulated in the policy, known as benefit triggers. For an LTCI policy to be deemed "tax-qualified" under HIPAA, the policy must meet certain requirements in relation to benefit triggers:

- Standardized Activities of Daily Living (ADLs). HIPAA establishes six standard ADLs (bathing, dressing, toileting, transferring, continence, and eating) and defines them in detail. Tax-qualified policies must include at least five of these six and must use the HIPAA definitions. Also, they must define a physical impairment as the inability to perform at least two of the standard ADLs without substantial assistance from another person.

- Substantial assistance. A TQ policy may define substantial assistance in two ways. Hands-on assistance is the physical assistance of another person without which the impaired individual would be unable to perform the ADL. Stand-by assistance is the presence of another person within arm's reach of the impaired individual that is necessary to prevent, by physical intervention, injury to the individual while she is performing the ADL. For example, if a person cannot wash herself and must be washed by another, she needs hands-on assistance with the ADL of bathing. If, on the other hand, she can take a bath without any help but needs someone there in case she falls getting into or out of the bathtub, she needs only stand-by assistance. A TQ policy may require an insured to need hands-on assistance, or it may require only a need for stand-by assistance, or it may accept either standard, or it may use a more rigorous standard, but it may not use a standard less rigorous than stand-by assistance.

- The 90-day certification requirement. A licensed healthcare practitioner must certify that the insured's inability to perform ADLs is expected to last at least 90 days. This provision is required because LTCI benefits are not intended for those unable to bathe themselves or dress for a short time while they are recovering from an illness or injury. (Medicare or medical expense insurance generally covers the care of those with temporary conditions.) This 90-day requirement does not apply to cognitive impairment; as such impairments are not usually temporary.

- Severe cognitive impairment. To qualify for benefits on a cognitive basis, the insured must suffer a severe cognitive impairment such that substantial supervision is needed to protect her from threats to her health and safety. A TQ policy cannot pay benefits for mild disorders such as the increased forgetfulness that often accompanies aging. HIPAA defines a severe cognitive impairment as a loss of or deterioration in intellectual capacity -- including Alzheimer's disease or irreversible dementia.

Variation in Benefit Triggers

To a great extent, benefit triggers have become standardized, as tax-qualified policies must adhere to the HIPAA requirements described above. In the past "medical necessity" was a trigger in many LTCI policies. In the context of long-term care insurance, medical necessity means that a physician determines that a person has a need for long-term care. Medical necessity may not be a benefit trigger in a TQ policy, nor may "prior hospitalization", another benefit trigger found in some older policies.

But the few policies that are nonqualified may base benefit eligibility on other criteria (such as medical necessity). And even among tax qualified policies, there is room for some variation: Although most TQ policies include all six standard ADLs, a few include only five. Some TQ policies require the inability to perform only two ADLs, while others require three (requiring more is permitted but rare). Finally, under some TQ policies the insured must need hands-on assistance to qualify for benefits, while under others the less rigorous standard of stand-by assistance is used. Seemingly minor changes in a policy's benefit trigger can have a large impact on the insured's level of coverage.

In most policies the benefit triggers for home care coverage are the same as for nursing home coverage, but a few policies use different triggers for each.

Please note: in most policies, after an insured has met a benefit trigger, she must also satisfy an elimination period before she can receive benefits. Elimination periods are examined in the following section.

Covered Settings and Services

Once the insured meets the benefit trigger, the LTCI policy will cover only services in certain settings. Most LTCI policies address services provided in one of three settings:

- Facility-only policies pay benefits only for care in a nursing home or other residential facility.
- A few insurers offer policies that cover only home health care, or only home care and community -based care.
- Comprehensive policies cover both nursing home care and home healthcare. Most also pay benefits for care provided in assisted living residences and other residential settings and for a variety of home-based and community-based services, such as adult day centers. This is the most common policy type.

Some comprehensive policies pay the same benefit amount for facility care and home care, while others pay different amounts. Most policies use the same benefit triggers for facility care and home care, a few use different triggers. And of course, different insurers may choose to cover different types of services within the approved settings. Among the services commonly found in some policies are:

- **Homemaker services and transportation**. A policy may pay for help with household chores and transportation to medical appointments and shopping. Some policies pay for these services only if other home healthcare services (such as those provided by a home health aide, nurse, or therapist) are needed. For other policies, the only requirement is that a benefit trigger be met.

- **Informal care giving**. Some policies pay a benefit when a family member or other informal caregiver provides care to the insured. Others pay for the training of an informal caregiver.

- **Respite care.** Most policies cover paid services needed for a short period so that a family caregiver can take a break. For respite care benefits to be paid, the insured must meet a benefit trigger. A policy may cover a certain number of days of respite care per calendar year (typically from 14 to 30), or it may pay up to a certain dollar amount per year.

- **Bed reservation**. Because of the high demand for beds in nursing homes and rooms in assisted living residences, a person can lose his place while he is in the hospital or away for some other reason unless he continues to pay for it while he is gone. Many policies pay the facility to hold the insured's bed or room during his absence. Some policies pay this benefit only if the insured is away for a specified reason (such as medical care); others pay regardless of the reason for the absence. (An insured might want to spend time with his family, for example.) Benefits are usually limited to a specified number of days (such as 20 or 50) per calendar year.

- **Care coordinator.** A care coordinator is a specially trained nurse or social worker who works on behalf of the insured to see that she receives the best care possible and gets the most out of the benefits her policy provides. For example, care coordinators can identify the best local providers of the services the insured needs or send regular care reports to family members. A policy that pays for a care coordinator is especially desirable when the insured has no relative who lives nearby and can look after her welfare. Some insurers maintain networks of contracted care coordinators and provide their services to insureds free of charge. In other cases, the insured hires a care coordinator himself, and the insurer pays benefits to cover the cost.

Some policies also pay benefits for durable medical equipment (such as wheelchairs), and medical alert systems. Many policies include an alternate plan of care provision (also called an alternative care benefit, supplementary care benefit, emerging trends benefit, and other names). Under this provision, the insurer may pay for a variety of goods and services not specifically covered by the policy. For example, an insurer might pay for home enhancements such as bathroom alterations, handrails, and ramps to enable a person to safely remain at home instead of going into a nursing home. Or an insurer might cover long-term care services that are not mentioned in the policy because they had not been developed when it was written. In this way an alternate plan of care provision makes a policy more flexible and helps keep it from becoming obsolete. Generally, for benefits to be paid for an item not specified as covered in the policy, three parties must agree -- the insured, the insured's physician, and the insurance company.

Exclusions

Even if benefit triggers are met, an LTCI policy will not pay benefits if long-term care results from a cause excluded by the policy. Such causes may include alcohol and drug abuse as well as illnesses or medical conditions resulting from participation in a felony, attempted suicide, war or service in the armed forces, or aviation if the insured is a not a fare-paying passenger. Mental or nervous disorders (except cognitive disorders of an organic nature, such as Alzheimer's disease) were previously often excluded, but this exclusion has become less common and is not permitted in several states.

Some policies limit the payment of benefits for preexisting conditions. A preexisting condition is a medical condition for which treatment was received or recommended within a certain period before a policy was purchased. This period is normally six months or less, and typically benefits are not paid for a preexisting condition for the first six months that a policy is in force. It is becoming much less common for insurers to exclude preexisting conditions in individual LTCI policies. Instead, they simply require applicants to disclose such conditions and underwrite the policy accordingly. In group insurance, in which there may be no underwriting of individuals or only very limited underwriting, preexisting condition exclusions are still used.

Policies also generally exclude services for which no charges were incurred. For example, if Medicare or another government program covers a service and the insured pays nothing, she cannot submit an insurance claim for the service.

Benefit Payment

LTCI policies express benefits as a fixed dollar amount per day, week or month. There are three models in terms of how the daily or monthly benefit is paid:

- reimbursement (or expense-incurred),
- indemnity, and
- disability (or cash).

The reimbursement (or expense-incurred) model is the most common. In this model, the insured is reimbursed for the actual expenses he incurs that are covered by the policy, up to the daily or monthly benefit amount. In other words, the daily or monthly benefit amount serves as an upper limit on benefits, and for this reason it is sometimes referred to as the maximum daily (or monthly) benefit.

Marianne has a reimbursement LTCI policy with a daily benefit of $200. For several months she receives home healthcare services costing $80 daily, and the insurer pays her $80 per day. Later she enters a nursing home where care costs $220 per day, and the insurer pays the full daily benefit, $200.

In the other two models, the full daily or monthly benefit amount is paid regardless of the actual amount of covered expenses incurred. Under the disability (or cash) model the benefit is paid when the insured meets a benefit trigger whether he is actually incurring expenses for long-term care services or not. Under the indemnity model the insured must both meet a benefit trigger and be receiving services covered by the policy for benefits to be paid.

Norma has an LTCI policy that covers facility care on an indemnity basis and has a daily benefit of $200. For several months she receives nursing home care costing $150 daily; later she needs more care, and the daily nursing home charge is $180; still later she receives care costing $220 per day. The insurer pays the daily benefit amount of $200 for all days on which Norma meets a benefit trigger and is receiving services covered by the policy, regardless of the cost of those services.

Oliver has an LTCI policy that pays for home care on a disability basis and has a daily benefit of $150. For several months he meets the physical impairment benefit trigger of the policy, but instead of receiving paid services, he is cared for by his daughter. Later he receives paid home healthcare services costing $80 daily, and still later he receives home care costing $125 per day. The insurer pays the daily benefit amount of $150 for all days on which Oliver meets a benefit trigger, whether he is receiving paid services covered by the policy or not, and regardless of the cost of any services may he receive.

Daily, Monthly, and Weekly Benefits

Many policies (especially newer ones) pay a monthly benefit instead of a daily benefit, and some policies pay a weekly benefit. A monthly or weekly benefit allows for greater flexibility in meeting expenses.

Joyce has a reimbursement policy with a daily home care benefit of $100. Her family provides much of her care, so on Saturdays and Sundays she needs no paid services. On Mondays, Wednesdays, and Fridays a home health agency provides services costing $150, and on Tuesdays and Thursdays the agency provides services costing $75. Her total expenses for the week are $600, but because she can receive no more than her daily benefit of $100 for anyone day of care, she receives $450 in benefits ($100 for Monday, Wednesday, and Friday, and $75 for Tuesday and Thursday) She must pay the other $150 out of her own pocket.

Now let us assume Joyce has a reimbursement policy with a weekly benefit of $700 (as opposed to $100 per day). Her weekly expenses fall below this amount, so she receives $600 in benefits.

A monthly or weekly benefit may cost slightly more than an equal daily benefit, but it can enable an insured to cover more services for the same state benefit.

Renewability

By law, all tax-qualified LTCI policies must be either guaranteed renewable or noncancellable.

If a policy is **guaranteed renewable**, the insurer must renew the policy (that is, continue it year after year) as long as the insured pays the premiums. The insurer may not decline to renew because of the insured's age, health, claim history, or for any other reason. Furthermore, an insurer may not single out policies for a premium increase. An insurer may increase premiums only when it makes the same increase on all the policies of a certain class or form number that have been issued in a state, and only with the approval of the state insurance department. Approval is generally granted only when the claims experience of the class has been worse than projected. In short, an insurer cannot raise an individual policy's premium; it can only raise the premiums of an entire actuarial class.

A **noncancellable policy**, like a guaranteed renewable policy, cannot be terminated by the insurer unless the insured stops paying premiums. But unlike with a guaranteed renewable policy, a noncancellable policy's premium can never be increased under any circumstances. Because of this lack of flexibility, insurers must charge higher premiums for these policies. Noncancellable LTCI policies are rare and disappearing.

The NAIC Models

The National Association of Insurance Commissioners (NAIC) has developed two models for the regulation of long-term care insurance: the Long-Term Care Insurance Model Act and the Long-Term Care Insurance Model Regulation. The act and the regulation have been adopted, in whole or in part, by most states. The key points related to policy provisions are the following:

- Certain terms such as "home healthcare services," "personal care," and "skilled nursing care" may be used in an LTCI policy only if they are defined as specified by the NAIC act or regulation
- Eligibility for benefits cannot depend on the insured having been previously hospitalized or having previously received a higher level of long-term care.
- Only certain exclusions are allowed. These include preexisting conditions and the other exclusions discussed earlier.

- If one policy replaces another, any exclusion of preexisting conditions must be waived to the extent that similar exclusions were satisfied in the earlier policy. For example, if the new policy excludes conditions for which treatment was received within six months before the policy goes in force, this exclusion cannot be enforced if the insured has already fulfilled a six-month period for the previous policy.
- A policy must offer an inflation protection option. An added premium charge for inflation protection is permitted.
- A policy may cover nursing home care only, but it cannot cover only skilled care in a nursing home. All levels of care must be covered. Nor may a policy provide significantly more benefits for skilled care than for other levels of care received in a nursing home.
- The only allowable renewal provisions are guaranteed renewable and noncancellable.
- A policy must have a third-party notification of lapse provision.
- A policy must offer a non-forfeiture option.
- A policy must have an incontestability clause. This clause limits the insurer's right to contest the policy based on misrepresentations made in the application.

As stated above, most states have adopted the NAIC models, but some have adopted them only in part and others not at all. And different states have adopted different versions. (Several versions have been developed over time by the NAIC.) Consequently, not all the rules listed above apply in every state. Also, in many regulatory areas the NAIC models provide only general guidelines within which each state must develop its own specific rules. Finally, some states have enacted additional laws and regulations governing long-term care insurance that are not based on the NAIC models. For example, some states require that certain types of care be covered (for example, home care as well as nursing home care), and some states mandate minimum benefit amounts and prohibit certain policy provisions. NAIC models have created some degree of standardization of long-term care insurance, there are nonetheless many differences.

LTCI Policy Options

Once insurers have designed their policies, consumers must choose among the LTCI products in the marketplace – and then tailor the selected product to meet their specific needs and circumstances.

The Elimination Period

An elimination period (sometimes called a waiting period or deductible period) is the time between when the benefit trigger occurs and when the policy begins to pay benefits. In other words, when an insured begins to need long-term care services, she normally has to pay for them herself for a certain time before benefits begin. Most policies offer applicants a choice of elimination periods -- 30, 60, 90, 180 and 365 days are common options. The elimination period functions like a deductible in other forms of insurance. It is designed to reduce an insurer's benefit and administrative costs and thereby enable the insurer to offer a lower premium.

By selecting a longer elimination period, the policyholder will pay a lower premium. However, the longer the elimination period, the more the insured will pay out of pocket if she needs care. Each individual must weigh paying a higher premium for a short elimination period against pay-

ing a lower premium but having to fund care out of her own pocket during a long elimination period.

While the purchaser sets the length of the elimination period, the insurer determines how it functions. For some insurers, the elimination period begins as soon as the insured meets a benefit trigger, whether he incurs expenses covered by the policy or not. For others it starts only when the insured meets a benefit trigger and begins incurring covered expenses.

Dave has a 90-day elimination period that begins as soon as he meets a benefit trigger, whether or not he receives any paid services. He meets the policy's physical impairment benefit trigger, and for 90 days his wife takes care of him and he does not pay for any services. At the end of 90 days, the elimination period is satisfied and he can begin receiving benefit for covered services.

Margaret also has a 90-day elimination period, but hers does not begin until she both meets a benefit trigger and is receiving paid services covered by the policy. Unlike Dave, she must pay for care for 90 days before she can receive benefits.

Companies that require insureds to receive paid services during the elimination period differ in how they count days toward satisfying the period. Some take the service day approach -- they count only the days on which services are provided. Others take the calendar day approach -- they count all days while services are received, whether these services are provided every day or not. Typically the insurer gives the insured credit for every day of any week in which he received services on at least one day, or sometimes two or three days. Some insurers allow the purchaser to choose the approach to counting days, with the calendar day option costing more since benefits begin sooner.

Judy has a 60-day elimination period that counts only service days. On May 1 she begins receiving home healthcare services three days a week, so that it takes her 20 weeks (or five months) to satisfy her elimination period.

David has a 60-day elimination period that gives him credit for every day of any week in which he receives covered services on at least one day. On May 1 he begins receiving home healthcare services three days a week. Every day of the week is counted, and he satisfies his elimination period in 60 calendar days (two months).

Most newer policies allow days to be accumulated over the life of the policy. For example, if a person with a 90-day elimination period receives covered services for 70 days but then no longer needs care, the next time he meets a benefit trigger, the original 70 days will count and he will need only 20 more days to satisfy the elimination period. But some policies have an accumulation period -- if the insured does not accumulate 90 days within a certain time (such as two years), he loses any days he has accumulated and must begin again.

Under most policies today the elimination period must be satisfied only once during the life of the policy. That is, an insured who satisfies the elimination period, receives benefits, then stops needing care, and after an extended time needs care again is not required to satisfy the elimination period again. But a few older policies require the insured to begin a new elimination period under these circumstances.

Some insurers offer the option of no elimination period (called a zero elimination period). Many

newer policies offer the option of a zero elimination period for home care combined with a regular elimination period (often 90 days) for facility care. Sometimes under this approach the days on which home care is received are counted toward the facility elimination period, so that if a person receives home care for at least a few months before going into a nursing home, she will have already satisfied her facility elimination period.

The 90- Day Certification Requirement

Under HIPAA's standardized benefit trigger for tax-qualified policies, a licensed healthcare practitioner must certify that the insured's inability to perform ADLs is expected to last at least 90 days. This 90-day certification requirement should not be confused with an elimination period. The two are separate and distinct concepts -- the 90-day certification requirement does not establish an elimination period. Elimination periods are chosen by the policyholder.

Doug has an LTCI policy with a zero elimination period. He becomes unable to perform two ADLs, and a licensed healthcare practitioner certifies that this inability results from a physical condition that is expected to last more than 90 days. Doug is eligible for benefits and begins receiving them immediately, since he does not have to satisfy an elimination period.

Betty has an LTCI policy with an elimination period of 180 days. A licensed healthcare practitioner certifies that she cannot perform two ADLs and is expected to be unable to do so for more than 90 days. Betty is eligible for benefits, but she will begin receiving them only after 180 days have elapsed.

Larry has an LTCI policy with a 30-day elimination period. He becomes unable to perform two ADLs. However, this inability is the result of an accident, and he is expected to be fully functional in a few weeks. Since Larry's impairment is not expected to last 90 days, he is not eligible for LTCI benefits.

In other words, the 90-certification period determines whether an insured is eligible to receive benefits, the elimination period determines when those benefit payments will start.

The Benefit Amount

As explained earlier, LTCI policies have a benefit amount per day or month (or sometimes per week). A person buying a policy selects a benefit amount, which typically ranges from $50 to $500 per day and from $1,500 to $15,000 per month.

Of the choices made by the purchaser, the benefit amount normally has the greatest impact on the amount of the premium. In general, there is a direct proportional relationship -- a daily benefit of $120 is 20 percent more expensive than a daily benefit of $100, and a daily benefit of $80 costs 20 percent less than a daily benefit of $100.

LTCI purchases should select a benefit amount based on how much is charged by nursing homes, assisted living residences, and home healthcare agencies where she expects to spend her old age. (This might be where she lives now, or it might be where her children live or where she plans to retire.) It is important to remember that actual charges may exceed stated daily rates. For example, a nursing home may charge extra for drugs, supplies, and special services, and this can increase costs by several hundred dollars each month. The buyer should also consider how much of the cost

of long-term care (if any) he is willing and able to pay out of his own pocket. Some people prefer to rely on insurance to cover only a portion of long-term care expenses and pay the rest out of their income and assets. And of course the buyer must keep in mind how much she can afford to pay in premiums.

Some policies pay the same benefit amount for different types of care, while others pay different amounts. When amounts differ, the home care benefit is often defined as a percentage of the facility benefit (normally from 50 to 100 percent). The purchaser often selects this percentage, and of course the higher the percentage, the higher the premium. Some advisors recommend choosing at least 75 percent or (if possible) 100 percent, since most people prefer to remain at home as long as possible and extensive home care services can be expensive. On the other hand, those seeking to hold down the premium may be able to get by with a lower percentage, especially if family members are available to provide some care.

The Lifetime Maximum Benefit

LTCI policies normally have limits on the total amount the insurer will pay in benefits during the life of the policy. Some older policies have a benefit period, a maximum amount of time benefits will be paid, and some have different benefit periods for different types of care. (For instance, a policy might pay for nursing home care for four years and home care for two years.) Most policies today have a lifetime maximum benefit (commonly called a "pool of money"). Under this approach an insured receives benefits until the total amount received for all types of care reaches a maximum amount stipulated by the policy, regardless of how much time has elapsed. The insured chooses this amount at the time of purchase.

Some insurers have the purchaser choose among round dollar amounts, such as $100,000, $200,000, or $500,000. Other companies define the pool of money as the daily or monthly benefit amount multiplied times a certain period of time, and the purchaser chooses among options such as two, three, five or ten years. For example, an insured might choose a daily benefit of $200 and a lifetime maximum based on three years. His pool of money would be calculated by multiplying $200 times 365 days times three years, or a lifetime maximum of $219,000.

Please note that a pool of money's maximum lifetime benefit might be expressed as a period of time, the benefits are not limited to that period. The insured will receive benefits until he has exhausted the pool of money, regardless of the time elapsed. If an insured spends less than the daily benefit amount on some days, the unspent balance remains in his pool of money, and this allows him to receive benefits beyond the time period on which the pool of money was based.

Barbara buys a reimbursement LTCI policy and chooses a daily benefit of $150 and a lifetime maximum based on five years. Her pool of money is $273,750 ($150 daily benefit X 365 days X 5 years = $273,750). Suppose Barbara enters a nursing home and receives her full $150 daily benefit every day for five years. At the end of five years, she will have spent $273,750, and her benefits will end.

Now suppose that instead of going into a nursing home, Barbara receives limited home healthcare services and needs only $100 of benefits per day. At the end of five years, she will have spent $182,500 ($100 X 365 days X 5 years), leaving $91,250 in her pool of money ($273,750 minus $182,500). In this case, Barbara can continue receiving benefits beyond five years, for as long as there is still something left in her pool of money.

Finally, suppose that Barbara has an older policy with a five-year benefit period instead of a pool of money. Barbara will receive benefits for no more than five years, even if she receives less than her daily benefit amount on many days during those five years.

Under the NAIC Model Act, a LTCI policy must provide at least 12 months of benefits, and some states impose 24- or 36-month minimums. But there is no upper limit -- some policies (called lifetime policies) have an unlimited lifetime maximum. The insured can continue receiving the daily or monthly benefit amount indefinitely.

How large should the lifetime maximum benefit be? It is difficult to judge, because it is hard to know how much long-term care one might need. The average nursing home stay is two-and-a-half years, but one stay in six exceeds five years. Plus, it is not uncommon for many people to receive home care or assisted living before they enter a nursing home. Of course, the larger the lifetime maximum, the higher the premium, and an unlimited lifetime maximum can be very expensive.

Inflation Protection

Long-term care costs, like most health-related costs, have been rising steadily for many years, and this trend is expected to continue. LTCI policyholders run the risk that his daily or monthly benefit and lifetime maximum will become inadequate to cover the increased cost of services in the future. Consumers can add optional provisions that protect against inflation -- for an additional premium. Inflation protection can be one of the most important features of an LTCI policy, especially for those purchasing coverage many years before they expect to need benefits.

For tax-qualified policies and those governed by the NAIC Model Regulation, an inflation protection option must be offered, although a purchaser may choose not to take it. For group coverage, this option must be offered to the group policyholder (usually an employer), but it is not generally required that it be offered to each individual group member (although some states require this as well).

Automatic Inflation Protection

With automatic inflation protection, benefit amounts are increased every year at a set rate with no action by the insured required and with no corresponding increase in premium. There are two common versions:

- The 5 percent simple rate. Benefits are increased each year by 5 percent of the initial amount. For example, a daily benefit of $100 would rise $5 each year (5% of the $100 daily benefit). The daily benefit would be $105 in the second year, $110 in the third year, $115 in the fourth year and so on, reaching $200 in 20 years.
- The 5 percent compound rate. The increase is compounded, like interest in a savings account. In other words, each year there is a 5 percent increase based on the previous year's amount. This leads to a snowballing effect -- in the early years of the policy the increases are not much greater than with the 5 percent simple option, but in later years they are substantially greater. For example, a daily benefit of $100 would rise to $105 in the second year, $110.25 in the third year, and $115.76 in the fourth year. But after 20 years, the daily benefit amount would increase to $265, or an annual difference of $23,725 over the simple rate.

The simple rate option costs less, since in the long run it results in significantly smaller benefit increases. However, as noted, during the early years of the policy benefit increases are almost as great as with the compound rate. Therefore, the simple rate option is probably sufficient for a person who is likely to need benefits fairly soon, such as someone who is already elderly when the policy is purchased. On the other hand, the compound rate provides better protection when the need for the benefit is not expected to occur for 15 or more years, as is the case with younger buyers of LTCI.

Some insurers have introduced additional automatic inflation protection options, ranging from 1 percent to 6 percent, simple or compound. In most LTCI policies, automatic inflation increases continue for the life of the policy, however, some policies impose a cap on benefits of double the original amount, and others stop automatic increases after 20 years or when the insured reaches a specified age (such as 80 or 85). These limitations provide lower-cost alternatives to lifetime automatic increases.

An automatic inflation protection option generally also increases a policy's lifetime maximum benefit. The same rate usually applies to both the daily or monthly benefit and the lifetime maximum, but in some cases the maximum is increased at a lower rate. (For example, an insurer might offer a split rate, with the daily benefit increasing by 5 percent and the lifetime maximum by 3 percent.)

Guaranteed Purchase Option

Another kind of inflation protection is the guaranteed purchase option (GPO) (also called the future purchase option, or FPO). This feature gives the insured the right to purchase additional coverage to keep up with rising costs. At set intervals (such as every year or every three years), the insured has the option of increasing benefit amounts. He does not have to reapply for coverage or submit evidence of insurability, as would an insured without the guaranteed purchase option. If an insured chooses to increase his benefits, his premium is also increased. The increase in premium is based on the amount of the benefit increase and the insured's age at the time of the change.

Some policies include the guaranteed purchase option at no additional cost; others charge a higher premium simply to have this option, whether or not the policyholder ever elects to raise benefits.

A policy with a guaranteed purchase option usually has a lower premium than a comparable policy with automatic inflation protection. But the GPO offers less-effective inflation protection for those buying a policy at a relatively young age. Over a long time, the benefit increases needed to keep pace with inflation result in larger and larger premium increases, eventually making the policy unaffordable. Automatic inflation protection, on the other hand, gives the insured a known, budgetable premium.

In addition, the GPO is subject to certain limitations. If an insured declines a certain number of opportunities to increase coverage, most insurers stop offering them. And most insurers will not allow GPO benefit increases after the insured triggers benefit payments.

Non-forfeiture

Non-forfeiture options allow an insured who stops paying premiums and lets her policy lapse to receive something for the premiums she has already paid. This could be a cash payment or continuation of coverage for a limited time. Non-forfeiture options are available for an additional premium.

Under the cash surrender value option or return of premium option, a cash payment is made.

- If the insured surrenders (terminates) the policy during her lifetime, the cash surrender value option returns the total amount of premiums paid over the life of the policy less any claims paid. (This option is not available in TQ policies.)
- The return of premium option is triggered by the death of the insured. A payment, based on premiums paid and other factors, is made to her estate or designated beneficiary. Some insurers require the policy to have been in force for at least 10 years before the death of the insured.

Under the shortened benefit period option, an insured who quits paying premiums retains the right to benefits equal in amount to the total premiums she has paid (without interest), or 30 days of benefits if this is greater, provided the policy was in force three years or more. The name "shortened benefit period" is used because the policy remains in force but the lifetime maximum benefit is reduced to the amount of premiums paid.

Marianne purchases a $100 per day policy for an annual premium of $1,500. Ten years later, after she has paid a total of $15,000 in premiums, she lets the policy lapse. She is entitled to $15,000 in benefits. Two years later, when she enters a nursing home, she is entitled to receive the policy's daily benefit ($100) for 150 days.

The extra premium charged for non-forfeiture options can be quite substantial, depending on the age of the insured and the type and amount of non-forfeiture benefits selected.

Most newer LTCI policies generally provide "contingent non-forfeiture benefits" at no extra charge (some states require them). These provide benefits to insureds who let their policy lapse due to large premium increases. In order for an insured may receive contingent non-forfeiture benefits, the insurer must increase the premium above a specified level set forth in the policy.

LTCI Premiums

The types of benefits offered by the insurer and the various choices that purchasers of LTCI make have a direct impact on the cost of a policy. Let us review the elements that have the greatest impact on the amount of the premium:

- The larger the daily or monthly benefit amount, the higher the premium. There is generally a direct proportional relationship.
- The larger the lifetime maximum benefit (or the longer the benefit period), the higher the premium.
- The longer the elimination period, the lower the premium.
- Comprehensive policies are more expensive than those that cover only facility care or only home care. In a comprehensive policy, the higher the percentage of the facility benefit that is paid for

home care, the higher the premium.
- An automatic inflation protection option increases the premium. A simple rate option is cheaper than a compound rate. There may or may not be a charge for adding a guaranteed purchase option to a policy.
- An optional non-forfeiture provision adds to the premium.

Other factors also affect the premium amount. As a general rule, any policy provision that increases the likelihood that the insurer will pay benefits or increases the amount of benefits it will likely pay contributes to a higher premium. Thus a policy with less restrictive benefit triggers would tend to be more expensive than one with more rigorous triggers, and a policy that covers items such as respite care, transportation, and informal caregiving tends to cost more than one that does not. Likewise, the premium of a disability or indemnity policy is usually higher than the premium of a comparable reimbursement policy.

While the insurer's basic policy design and the policy options the insured selects directly affect the policy's premium, there are several other factors that have an impact on the policy's cost:

- the age of the applicant,
- the health of the applicant (in some cases), and
- any discounts the applicant may qualify for.

Age

Age has a substantial impact on premium. The older a person is at the time she applies for an LTCI policy, the higher her premium. Keep in mind, the premium is designed to remain the same over the life of the policy -- that is, the premium is not automatically increased as the insured's age increases. (Nevertheless, except for the few noncancellable policies, there is no guarantee that a premium will not increase.

Health -- Individual Insurance

All insurers conduct underwriting of applicants for individual LTCI policies -- that is, they seek information about the applicant and, based on that information, decide whether to offer him coverage, and if so, on what terms. Most commonly, the insurer simply has the applicant answer questions about his current physical condition and health history on the insurance application. In some cases the insurer may request a report from the applicant's physician or arrange for a telephone interview or an in-person assessment.

How companies use information about an applicant's health differs. Many insurers take health into account only in deciding whether to accept or decline an applicant; they do not consider it in setting premiums for those they do accept. Other insurers place accepted applicants into two or three risk classes based on health and charge these classes different rates. The majority of applicants fall into the standard risk class, but the healthiest people are placed in a preferred risk class and the less healthy may be accepted into a nonstandard (or substandard) risk class.

Health -- Group Insurance

Most long-term care insurance in the United States is bought by private persons for themselves (and sometimes a spouse), without any involvement by their employers. But employer-sponsored coverage is the fastest growing segment of the LTCI market.

There are two approaches to employer sponsorship of long-term care insurance. One is group insurance, in which the employer owns a group policy that provides coverage to those employees who enroll in it (and sometimes spouses, other family members, and retirees). The other approach is worksite marketing of individual insurance, in which the employer sponsors the sale of individual LTCI policies to employees. Each participating employee purchases his or her own policy and is responsible for paying the premium. The employer is not a party to any insurance contract (although the employer may facilitate the purchase through payroll deductions.).

Each LTC insurer establishes its own criteria for evaluating the health of group applicants. An insurer may issue group policies in many ways depending on the group being insured:

- Guaranteed issue – the insurer accepts all applications for group coverage. This method can expose the insurer to adverse selection. Guaranteed issue is typically used only for large employers with many employees -- and the insurer will typically impose a minimum level of participation.

- Modified guaranteed issue – the insurer asks applicants a few basic questions, such as the use of long-term services in the recent past, current inability to perform ADLs or cognitive impairment. Applicants who indicate such conditions may be denied coverage while the vast majority of employees will be covered.

- Short form (or simplified) underwriting – a more extensive questionnaire covering medications, medical history, etc. is used for underwriting purposes. Applicants who have reached a certain age may also be more strictly scrutinized.

  Full underwriting – insurers use a system similar to individual LTC, a long questionnaire of medical history, physician's statements and possibly physical or cognitive exams.
  As a general rule, the smaller the employee group, the less likely an insurer is to offer guaranteed issue. If underwriting is conducted, the smaller the group, the more rigorous the underwriting.

Premium Discounts

As discussed above, some insurers offer a premium discount to applicants who qualify for a preferred risk class. Some individuals may be eligible for other discounts.

Group Discounts

A group discount normally applies to the premiums paid by those covered by an employer-sponsored group policy. Some insurers offer discounts to those who purchase individual policies through worksite marketing. In both cases the discount may be extended to employees' spouses and other family members. Discounted group coverage or discounts on individual policies may be

offered to members of non-employee groups, such as service clubs (Rotary or Lions, for instance), college alumni associations, or customers of a bank.

Spousal and Family Discounts

Many insurers offer a spousal discount ranging from 20 to 40 percent if both husband and wife purchase an LTCI policy, based on the assumption that married people can care for each other and so are less likely to file claims for paid long-term care services. Some insurers in some states extend a spousal discount to same-sex couples, other committed couples not legally married, and/or siblings living together.

There is considerable variation by company and state in this area. Some insurers require that both spouses obtain coverage; others require only that both apply for coverage and grant the discount even if one of them is declined. Many companies grant a smaller discount to any married person, even if her spouse does not apply for or purchase LTCI coverage. Some states do not allow any discounts for married couples; other states allow insurers to grant discounts to married person, but they may not require that both spouses be insured. Most companies maintain the spousal discount even if the couple divorces or one spouse dies.

Taxation of LTCI

For many years the tax treatment of long-term care insurance was in dispute. Some argued that LTCI was a type of health insurance – that benefits should be tax-free and premium payments were tax-deductible expenses. Others took the position that because LTCI covers items such as room and board or assistance with ADLs, rather than "medical care", LTCI was not health insurance – premiums should not be deducted as medical expenses and benefits had to be considered taxable income. The Internal Revenue Service simply didn't address long-term care in its regulations and the issue remained unresolved until 1996.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addressed a wide array of health insurance issues, including the tax treatment of LTCI. As we noted earlier, HIPAA established a new class of LTCI policies, federally tax-qualified (TQ) policies, set requirements that must be met for a policy to be tax-qualified, and granted favorable tax treatment to the policies that meet those requirements.

The Tax Status of LTCI Policies

Federally tax-qualified policies now make up a very large majority of the LTCI policies sold and have become the industry standard. The benefits of TQ policies are generally tax-free, and premiums may in some circumstances be partially tax-deductible. (The requirements for TQ status and the tax treatment of TQ policies are discussed later.)

However, not all LTCI policies are tax-qualified. HIPAA allows insurers to continue to market products that do not meet the requirements for TQ status – these are referred to as nonqualified (NQ) policies. But the owners of these policies do not enjoy the tax advantages that apply to TQ policies, their tax status is the same as that which applied to all LTCI policies before HIPAA. In other words, whether benefits are taxable remains unresolved and premium payments are not tax-deductible.

To be federally tax-qualified, LTCI policies issued after 1996 must meet all HIPAA requirements. However, policies that were issued before that date and so were already in force when HIPAA's long-term care provisions took effect are governed by HIPAA's "grandfather" clause and referred to as grandfathered policies. These policies are deemed tax qualified (that is, the same tax treatment applies to them as to regular TQ policies) even if they do not meet HIPAA requirements. An important restriction applies -- an insurer cannot make changes in a grandfathered policy so substantial that the insurer is in effect issuing a new policy that does not meet HIPAA standards. If such changes are made, the policy may lose its grandfathered status.

Tax Qualified Status

The requirements an LTCI policy must meet to be deemed federally tax-qualified are numerous, and in some cases, complex. We will summarize the most important ones in this section.

The Cover Page

The cover page of a tax-qualified LTCI policy must include certain information:

- It must clearly indicate that the policy is intended to be federally tax-qualified. A typical statement would be, "This policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code."
- It must notify the insured that for 30 days after delivery, he has the right to return the policy for a full refund of all premiums and fees paid, even though the policy has already gone into effect. (This is called the 30-day free look or right to return provision.)
- If the policy includes a pre-existing condition exclusion, this must be explained on the cover page.

Covered Services and Benefit Triggers

HIPAA requires that a tax-qualified LTCI policy pay benefits only for "qualified long-term care services." HIPAA defines qualified long-term care services as "necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services" that are "required by a chronically ill individual" and "provided pursuant to a plan of care prescribed by a licensed healthcare practitioner."

In defining "qualified long-term care services," HIPAA does not name specific services (such as skilled nursing care, assistance with bathing, supervisory care, etc.) but rather deems a service qualified if it has one of several purposes ("diagnostic, preventative, therapeutic," etc.). This purpose-based approach allows for a great deal of flexibility in the care of an individual. Any service that serves one of the purposes approved by HIPAA is acceptable, and benefits may be paid for it. This

approach also makes possible the introduction of newly developed services, which is particularly important in an ever-evolving field like long-term care. (If HIPAA had dictated a list of specific long-term care services, new services not on the list would not be reimbursable without a change in the law.)

A chronically-ill individual is defined by HIPAA as one who meets the benefit triggers for TQ policies. Essentially, a chronically ill individual is a person who is expected to be unable to perform at least two of the standard ADLs without substantial assistance from another person for at least 90 days, or one who suffers a severe cognitive impairment such that substantial supervision is needed to protect her from threats to her health and safety.

HIPAA requires that long-term services be appropriate for the insured's impairment – this requires "a plan of care prescribed by a licensed healthcare practitioner." Physicians, registered nurses, and discharge planners at hospitals look at the underlying cause of a person's need for services, her overall medical condition, and the types of services available. They also consult with her and her family on their care and setting preferences. They then draw on their expertise and experience to summarize the insured's needs and broadly outline the services that can meet those needs in a "plan of care". This ensures that a person receives safe and appropriate services, which might not occur if she and her family had no professional guidance. A plan of care should be reviewed and updated frequently. As a person's condition changes, so may the services he or she may need. HIPAA requires insurers to recertify an insured's impairment by a licensed health care practitioner every 12 months. (Many insurers review an insured's case more frequently if her condition is one that could change in the near term.)

Consumer Protection

HIPAA requires TQ policies to include many of the consumer protection provisions mandated by the NAIC LTCI Model Act and Model Regulation discussed earlier. To mention a few of the most important, a TQ policy must:

- be either guaranteed renewable or noncancellable,
- include a third-party notification of lapse provision,
- offer an inflation protection option,
- offer a non-forfeiture option.

The Tax Treatment of TQ Policies

Benefits

Benefits paid by TQ reimbursement LTCI policies are not considered income for purposes of federal income tax. Benefits paid by TQ "per diem" policies (indemnity or disability policies fit this

category because they pay a flat dollar amount per day) may be taxed if they exceed a certain limit ($280 per day in 2009, adjusted annually for inflation). However, if an insured with a per diem policy can furnish proof that her qualified long-term care expenses were greater than this limit, benefit payments up to the actual amount of expenses may be excluded from taxable income, even if they exceed the limit. This rule is based on the principle that LTCI benefits that are not actually spent on long-term care should not be tax-free, but rather treated as ordinary income.

Gary has a TQ reimbursement policy with a daily benefit of $300. He receives benefit amounts ranging from $225 to $300 for different days, depending on the amount of covered expenses he incurs. Since all his benefits go to pay for care, the entire amount each day is tax-free.

David has a TQ policy that pays a daily benefit of $300 on a disability basis. He is paid $300 for every day he meets a benefit trigger of the policy, even though his actual long-term care expenses range from $180 to $240. Only $280 of each daily benefit is tax-free (in 2009), and the other $20 is taxed as ordinary income.

Robert also has a TQ policy that pays a daily benefit of $300 on a disability basis. He is paid $300 for every day he meets a benefit trigger of the policy, even though his actual expenses range from $200 to $330. For days on which he receives services costing $280 or less, only $280 is tax-free, but if he can show that he received qualified services costing more than $280 on certain days, his benefits for those days are tax-free up to the actual amount of incurred expenses.

The above rules apply to both individually-purchased policies and group coverage.

Premiums -- Individual Policies

Premiums paid by an individual on a tax-qualified LTCI policy may in certain circumstances be partially tax-deductible. The tax deduction works like this: A taxpayer may include premiums (up to a maximum amount) as an itemized deduction on Schedule A. This maximum depends on the taxpayer's age at the end of the tax year and is adjusted annually for inflation. If LTCI premiums (up to the allowed maximum) plus other deductible medical expenses add up to more than 7.5 percent of the taxpayer's adjusted gross income (AGI), the amount in excess of 7.5 percent of AGI is deductible from taxable income.

Limits on Tax Deductibility of LTCI Premiums for 2009 -- adjusted annually for inflation

Age of the insured at close of tax year	Maximum amount includable for deduction:
40 and under	$320
41 – 50	$600
51 – 60	$1,190
61 - 70	$3,180
71 and over	$3,980

Glo- ria is 57. In

2009 she pays an annual premium of $1,250 on a tax-qualified LTCI policy. In addition, she had $4,000 in deductible medical expenses that year, and her adjusted gross income was $35,000. At her age, she can add $1,190 of her LTCI premium to her deductible medical expenses for a total of $5, 190. This amount exceeds 7.5 percent of her AGI ($2,625) by $2,565. Therefore, Gloria may deduct $2,565 from her taxable income on Schedule A of her Form 1040.

For the self-employed, premiums are treated somewhat differently. The same age-based maximums listed above apply, but a self-employed person may exclude the full amount of premiums up to these maximums from taxable income (unlike an employed person, who may only deduct any amount that, together with other deductible medical expenses, exceeds 7.5 percent of adjusted gross income).

In addition, a growing number of states offer credits or deductions on state income taxes for LTCI premiums.

Premiums -- Employer-Sponsored Coverage.

As a general rule, employers paying premiums or portions of premiums for TQ long-term care insurance on behalf of their employees may deduct their payments. The premium payments must be deemed reasonable and ordinary business expenses, but meeting this test is relatively easy, and the deduction is unlikely to be challenged as long as the long-term care insurance is offered as an employee benefit.

Employees may exclude as taxable income any LTC premium payments made on their behalf by their employer. The tax treatment of premium payments made by employees themselves for employer-sponsored coverage is the same as for individual policies -- that is, premiums may be partially deductible in certain circumstances, according to the rules explained above.

There is an exception for employees who are self-employed owners. A self-employed owner is someone who is both an owner and an employee of the same business, such as a partner in a law firm. Unlike other employees, a self-employed owner may not exclude from her taxable income LTCI premium payments made by her employer on her behalf. However, a self-employed owner can take a deduction for a portion of such premium payments; the rules are similar to those for the self-employed, described above.