Long Term Care Fundamentals

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**Long Term Care Fundamentals**

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## Introduction to the Course

The risk of needing long term care—a designation given to a broad range of services designed to meet an individual’s mental, emotional or physical health and personal needs and which are often provided over an extended period of time—is present at all ages. However, as individuals become older the risk of requiring long term care increases significantly.

The U.S. population is expected to increase in size by about 27% by the year 2050. In contrast, the part of the U.S. population most at risk for needing long term care—the segment comprised of individuals 85 years old or older—is expected to grow about 280% during this same period. Not only is the part of the population most at risk for needing long term care growing disproportionately, the cost to provide that care is also increasing. Long term care costs are substantial and, over the last several years, have been increasing at a rate that exceeds the inflation rate.

The growing risk of needing long term care fueled by a rapidly aging population coupled with the high and continually increasing cost of such care can present burdensome financial concerns to many clients and their heirs. This course examines the nature of long term care, the forms in which it may be delivered, the risk of needing such care, the costs of long term care, the sources available to pay long term care costs and the features of long term care insurance.

## Learning Objectives

Upon completion of this course, you should be able to:

* Recognize the types of services that constitute long term care and the settings in which they are provided;
* Compare the benefit triggers associated with qualified and nonqualified long term care;
* Identify the national average cost in the United States of obtaining various types of long term care and the sources available to pay for the care;
* Recognize the benefits and tax treatment of long term care insurance and the alternatives for funding long term care; and
* Describe the suitability and ethical issues associated with recommending the purchase of long term care insurance.

# Chapter 1- The Nature of Long Term Care

## Key Points

* Long term care is a continuum of services, devices and assistance designed to meet an individual’s health or personal needs.
* Six basic activities comprise the activities of daily living: bathing, continence, dressing, eating, toileting, and transferring.
* Cognitive impairment means a deficiency in the individual’s a) orientation as to person, place, or time, b) memory, c) deductive or abstract reasoning, or d) judgment.
* Increased life expectancy is partly responsible for the increasing need for long term care.
* Long term care may be skilled care, intermediate care or custodial care.
* Skilled careis nursing care generally required for patients with uncontrolled, unstable or chronic conditions, or for patients recovering from a medical condition that required hospitalization or from surgery.
* Intermediate care is skilled care provided on an intermittent basis.
* Custodial care is care that involves assisting individuals with the activities of daily living.
* Long term care is provided in the recipient’s home and in nursing homes, alternate care facilities, and community-based facilities.
* A nursing home is a facility that provides long term care services which are performed by, or under the supervision of, a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN).
* An alternate care facility is a facility that provides long term care in a venue that is an alternative to a nursing home.
* Alzheimer’s facilities provide long term care services solely to individuals suffering from Alzheimer’s disease and other types of dementia.
* Custodial Care Facilities provide assistance with ADLs, a high level of supervision for residents who find it difficult to live on their own, room and board, and personal attendance services.
* Community-based long term care services are services provided in the individual’s community that generally enable the care recipient to continue living at home rather than in an institution.
* Home health care services include custodial and skilled care and are designed to enable the care recipient to continue to live at home.
* Adult day care services are community-based services for individuals that are frail or impaired and may provide traditional “sitting” services, medical services, or Alzheimer’s care.
* Respite care is short-term care offered by various facilities that is designed to provide temporary relief to an uncompensated caregiver from caregiving duties.
* Hospice care is a wide range of services designed to provide health and comfort to individuals who are nearing the end of their life.
* Informal care is care provided to a recipient in his or her home by a caregiver other than someone who provides such care as a way to earn a living.

## Introduction

*Long Term Care*, for many the very name conjures up images of heavily medicated elderly staring into the middle distance, taken from productive society as they wait in warehoused fashion for eventual death. Although there is little question this image has more than scant basis in reality, the facts indicate that long term care is much broader than this unpleasant picture we have envisioned.

This chapter will consider the nature of long term care, the typical conditions normally requiring it, the settings in which such care may be provided and the likelihood of needing it.

## Chapter Learning Objectives

When you have completed this chapter, you should be able to:

* Define long term care;
* Describe the normal activities of daily living;
* Identify the settings in which long term care may be provided;
* Recognize the risk of needing long term care and the factors that may affect the risk; and
* Describe the social factors affecting the need for long term care.

## Long Term Care Defined

Long term care is not a singular mode of care; rather, it describes a continuum of services, devices and assistance designed to meet an individual’s health or personal needs. Those needs may be mental, emotional or physical ones, and the services offered may or may not be provided over an extended period of time.

While some authorities suggest a minimum period during which care is required for such care to be considered *long term* care—90 days, for example—we will be somewhat more inclusive in our use of the term in this course. In the text that follows, the term *long term care* will also be used to refer to care that seldom extends beyond a few weeks, as in the case of hospice care.

### Activities of Daily Living

According to CMS, the Centers for Medicare and Medicaid Services, “…l[ong-term care is a variety of services](http://www.medicare.gov/LongTermCare/Static/TypesOverview.asp) that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom.”[[1]](#footnote-1)

The help required may involve any of the activities healthy and active people generally take for granted such as walking, taking a shower, alleviating pain, eating, taking prescribed medication, and many other normal activities. In order to bring a more organized approach to determining who is eligible for long term care services, eligibility for these services and the insurance benefits that may pay for them generally requires:

* An inability to perform a certain number of activities that are considered basic to normal living, activities that are called *Activities of Daily Living* (ADLs); or
* The presence of a cognitive impairment.

Six activities, each of which is generally considered central to leading a normal life, comprise the activities of daily living. These activities are usually shortened to *ADLs*, and include:

* Bathing,
* Continence,
* Dressing,
* Eating,
* Toileting, and
* Transferring.

Although the specific definition of these activities may vary slightly from one source or insurer to another, the definitions are commonly those discussed below.

*Bathing* means washing oneself in a tub or shower, or by sponge bath. It also includes the individual’s ability to get into and out of a shower or tub.

*Continence* means the individual’s ability to:

* Control his or her bowel or bladder functions; or
* Adequately perform needed person hygiene, including taking care of a catheter or colostomy bag, when unable to control bowel or bladder functions.

*Dressing* means the individual’s ability to put on and take off:

* All items of clothing; and
* Any needed braces, fasteners or artificial limbs.

*Eating* means the process of putting food into the body:

* From some receptacle, such as a cup or plate;
* By means of a feeding tube; or
* Intravenously.

*Toileting* means:

* Getting to and from the toilet;
* Getting on and off the toilet; and
* Performing associated personal hygiene.

*Transferring* means moving into or out of a:

* Chair;
* Bed; or
* Wheelchair.

### Cognitive Impairment

We noted just above that eligibility for long term care treatment and benefits may be satisfied by the individual’s cognitive impairment. Somewhat similar to the definition of cognitive dysfunction,[[2]](#footnote-2) *cognitive impairment* is more specific and generally means a deficiency in the individual’s:

* Orientation as to person, place, or time. In other words, the individual does not know where he or she is, the people around him or her even though normally familiar, or the time of day or season of the year;
* Memory, either short-term or long-term. He or she cannot remember shared experiences, important dates, the places visited just yesterday, etc.;
* Deductive or abstract reasoning. For example, the individual may be unable to balance a checkbook, something he or she has done well for years; or
* Judgment with respect to his or her awareness of safety issues. For example, a doting grandmother may temporarily forget she was caring for her active toddler grandson and leave the playground without him. Or, the individual may attempt to walk across a busy highway, unmindful of speeding trucks.

## Typical Conditions Requiring Long Term Care

Earlier, we described long term care as “…a continuum of services, devices and assistance designed to meet an individual’s health or personal needs.” Although we can probably all think of one or more situations in which an individual might require such assistance, certain situations and conditions are generally more prevalent among people receiving long term care. They include all of the following:

* Generally temporary situations, such as:
	+ Rehabilitation following a hospital stay,
	+ Recovery from an illness, injury or surgery; and
* Permanent and/or terminal conditions, including:
	+ Chronic, severe pain,
	+ Alzheimer’s Disease and dementia,
	+ Multiple Sclerosis,
	+ Parkinson’s Disease,
	+ Heart Disease,
	+ Stroke,
	+ Head injury,
	+ Need for supervision or assistance in performing ADLs, and
	+ Chronic or terminal medical conditions.

### Role of Increased Life Expectancy

There is no question about the need for long term care experienced by a large percentage of the United States population. An understanding of the cause for much of the long term care need, however, may be eye-opening.

At the beginning of the twentieth century, the average American then living had a life expectancy of about 47 years. Data from the National Center for Health Statistics indicate the average life expectancy at the beginning of the twenty-first century is 77.9 years.[[3]](#footnote-3) The genius of humanity in eradicating many illnesses that plague us has increased our life expectancy by more than 60 percent in a mere hundred years! That’s the good news, but, in certain ways, it is also the bad news.

In some cases—perhaps a large percentage of them, judging from long term care statistics that we will review later—an early death has been replaced by a prolonged period of disability or chronic illness. One hundred or more years ago, well before the discovery of penicillin and other lifesaving drugs, people with serious illnesses often just died. Witness the influenza pandemic of 1918 during which 675,000 Americans died of the disease, a death toll that exceeds American deaths in all of its wars and a mortality rate that would be unthinkable today.

Today, medical advances have ended many dread diseases; for example, poliomyelitis was the scourge of the 1950s, and it has been eradicated. However, these advances may have simply postponed the graveyard until after an extended period of debilitation during which we require long term care. Medicine and the pharmaceutical industry may have permitted us to extend the quantity of our life at the expense of its quality.

## Types of Long Term Care

Health care—a term that is broader than, and includes, long term care—is typically categorized with respect to the level of the severity of the health problem it seeks to remedy and may range from intensive care to custodial care. It is convenient and helpful to view health care as being comprised of the following in declining level of criticality:

* Intensive care;
* Acute care;
* Skilled care;
* Intermediate care; and
* Custodial care.

Although intensive care and acute care may certainly be accessed by patients receiving long term care, those levels of care are not considered long term care. However, regardless of the setting in which long term care is provided, such care falls into one (or more) of the last three general categories, i.e., skilled care, intermediate care, and custodial care. As you review the definitions of these care types, keep in mind that skilled and intermediate care both require the supervision of care by skilled medical personnel; custodial care, however, does not.

*Skilled care* is a type of nursing care generally required for patients with uncontrolled, unstable or chronic conditions, or for patients recovering from a medical condition that requires hospitalization or from surgery; these patients usually need a relatively high level of monitoring by nursing professionals. It is care provided under a doctor’s order by a licensed healthcare professional, such as a physical therapist or nurse.

*Intermediate care* is a similar high level of skilled care, except that it is provided on an intermittent basis. Like skilled care it stresses rehabilitation, and its goal is to return function to the patient to enable him or her to return home. It is usually provided to patients in a stable condition who, nonetheless, requires daily medical assistance on a basis that is less frequent than that provided in skilled care.

Intermediate care is care ordered by a physician and normally carried out under the supervision of a registered nurse. An example of intermediate care is a patient’s every-six-hour dressing change. Although intermediate care continues to be provided to patients requiring it, as a term its use is declining. Current requirements for long term care are generally described in terms of skilled care or custodial care, our next category of long term care.

*Custodial care* is care that primarily involves assisting individuals with the activities of daily living—the ADLs we examined just above. The help with ADLs may be required because of some physical infirmity or condition or because of a cognitive impairment that mandates supervision to ensure the individual does not injure him- or herself or others. Although custodial care is clearly less intensive and does not require the high level of healthcare training required of those administering skilled or intermediate care, the individual providing custodial care must have some training in order to properly assist an individual in performing ADLs.

Unlike skilled care or intermediate care, the objective of custodial care is not to rehabilitate the individual. Instead, it is simply to assist him or her to lead an independent or semi-independent life.

## Settings in Which Long Term Care is Provided

We described long term care earlier as being comprised of “…a continuum of services, devices and assistance designed to meet an individual’s health or personal needs,” so it should come as no surprise that the *settings in which long term care takes place* are somewhat diverse. In addition to an individual’s home, the settings in which long term care is provided are:

* Nursing homes;
* Alternate care facilities; and
* Community-based facilities.

### Nursing Homes

*Nursing homes* are often defined as much by what they are not as by what they are. A nursing home is generally defined as a facility that provides long term care services which are performed by, or under the supervision of, a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Such services are provided at the facility 24 hours per day. In addition, for a nursing home to be eligible to receive payment of benefits for the nursing services it provides, it must also be licensed and operated to provide nursing care for a charge by the jurisdiction in which the services are performed.

Although a nursing home may be either a free-standing facility or a separate and distinct part of another facility, such as a hospital wing or ward, it is important to understand that none of the following is normally considered a nursing home for purposes of receiving benefits under a long term care insurance policy:

* A hospital;
* A clinic;
* A rest home that does not provide custodial care as its primary function; or
* A facility for the treatment of mental illness, drug addiction or alcoholism.

In addition, neither the individual’s home nor a swing-bed facility[[4]](#footnote-4) is normally eligible for benefits as a nursing home.

A nursing home may be:

* A skilled care facility;
* An intermediate care facility; or
* A custodial care facility.

#### Nursing Home Services

A nursing home’s services will vary—often substantially—depending on whether it is a skilled care facility (full-time or intermediate) or custodial care facility. A skilled care facility is a facility primarily engaged in providing skilled nursing care or rehabilitation services for individuals that are injured, disabled or sick. Of course, a skilled care facility also provides services that are normally considered “custodial” but only if those custodial services are incident to its providing skilled nursing care. For example, personnel in a skilled care facility would certainly assist a patient in transferring from the bed to a chair or help him or her dress. Any nursing home that provided only custodial care would not be considered a skilled care facility, however.

Skilled nursing care is patient care that may only be performed by licensed nursing personnel or under their supervision. It must provide 24-hour nursing services and employ a registered nurse during a day tour of duty of at least 8 hours a day, 7 days a week. In addition, resident medical care must be provided under a physician’s supervision, and the facility must have a physician available to furnish needed medical care in the event of an emergency.

Nursing homes providing custodial services typically provide a secure environment and many services that are designed to help meet the needs—medical, physical, and social—of their residents. Although the quality of services offered by nursing homes, depending on type and costs, may range from very modest to absolutely sumptuous, the services provided by nursing homes principally providing custodial care generally include:

* Room, which may be private or semi-private;
* Meals;
* Management of residents’ medications;
* Assistance with ADLs;
* Social activities that may include bingo, bridge, dances, parties, etc.; and
* Recreational activities such as day trips to places of interest.

There were approximately 1.4 million nursing home residents in the United States in 2010[[5]](#footnote-5).

#### Nursing Home Size

Although there is significant size variation among nursing homes, U.S. nursing homes averaged 109 beds in 2009. Kaiser Family Foundation statistics indicate that from the period 2000 to 2011, the number of U.S. nursing homes has declined from 16,886 to 15,465, a decline of approximately 8 percent.[[6]](#footnote-6) The most recent national nursing home survey that is publicly available reflects 2004 statistics[[7]](#footnote-7). The following table illustrates the changes in nursing home size over the period 1973 - 2004:

|  |  |  |  |
| --- | --- | --- | --- |
| ***Number of Beds*** | ***1973-1974*** | ***1999*** | ***2004*** |
| Fewer than 50 | 40.8% | 11.5% | 13.9% |
| 50 – 99  | 35.0% | 38.7% | 37.3% |
| 100 – 199  | 20.4% | 41.8% | 42.5% |
| 200 or more | 3.8% | 8.0% | 6.2% |

Source: CDC/NCHS, National Nursing Home Survey

The vast majority of nursing homes in the United States are not skilled care nursing facilities. Instead, they are principally in the business of providing assistance with ADLs.

### Alternate Care Facilities

Various levels and types of long term care may also be provided in certain facilities known as alternate care facilities*.* An *alternate care facility* is a facility that may provide needed long term care in a venue that is an alternative to a nursing home. In many cases, the costs of an alternate care facility are less than those of a nursing home.

An alternate care facility is generally defined as a facility that is primarily engaged in providing ongoing care and related services to inpatients in a single location and which meets all of the following criteria:

* It provides 24 hour-a-day care and services that are sufficient to support its residents’ needs arising from a cognitive impairment or an inability to perform ADLs;
* It has a trained employee on duty at all times who is ready to respond to provide needed care to the facility’s residents;
* It provides 3 meals daily and accommodates the residents’ special dietary needs;
* It is licensed or accredited, as required, by the appropriate state agency to provide such care;
* It maintains formal arrangements for the services of a physician or nurse to provide medical care to residents in case of an emergency; and
* It has appropriate methods and procedures for handling and administering drugs and biologicals.

Although the criteria defining an alternate care facility are not generally met by individual homes or independent living units, they are usually met by:

* Assisted living facilities,
* Alzheimer’s facilities, and
* Custodial care facilities.

#### Assisted Living Facilities

We noted earlier that the term “long term care” describes a *continuum* of services. Assisted living facilities can be seen as the portion of that continuum forming a bridge between long term care received in the individual’s home and nursing home care.

Residents in assisted living facilities—facilities that are often referred to as ALFs—are unable to live independently because they suffer from dementia or similar disorder and/or they require assistance with:

* The preparation of meals;
* Activities of daily living (bathing, dressing, eating, transferring, or continence); or
* Household chores.

ALFs normally provide a certain level of medical care, but they don’t offer the skilled care or intensive medical care found in nursing homes. The care provided in most ALFs is based on a service plan that details the services that each resident requires. That service plan is updated regularly to help ensure appropriate care continues to be provided as the individual’s needs change.

The services usually provided as a basic package in an ALF include:

* Care management and monitoring;
* Assistance with ADLs;
* Laundry and housekeeping;
* The management of prescribed medications;
* Recreational activities (bingo, bridge, dances, outings, etc.);
* Security; and
* Transportation to and from houses of worship, shopping, etc.

In addition to the basic package described above, some ALFs offer additional services and assess additional costs for them. Such additional services may include, although not be limited to, the following:

* Extra transportation services;
* Special care for residents suffering from dementia; and
* Delivery of meals to the residents’ living quarters.

Although the term “assisted living facility” is generally used to describe the kind of long term care facility just discussed, facilities offering the same or similar services may describe themselves as:

* Residential or personal care facilities;
* Adult congregate living care facilities;
* Adult living facilities;
* Board and care facilities;
* Domiciliary care facilities;
* Supported care facilities;
* Community-based retirement facilities;
* Adult homes; and
* Retirement residences.

While any particular facility may offer more or fewer services, they all generally fall under the rubric “assisted living facility.” It is estimated that there are approximately 39,500 assisted living residences in the United States. According to current estimates, as many as 1 million Americans may reside in them.[[8]](#footnote-8)

#### Alzheimer’s Facilities

Alzheimer’s disease is a progressive, degenerative disease that currently affects 4 million Americans over the age of 65. It impairs the individual by attacking the brain. The disease normally becomes apparent because of the individual’s forgetfulness, and it progresses slowly until the individual is unable to care for him- or herself. Alzheimer’s facilities provide long term care services solely to individuals suffering from Alzheimer’s disease and other types of dementia.

Although Alzheimer’s disease eventually results in the individual’s death, an Alzheimer’s patient typically exhibits certain telltale symptoms long before that time. Alzheimer’s symptoms may include any or all of the following:

* Short-term memory loss;
* Difficulty learning;
* An inability to perform routine tasks;
* A lack of ability to think abstractly or to reason;
* Poor judgment;
* Disorientation with respect to place and/or time;
* A decline in language skills; and
* Changes in personality and mood.

The number of Americans with Alzheimer’s disease is predicted to reach 14 million by the middle of the 21st century.

Although the progression of Alzheimer’s disease may take longer or shorter in any particular individual, it follows a fairly predictable path from stage 1, characterized by short-term memory loss and disorientation, to stage 3 when patients are unable to function independently or to use or understand language. Because the disease tends to be predictable, it lends itself to care provided by specialized Alzheimer’s facilities.

Because of the special nature of Alzheimer’s facilities and the opportunity of staff to specialize in the treatment of residents with dementia, individuals with Alzheimer’s disease generally function better in separate facilities that deal principally with Alzheimer’s patients than they do in facilities that also provide care to residents with other conditions.

#### Special Alzheimer’s Facility Considerations

Because of the effects of Alzheimer’s disease on the affected individual, the needs of individuals with Alzheimer’s disease are different from those of other individuals in need of long term care. Those special needs are reflected in Alzheimer’s facilities.

The principal Alzheimer’s facility considerations include the following:

* Safety and the need to be in a familiar environment are particularly important issues for Alzheimer’s residents. Accordingly, appropriate Alzheimer’s facilities provide a living environment that is particularly free of safety hazards.
	+ Facility furniture is generally kept in the same place;
	+ Rooms and apartments are clutter-free;
	+ Residents are often encouraged to bring their own furniture to enhance the familiarity of the patient’s surroundings;
	+ Facilities are generally light and airy, with high levels of natural sunlight exposure, since a lack of light may cause depression;
	+ Many large windows permit Alzheimer’s patients to see darkness, daylight and the changes in weather and seasons, all of which help them to establish the time of the year;
* Alzheimer’s patients may wander and become lost and disoriented; sometimes such wandering may be attributed to the individual’s experiencing pain or hunger.
	+ Alzheimer’s facilities often provide “wandering paths” that give residents a sense of personal freedom and give them a way to expend energy. It also encourages socialization;
	+ Hallways in Alzheimer’s facilities are often rounded, giving residents an encouragement to move forward;
* Alzheimer’s patients sometimes become delusional and argumentative. They may engage in behavior that is socially unacceptable.
	+ Alzheimer’s facilities attempt to maintain a feeling of calm and serenity as well as an established structure and routine in order to reduce problems involving resident behavior;
	+ The level of noise, often a concern in facilities housing many residents, is intentionally reduced in Alzheimer’s facilities to help maintain a sense of serenity;
	+ The stress brought on by pressure to complete tasks—a cause of anxiety and confusion in many Alzheimer’s residents—is reduced in Alzheimer’s facilities by breaking such tasks into discrete steps, allowing residents additional time to complete the tasks, and by limiting the choices given to residents;
* Residents with Alzheimer’s disease may forget where things are, the time of day or where they need to go.
	+ Alzheimer’s facilities attempt to help residents maintain their independence by offering various memory aids. Such memory aids include written lists of the day’s activities and dresser drawers that are clearly labeled to indicate their contents;
	+ Calendars and clocks are placed in highly visible areas to help residents maintain orientation with respect to date and time;
* As Alzheimer’s disease progresses, affected individuals have increasing difficulty understanding language. Accordingly, Alzheimer’s patients respond better to information that is provided visually than information provided through language.
	+ Alzheimer’s facilities often use specific shapes and/or colors to identify particular locations, such as restrooms;
	+ Photographs of residents and memory boxes containing the residents’ personal items are often used to enable residents to easily identify their rooms;
	+ Contrasting colors may be used to help residents identify where the floor ends and the wall begins;

For these reasons as well as others, Alzheimer’s facilities may offer residents an environment that enhances their sense of well-being while minimizing their frustration at being unable to do the things they formerly did.

#### Custodial Care Facilities

We noted earlier that a great deal of custodial care—assistance with ADLs or in dealing with the effects of cognitive impairment—takes place in nursing homes. However, not *all* institutional custodial care takes place there. An alternate care facility providing custodial care—known, appropriately, as a custodial care facility—may be able to provide such services at a somewhat lower cost.

Custodial Care Facilities usually provide a high level of supervision for residents who find it difficult to live on their own. The facility provides assistance with ADLs and offers the following services as needed:

* Room,
* Board, and
* Personal attendance services.

However, unlike custodial care provided in a nursing home, a custodial care facility does not have a medical facility nor a contract with a medical facility to provide medical services. Instead, custodial care facilities look to outside offices to provide any type of medical services.

### Community-Based Care Services

There is little question about where individuals needing long term care would prefer to receive it if given the choice. Overwhelmingly, they would opt for receiving such care through community-based services rather than in nursing homes since community-based services are designed to enable individuals to live independently in their homes for as long as possible. The term *community-based long term care services* refers to an array of services designed to do just that.

Furthermore, community-based services received an important boost from the U.S. Supreme Court in 1999 when it handed down its decision in the Olmstead case. The United States Supreme Court held in Olmstead v. L.C., on June 22, 1999, that the unnecessary segregation of individuals with disabilities in institutions may constitute discrimination based on disability. The court ruled that the Americans with Disabilities Act may require states to provide community-based services rather than institutional placements for individuals with disabilities.

Community-based services are support services, generally of a long-term nature, available to individuals needing assistance with ADLs to enable them to live at home or in the community instead of in an institutional setting. Community-based services include the following:

* Home nursing care;
* Physical therapy;
* Respiratory therapy;
* Occupational therapy;
* Speech therapy;
* Nutritional counseling;
* Custodial support services;
* Homemaker, personal care and chore-assistance services;
* Adult day programs providing therapeutic activities, meals and transportation;
* Respite care;
* Home modifications and personal care supplies;
* Long term care planning and case management services;
* Vocational services, including job placement, vocational evaluation, job placement, and work adjustment programs; and
* Recreation and leisure activities.

Community-based care obviously covers a wide range of services that may be offered in various community-based settings. The principal types of services provided are:

* Home health care;
* Adult day care;
* Homemaker services; and
* Hospice care.

#### Home Health Care

Paid home health care services are often required by those individuals suffering from chronic or disabling conditions, or who are recuperating from an acute illness and want to remain in their homes rather than receive needed care in an institutional setting. The type of care provided in a care recipient’s home generally falls into two categories:

* Custodial or supportive care; and
* Skilled care.

Custodial or supportive care supplied in the individual’s home is typically provided to those individuals needing help with ADLs or dealing with some form of dementia and who want to age in place. It may also include companionship, transportation or similar tasks that are normally performed by companions or homemakers.

Skilled care provided in an individual’s home is usually obtained for patients recovering from a heart attack, stroke, or similar catastrophic event. It is typically provided by nurses, therapists or specially-trained home health aides under a physician’s or nurse’s direction.

Home health care services include the services of various licensed therapists, including physical therapy, respiratory therapy, occupational therapy and speech therapy.

#### Adult Day Care Services

Adult day care services are community-based services for individuals that are frail or impaired, either physically or cognitively. They are generally offered during what is usually considered “normal working hours,” i.e. Monday through Friday from 7:00 a.m. to 6:00 p.m., although the times and days of operation may vary from one adult day care facility to the next. This kind of schedule typically allows a working caregiver to drop off the adult care recipient on the way to work and pick him or her up on the drive home.

Services provided in adult day care settings vary from facility to facility but generally fall into three categories:

* Day care in which the individual enjoys social interaction in a safe environment in which he or she is supervised. This type of day care often provides activities and crafts in which the individuals may participate and is sometimes referred to as the traditional adult day care model;
* Day care in which the individual enjoys the social interaction provided in the “traditional” model above, but also receives medical care and therapy as needed. This category of adult day care is appropriate referred to as the medical adult day care model; and
* Day care directed solely to individuals with Alzheimer’s disease or other forms of dementia, appropriately labeled the Alzheimer’s adult day care model.

Adult day care centers, in addition to the services noted above, may offer transportation to and from the center, baths, and various personal services such as:

* Haircuts,
* Hair shampoos and sets, and
* Permanents.

Each of these additional services is normally provided at an additional charge.

Adult day care facilities offer benefits for the care recipient and his or her caregivers. For the senior care recipient, an adult day care facility offers:

* An opportunity to live with family without being an around-the-clock responsibility;
* A chance for the individual to enjoy social interaction with his or her peers;
* Stimulating activities in which the individual may participate;
* Speech, occupational or physical therapy in a non-medical environment; and
* Assistance with ADLs that enables the individual to retain his or her dignity.

Caregivers may similarly enjoy the benefits of adult day care facilities, including:

* The ability to continue employment outside the home;
* Obtaining assistance with the physical demands incident to providing care to an adult;
* The avoidance of a sense of guilt that may accompany the institutionalizing of a family member; and
* A respite from the need to provide care on an ongoing basis.

#### Respite Care

Dictionaries define “respite”[[9]](#footnote-9) as “an interval of temporary relief or rest, as from pain, work, duty, etc.” That is precisely what respite care is designed to provide for a caregiver. Respite care is short-term care offered by various facilities that is designed to provide temporary relief to an uncompensated caregiver from caregiving duties.

There is little disagreement that caring for an aging adult who may require assistance performing the day-to-day activities of living or who may be suffering from some type of dementia is difficult and demanding. Regardless of the nature of the relationship between the caregiver and the care recipient, providing continual care takes a substantial toll on the caregiver.

Not surprisingly, caregivers are at an increased risk of depression and other symptoms of psychological distress. A study in the *Journal of the American Medical Association* showed that seniors who provided care for an ailing spouse became ill more frequently and suffered more stress than non-caregivers. In order for a caregiver to continue to provide effective, ongoing care to an ill or aging individual, the caregiver must meet his or her own needs for reassurance, support and periodic respite.

Respite care—not unlike other types of adult care—is provided in varying ways and settings. It is provided most frequently in three settings:

* In nursing homes that may take a care-recipient for a day, a weekend, or for a week or more while the caregiver takes a needed vacation;
* In adult day care facilities that may care for an individual for a day or two; and
* In the caregiver’s home.

#### Hospice Care

It is not uncommon to talk of “a hospice” as though it were a place, like a hospital, clinic or nursing home. It’s not; instead, it is a wide range of services designed to provide health and comfort to individuals who are nearing the end of their life. Accordingly, individuals eligible for hospice care are terminally-ill and expected to live for six months or less. Often, these are people who have refused additional treatment or who are ineligible for further curative measures, such as additional surgery, further chemotherapy, etc.

Although hospice care may be provided in any setting, including a free-standing hospice facility, it is usually provided in the terminally-ill individual’s home. In fact, it is estimated that 90% of hospice care is provided in the home under the care of a hospice team made up of:

* Physicians,
* Nurses,
* Social workers,
* Therapists,
* Aides,
* Pastors, and
* Volunteers.

Unlike the objective of acute care, which seeks to cure, the objective of hospice is to assist terminally ill individuals continue their life with the smallest amount of disruption to their daily activities as possible. For that reason, the focus of care changes from curative to palliative, i.e., relieving pain and other uncomfortable symptoms, when the individual enters hospice. In short, the principal objective of hospice is to make the dying individual as physically and emotionally comfortable as possible.

The unit of care with respect to hospice—the “patient” so to speak—is comprised of the individual nearing death and his or her family. So, counseling and respite services are available also to the individual’s family members.

Hospice employs an interdisciplinary approach to the providing of care. Hence, it delivers various types of care—such as pain relief, symptom management and supportive services—through the efforts of many professional and other caregivers, that provide:

* Medical services,
* Social services,
* Psychological and emotional services, and
* Spiritual services.

 The health and comfort services offered to the individual by hospice include:

* Health and comfort assessments;
* Assistance with ADLs; and
* Providing certain medical equipment and supplies in the home, such as-
	+ Hospital beds, and
	+ Bandages.

Hospice care differs from many other types of healthcare in another important aspect: the services themselves. Specifically, there are no “pre-packaged” hospice services. Instead, the particular hospice care services provided to a terminally-ill individual are based on an assessment by the hospice team of the individual’s particular needs and comfort levels.

Since people of different backgrounds, religions and cultures may face impending death differently, the individual’s and family’s needs are also likely to be diverse. Accordingly, the range of hospice care services is very large. For example, a nurse member of a hospice team may focus attention on relieving and managing pain, while a team member who is a social worker may assist the family in identifying community organizations that are able to provide them with the tools to deal with their impending lifestyle changes and the stress normally felt by family caregivers.

Despite the obviously beneficial services that are offered by hospice to individuals and families dealing with the impending death of a loved one, hospice care services are not used as much as we might expect. In fact, estimates suggest that only 25% of Americans utilize the comfort and other services provided by hospice at the end of their life.

Part of that low level of hospice utilization may be due to an erroneous perception that hospice care is provided solely to cancer patients. Although individuals suffering from cancer make up the largest group using hospice, a study by the National Hospice and Palliative Care Organization indicates that hospice is used by patients with many other health conditions as shown in the graph below:

### Informal Care

Informal care, as its name suggests, is care provided to a recipient in his or her home by a caregiver other than someone who provides such care as a way to earn a living. The care may be provided by a relative, friend or neighbor and is normally uncompensated. According to CMS statistics, family and friends are the sole caregivers for 70% of the elderly.

The care provided by informal caregivers is normally the type of care for which little or no professional training is needed, including:

* Providing companionship;
* Assisting with errands and/or shopping;
* Assisting with the individual’s medications;
* Communicating with medical providers
* Preparing meals;
* Providing transportation; and
* Managing finances, e.g. paying monthly bills, etc.

## Likelihood of Requiring Long Term Care

Now that we have looked at the range and types of long term care generally available, we need to consider the answer to an obvious question: “How likely is it that my client will need long term care?”

The answer to the question—or more properly *answers*, because there is more than one correct answer—depends, in large measure, on the definition of long term care being used and the population being measured. Because of those multiple answers, there is understandably some confusion about the risk.

According to testimony before the Subcommittee on Health of the House Committee on Ways and Means given by the dean of the Georgetown Public Policy Institute, “…10 million people of all ages are estimated to need long-term care, close to 40 percent of whom are under the age of 65.”[[10]](#footnote-10)

Based on a study by Conning & Company[[11]](#footnote-11) 60% of people who reach age 65 will require long term care *at some time in their lives*. If we extend that Conning & Company statistic slightly to include the unit insurance agents most frequently counsel, i.e., couples, the risk of requiring long term care increases further. According to an observation made in the *Wall Street Journal[[12]](#footnote-12)* “… a couple turning 65 [has] a 75 percent chance that one of them will need long term care.” The National Academy of Elder Law Attorneys[[13]](#footnote-13) compared the risk of needing long term care with the risk of other financially-injurious occurrences, such as an auto accident or a fire in one’s home. According to that comparison, those relative risks look like this:

|  |  |  |
| --- | --- | --- |
| ***Risk of…*** | ***Probability*** | ***Percentage*** |
| Automobile accident | 1 in 240 | .4% |
| Fire damaging a home | 1 in 1,200 | .08% |
| Needing long term care | 1 in 2 | 50% |

It is estimated that 20% of all individuals age 65 or older require assistance in performing the normal activities of life—the ADLs we considered earlier. At age 85 or older, that estimate grows to 50%.

No examination of the probability of needing long term care would be complete without separately addressing the risk of entering a nursing home. According to various studies, the risk of needing long term care *in a nursing home* at some point in a person’s lifetime is as follows, based on age:

|  |  |
| --- | --- |
| ***At age…*** | ***Percentage*** |
| 45 or older | 36%[[14]](#footnote-14) |
| 65 or older | 49%[[15]](#footnote-15) |
| 85 or older | 56%[[16]](#footnote-16) |

 According to those studies, the lifetime risk of admission to a nursing home for an individual age 45 is slightly more than one in three; by age 65, the lifetime risk of admission climbs to almost one in two, and by age 85, more than half can expect to be admitted to a nursing home. In short, the risk of needing nursing home care is significant.

But, not only is the likelihood of admission to a nursing home an important statistic, we also need to think about the length of nursing home stays. Based on the most recent National Nursing Home Survey, the average length of stay in a nursing home was 835 days.[[17]](#footnote-17)

Because of the increased availability of long term care services in alternative settings, nursing home residents have tended to become older and frailer than ever before as many individuals who might have previously entered a nursing home opt to access long term care services in their home or in assisted living facilities. Women comprise the largest percentage of nursing home residents, amounting to 71% of those individuals in nursing homes.

## Social and Demographic Factors Affecting Long Term Care

Not much more than 100 years ago, families were characterized by generally large size and an attachment to place. Although the Industrial Revolution had begun, the American economy was still principally agrarian. The large family size was the result of high infant and child mortality coupled with farm families’ need for additional hands at planting and harvest time.

Family farms remained in the same family for generations. Often, members of the family died in the same house in which they were born and raised. They cared for their ill and aged members at home, generally leaving hospitals for care of the affluent.

### Industrial Revolution Splits Families

As the Industrial Revolution continued to pick up steam and the number of family farms dwindled, farmers’ adult children found they could earn far more in the factories of the city than they were ever likely to earn as farm hands. It wasn’t too long before the exodus began from rural farms to city factories, a mass movement of people whose direction never changed.

The migration from the farm to the city began the geographical dislocation of families that continues today.

### Family Relocation to Achieve Professional Advancement

The movement from rural farms to cities to obtain employment was only the beginning of the enormous movement of people in the United States. Unlike children living on a family farm, children of those new city dwellers often had little or no attachment to the place of their birth. They may have obtained an education in a distant city and begun their careers with employers in cities even more distant from their parents and siblings.

As these second and third-generation city (or suburban) dwellers grew in their careers, they often found that advancement meant moving to another area of the country, either with their existing employer or a new employer. The connection with parents and siblings grew ever more tenuous. Visits home often became less frequent as distances increased. And the distance between family members—both geographically and emotionally—sometimes became enormous.

### Emergence of the Dual-Income Family

It is almost impossible to have come of age in the last half of the 20th century without having been exposed at least once to such television sitcoms as *Father Knows Best* and *Leave it to Beaver*, with their idealized version of the family. In that idealized family, father left for work each morning leaving mother to her baking, cleaning, and other family chores. Mother never even considered seeking employment outside the family.

However, that idealized nuclear family of a bygone era is just that—bygone, if it ever really existed at all. The family consisting of a working husband, a school-age child and a stay-at-home mom has generally ceased to exist on any broad scale. Most families today are two-income families, and those families depend upon both incomes to meet their basic monthly bills.

The Department of Labor reports14F13F[[18]](#footnote-18) that, in 2008, there were 58.125 million married couple families in the United States. Of those married couple families 29.9 million, or 51.4 percent, were dual-income families in which both husband and wife were employed, an increase of about 1 percent over 2004.

What those demographic phenomena mean with respect to long term care—and despite that 70% of long term care is informal care provided by friends and family—is that there is often no unemployed spouse to provide it.

## Summary

The term “long term care” includes a broad set of services, devices and assistance to meet the health and/or personal needs of the care recipients. The needs long term care is intended to meet can be mental, emotional or physical needs. In the majority of cases, long term care provides assistance with an individual in performing the activities of daily living. An individual’s eligibility for these services and the insurance benefits that may pay for them generally requires that an individual a) be unable to perform a certain number of activities deemed basic to normal living, activities that are called Activities of Daily Living (ADLs) or b) be suffering from a cognitive impairment.

Six basic functions normally comprise ADLs including bathing, continence, dressing, eating, toileting, and transferring (e.g. from a chair to a bed). A person suffering from a cognitive impairment is one who has a deficiency in his or her a) orientation as to person, place, or time, b) short-term or long-term memory, c) deductive or abstract reasoning ability, or d) judgment that may affect the safety of the individual or others.

While other conditions may call for long term care, individuals requiring such care include those dealing with relatively temporary situations—post-hospital rehabilitation or recovery from surgery, for example—or more permanent conditions, including those that could be terminal, such as chronic, severe pain, Alzheimer’s disease and dementia, multiple sclerosis, Parkinson’s disease, heart disease, etc.

Long term care may be skilled care, intermediate care or custodial care and can be delivered in multiple settings including nursing homes, alternate care facilities—assisted living facilities, Alzheimer’s facilities or custodial care facilities, in other words—or in community-based facilities. Community-based care includes support services, generally of a long-term nature, available to individuals needing assistance with ADLs to enable them to live at home or in the community instead of in an institutional setting and includes home health care, adult day care, homemaker services and hospice care.

Despite the availability of a broad range of more formal long term care services, informal long term care delivered by family and friends is the predominant form of long term care for approximately 70% of the elderly care recipients. Such informal care generally requires little or no professional training and includes providing companionship, assisting with errands and/or shopping, assisting with medications, communicating with medical providers, preparing meals, providing transportation and managing finances.

Although much long term care is provided on an informal basis by family and friends, the family’s support of its aging members—a support that was characteristic of an earlier period in time—has largely eroded and is continuing to erode. The factors that have caused a decline in family support for individuals needing long term care include the growth of business opportunities in locations distant from the family home, regular geographic dislocation in the pursuit of professional advancement and the importance of dual-income families.

Various studies suggest that the need for long term care is substantial: 60% of people who reach age 65 are expected to require long term care at some time in their lives; in the case of a couple turning 65, the likelihood of one of them needing long term care increases to 75%. Thus, while traditional family supports have eroded, the increased longevity characteristic of 21st century lives makes individuals at ever greater risk for needing long term care.

## Chapter Review

1. \_\_\_\_\_\_\_ is a type of nursing care generally required for patients with uncontrolled, unstable or chronic conditions.

A. Custodial care

B. Skilled care

C. Alzheimer’s care

D. Respite care

1. Which of the following is care that primarily involves assisting individuals with the activities of daily living?

A. Custodial care

B. Skilled care

C. Alzheimer’s care

D. Hospice care

1. Which of the following is generally defined as a facility that provides long term care services which are performed by, or under the supervision of, a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN)?

A. An alternate care facility

B. A community-based care facility

C. A nursing home

D. An adult day care facility

1. Which of the following is considered an alternate care facility designed to deliver long term care?

A. A nursing home

B. An Alzheimer’s facility

C. A hospice

D. An independent living unit

1. Which of the following can be seen as the conceptual “bridge” in the long term care continuum of services between home care and nursing home care?

A. An assisted living facility

B. A skilled care facility

C. An adult day care facility

D. Hospice services

[See answers to chapter quiz at end of course.](#_Chapter_1)

# Chapter 2 - Long Term Care Costs

## Key Points

* Most nursing home care is custodial;
* Skilled care is a type of nursing care generally required for patients with uncontrolled, unstable or chronic conditions, or for patients recovering from a medical condition that requires hospitalization or from surgery;
* Custodial care primarily involves assisting individuals with the activities of daily living;
* In 2014, the national average daily rate for a private room in a nursing home providing custodial care was $240;
* The national average daily rate for a semi-private room in a nursing home providing custodial care in 2014 was $212;
* Assisted living facilities are sought out for individuals who don’t require the more intensive care provided by nursing homes but who still require assistance in day-to-day living;
* Assisted living facilities provide residents with the management and monitoring of care and medication, assistance with ADLs, laundry and housekeeping services, security, transportation and recreational activities;
* In 2014, the national average, private pay monthly base rate for a care recipient in an assisted living facility was $3500;
* In 2014, the average hourly rate for a home health aide was $20;
* The average hourly rate for a homemaker/companion in 2014 was $19;
* The national average cost for adult day care facility services in 2014 was $65 per day;
* Half of Americans between the ages of 55 and 64 have high blood pressure;
* Two out of five Americans between the ages of 55 and 64 are obese;
* The population segment most likely to need long term care—those individuals age 85 and older—is expected to grow by 307% in the next 45 years during the same period in which the general population is expected to grow by only 42%;
* Medicaid generally pays about 43% of overall long term care costs;
* A care recipient becomes eligible for Medicaid long term care benefits only when he or she becomes impoverished;
* Virtually all hospice care is paid for by Medicare;
* The principal payment source for home health care services is Medicare;
* The principal payment source for nursing home custodial care is the individual care recipient, at least until assets are depleted and the individual qualifies for Medicaid.

## Introduction

Chapter 1 examined the nature of long term care and the risks your clients face of needing it. In looking at the costs of long term care—the focus of Chapter 2—we need to bear in mind that long term care is not a singular mode of care, such as nursing home care. Instead, it’s a broad range of care types provided in many possible settings, including:

* Nursing homes offering skilled care and/or custodial care;
* Alternate care facilities, such as assisted living facilities, Alzheimer’s facilities and custodial care facilities;
* Community-based care provided in the care-recipient’s home or in an adult day care facility, respite care facility, or hospice; and
* Informal care given principally by friends and family in the individual’s home.

Because the term *long term care* covers so many types of care provided in such a wide range of settings, the answer to the question “What’s the cost of long term care?” can only be correctly answered by a less-than-satisfying “It depends” response. The cost of long term care depends on the type of care provided and the facility in which the care occurs. Furthermore, as we will examine in this chapter, the likely payer of those costs may also depend on the type of long term care provided and where it takes place. The examination of long term care costs will begin with a consideration of care costs in the setting people generally envision when they hear the term *long term care*: a nursing home.

## Chapter Learning Objectives

When you have completed this chapter, you should be able to:

* Identify the national average cost of obtaining long term care in a nursing home;
* Recognize the average U.S. cost of residing in an assisted living facility;
* Identify the average costs normally associated with community-based long term care;
* Describe the U.S. population trends expected to affect the future cost and availability of long term care; and
* Recognize the various sources of long term care funding in the United States.

## Nursing Home Costs

The vast majority of nursing home stays—certainly the longer ones—are custodial in nature, where residents are principally provided assistance in performing the activities of daily living. Not all nursing home stays, however, are custodial; some are required because the care recipient requires skilled care.

### Skilled Care

You may recall that in Chapter 1, *skilled care* was defined as “…a type of nursing care generally required for patients with uncontrolled, unstable or chronic conditions, or for patients recovering from a medical condition that requires hospitalization or from surgery; these patients usually need a relatively high level of monitoring by nursing professionals. It is care provided under a doctor’s order by a licensed healthcare professional, such as a physical therapist or nurse.”

The intensive type of monitoring and nursing care that characterizes skilled care provided in a nursing home requires a high level of professional staffing. Not unexpectedly, skilled nursing home care is generally the most expensive type of long term care. Costs for this level of care provided in a nursing home frequently exceed $500 per day. Fortunately, the need for skilled care often does not last very long, and, for the elderly, the lion’s share of the costs for institutional skilled nursing care is borne by Medicare. (See below **Long Term Care Cost Payers**.)

### Custodial Care

Custodial care, as previously explained, primarily involves assisting individuals with the ADLs. Care-recipients may require such care because of a physical infirmity or condition; alternatively, it may be needed because of a cognitive impairment requiring the individual be supervised to ensure he or she is not injured nor injures anyone else. Even though custodial care providers don’t require the level of healthcare training needed by skilled care providers, some training *is* required.

Because the high level of expertise required of skilled care providers is not needed by caregivers providing only custodial care, nursing home costs for custodial care are generally much lower than costs for skilled care. According to a 2014 study of nursing home costs[[19]](#footnote-19) in the United States, daily costs for a nursing home stay varied considerably depending on the region of the U.S. in which the nursing home was located and vary as well based on the nature of the accommodations.

In 2014, the national average daily rate for a private room in a nursing home providing custodial care was $240; that is $87,600 each year. The range of average daily costs for a private room was a startling $104 to $954.

Similarly, the national average daily rate for a semi-private room in a nursing home providing custodial care in 2014 was $212, or $77,380 annually. The range of average daily costs for a semi-private room was $94 to $800.

Over the period 2010 through 2014, the national average daily costs in a nursing home providing custodial care have risen 16.5 percent for private room accommodations and 14.6 percent for a semi-private room. The national average daily costs for custodial care provided in nursing homes for this period are shown in the table below:

|  |  |
| --- | --- |
|  | Room Type |
| Year | Private | Semi-Private |
| 2010 | $206/day | $75,190/yr | $185/day | $67,525/yr |
| 2011 | $213/day | $77,745/yr | $193/day | $70,445/yr |
| 2012 | $222/day | $81,030/yr | $200/day | $73,000/yr |
| 2013 | $230/day | $83,950/yr | $207/day | $75,405/yr |
| 2014 | $240/day | $87,600/yr | $212/day | $77,380/yr |
| Change | 16.5% | 14.6% |

## Assisted Living Facility Costs

If we think of nursing homes as generally providing care at the highest level of institutionalization for an individual and home care as providing the least, assisted living facilities (ALFs) can be reasonably placed between the two. Accordingly, assisted living facilities are generally sought out for individuals who don’t require the more intensive care that may be provided by nursing homes but who still require assistance in day-to-day living.

The typical assisted living facility provides residents with the management and monitoring of their care and medication, assistance with ADLs, laundry and housekeeping services, security, transportation and recreational activities. All of these services are normally included in the base ALF rate. In addition to these basic services, an ALF may also offer other services at a fee. Additional charges may be levied for special services such as delivering meals to residents’ living quarters, providing additional transportation services, and for dementia care. In addition to these basic and additional fees, some ALFs charge a one-time entrance fee.

The monthly ALF costs shown below are monthly private pay base rates for a private room with a private bath and include:

* Room and board;
* Two or more meals daily;
* Housekeeping; and
* Personal care assistance.

In 2014, the national average, private pay monthly base rate for a care recipient in an ALF was $3,500, or $42,000 each year15F[[20]](#footnote-20) Just as was noted above with respect to nursing home costs, the monthly rates for assisted living facilities ranged substantially by region from $750 to $10,412.

Not unexpectedly, particularly because of the specialized care involved, not all ALFs offer dementia care for residents. When offered by an ALF, the monthly costs increase.

The change in the cost for a resident in an assisted living facility over the five-year period 2010 – 2014 can be seen in the chart below:

|  |  |  |
| --- | --- | --- |
| Year |  |  |
| 2010 | $3,185/mo | $38,220/yr |
| 2011 | $3,261/mo | $39,132/yr |
| 2012 | $3,300/mo | $39,600/yr |
| 2013 | $3,450/mo | $41,400/yr |
| 2014 | $3,500/mo | $42,000/yr |
| Change | 9.9% |

## Community-Based Professional Care Costs

We noted earlier in our Chapter 1 discussion about community-based services that they are designed to enable individuals to live independently in their homes for as long as possible. In large measure, that accounts for their relative popularity. Two forms of community-based professional care are:

* Home health care; and
* Adult day care.

Let’s consider the costs involved in each of these caregiving settings.

### Home Health Care Costs

Home health care may be skilled or custodial care. When custodial care is supplied in the individual’s home, it is normally to provide assistance with ADLs or to provide care for an individual with dementia who wants to remain in his or her home. In addition, home care may involve the services of a homemaker or companion without healthcare training.

When skilled care is provided in the care recipient’s home, it is usually to provide care to a patient recovering from a potentially catastrophic event such as a heart attack or stroke. Skilled care may be provided by nurses, therapists or specially-trained home health aides under a physician’s or nurse’s direction. There are more than one million individuals receiving home health care services at any time, supplied through more than 7,000 home health agencies.[[21]](#footnote-21)

In 2014, the national average hourly rate for a home health aide was $20 but ranged from a low of $9 to an average high of $39. The average hourly rate for a homemaker/companion in 2014 was similar at $19 and ranged from $8 to $39.

### Adult Day Care Facility Costs

The services provided in adult day care facilities are normally offered on weekdays from about 7:00 in the morning to about 6:00 in the evening. (Recently, some adult care facilities have begun experimenting with extended and overnight hours.) The services provided may vary considerably from traditional supervision of the individual while engaging in various activities, to the providing of medical and therapeutic services, to the delivery of care for patients with Alzheimer’s disease and other forms of dementia.

Although the national average cost for adult day care facility services in 2014 was $65 per day, a Midwest adult day care center has published a menu of services that can provide a better sense of the services provided in adult day care facilities and their costs, as shown in the chart below:

|  |  |
| --- | --- |
| ***Service*** | ***Cost*** |
| Assessment | $30 |
| Adult Day Care Level 1 | $60 per day |
| Adult Day Care Level II | $65 per day |
| Adult Day Care Level III | $70 per day |
| Respite Care | $275 per 24-hour period |
| Skilled Physical Therapy | $180 per hour |
| Occupational Therapy | $180 per hour |
| Speech Therapy | $180 per hour |
| Transportation | $7.00 one way/in county |
| Bath | $20 |
| Hair Wash & Set | $12 |
| Haircut | $12 |
| Permanent | $35 |

## Population Trends Affecting Long Term Care

There is little question that a substantial need for long term care exists in the U.S. population; it clearly does. But, what is the future likely to hold? If population trends are reliable predictors, the need for long term care is ready to explode.

### The Baby Boom Generation’s Health Issues

In 2011, the first baby boomer became age 65. The far-off rumble demographers hear may be the remainder of that generation coming right behind. Baby boomers—members of the generation born between 1946 and 1964—represent an enormous demographic bulge numbering 76 million people who can be expected to use the long term care facilities we have been discussing in numbers not previously experienced.

Not only is the baby boom generation an enormous cohort that the long term care industry must prepare for simply because of its population size. It will also tax the healthcare and long term care industries because of its lifestyle and resulting health problems, principal of which is its level of obesity.[[22]](#footnote-22)

The CDC National Center for Health Statistics published a press release titled *Obesity, High Blood Pressure Impacting Many U.S. Adults Ages 55 – 64.[[23]](#footnote-23)* That press release stated that half of Americans between the ages of 55 and 64 have high blood pressure, a major risk factor leading to heart disease and stroke. Furthermore, it stated that 40% of that group is obese. Among developed nations, the United States has the highest prevalence of obesity.

The implications of obesity and high blood pressure for long term care can be enormous, because these conditions weigh heavily on older individuals’ ability to care for themselves, i.e., perform ADLs. According to a Mayo Clinic article on obesity,[[24]](#footnote-24) obese people are more likely to develop a number of potentially serious health problems, including:

* High blood pressure;
* Diabetes;
* Abnormal blood fats, which can lead to coronary artery disease and stroke;
* Coronary artery disease, which can lead to a heart attack;
* Stroke;
* Osteoarthritis causing joint pain and stiffness;
* Cancer;
* Fatty liver disease, including cirrhosis;
* Gallbladder disease; and
* Gout.

In short, the aging of the baby boomers is likely to have an adverse effect on the utilization of long term care resources that is disproportionate to the size of the babyboomer cohort. While their general lack of fitness is likely to result in increased mortality, it is also likely to mean they will require far more long term care than previous generations.

### Census Bureau Projections

Even if members of the generation that have begun to enter their retirement years were as physically fit as those of previous generations, the need to accommodate the long term care needs of an additional 76 million people in the next 25 to 50 years may present staggering challenges. Let’s take a moment to look at some of the numbers presented by the U.S. Census Bureau to better understand the anticipated population changes and their likely consequences for long term care.

#### 30-Year Population Changes

The changes in the population over the 30-year period from 1980 to 2010 indicate the overall population has grown about 36%. However, the numbers of people in identified older cohorts of that population have grown disproportionate to the population’s overall growth. The growth in the population segments comprised of individuals age 55 and older has been as follows over that period:

|  |
| --- |
| **Population Growth 1980 – 2010 (in thousands)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Population Segment | 1980 | 1990 | 2000 | 2010 | Percentage Change |
| Age 55+ | 47,253 | 52,200 | 59,259 | 76,751 | 62% |
| Age 65+ | 25,550 | 31,084 | 34,986 | 40,268 | 58% |
| Age 75+ | 9,969 | 13,036 | 16,596 | 18,555 | 86% |

As we can see from the chart above, the oldest population segment—comprised of individuals age 75 and older—grew about 2½ times the overall population. While the overall population grew 36%, the size of this group grew 86%. Since the risk of needing long term care becomes significantly greater as an individual ages, the disproportionately high percentage growth of the older population signals an ever-greater need for long term care.

#### U.S. Census Projections

The U.S. Census Bureau has developed population projections through 2050 that are sobering for anyone concerned about possibly needing long term care at some time in the future[[25]](#footnote-25). During the period from 2010 to 2050, based on middle-series projections, the overall population is expected to grow about 27%. However, during that period the population most likely to require long term care is expected to grow at a substantially greater rate as we can see in the table shown below:

|  |
| --- |
| Estimated Population Growth 2010 – 2050 (in thousands) |
| Population Segment | 2010 | 2020 | 2030 | 2040 | 2050 | Percentage Change |
| Age 55+ | 76,751 | 97,363 | 110,831 | 121,679 | 132,427 | 73% |
| Age 65+ | 40,268 | 54,632 | 71,453 | 80,050 | 86,706 | 115% |
| Age 75+ | 18,555 | 22,852 | 33,506 | 44,579 | 48,763 | 163% |
| Age 85+ | 5,493 | 7,269 | 9,603 | 15,409 | 20,861 | 280% |

The population segment comprised of people age 55 and older is expected to grow 73%, more than twice the growth rate of the general population. Notice from the percentage change shown in the chart that the oldest segments are estimated to grow at the fastest rates. In fact, the population segment most likely to need long term care—those individuals age 85 and older—is expected to grow from 5.49 million to 20.86 million over the period, a whopping 280%.

If we think about what this combination of factors—a dramatically increased number of aged Americans and an anticipated higher morbidity—is likely to do to the need for long term care, it should be clear that the demand for these services will increase dramatically. That increase can be expected to affect the:

* Availability of long term care services; and
* Cost of long term care services.

## Long Term Care Cost Payers

We have already seen that long term care costs are substantial and that they vary by region as well as by the amenities provided in the particular facility. Furthermore, the aged population has increased significantly over the last 25 years and requires more long term care. These factors should prompt an obvious question as to who pays for these long term care services.

The funding sources families generally look to when long term care is needed for a loved one include:

* Medicare;
* Medicare supplementary insurance;
* Medicaid;
* The individual’s assets;
* The individual’s family’s assets; and
* Long term care insurance.

A 2013 study by the Kaiser Commission on Medicaid and the uninsured[[26]](#footnote-26) indicates that long term care funding in 2010 came from the sources shown in the chart below. Let’s consider the principal sources to determine why that source paid for long term care or did not.

### Medicare

Medicare is a federal health insurance program for persons age 65 or older, individuals of any age with permanent kidney failure, and certain disabled persons. It provides Hospital Insurance protection under Part A and a voluntary Medical Insurance program under Part B. In addition to providing hospital insurance, Medicare Part A also provides limited nursing home coverage. That limited nursing home coverage is for skilled care only.

For a nursing home stay to be covered by Medicare, the following conditions must be met:

* Daily skilled nursing or skilled rehabilitative services are required and can only be provided in a skilled nursing facility;
* The care recipient has been confined in a hospital for a minimum of 3 consecutive days (not counting the day of discharge) before admission to a participating skilled nursing facility;
* Admission to the skilled nursing facility must occur within a short time following hospital discharge, typically within 30 days;
* The skilled nursing facility care is to treat a condition that was treated in the hospital, or to treat a condition that arose while receiving care in the skilled nursing facility for a condition which was treated in the hospital; and
* A medical professional must certify the patient needs, and receives, skilled nursing or skilled rehabilitation services on a daily basis.

Medicare covers nursing facility care only when the care required is skilled care, and Medicare Part A will pay for the first 20 days of care in a skilled care facility in its entirety. After 20 days in a skilled care facility, the individual must pay a coinsurance amount from the 21st to the 100th day that tends to increase each calendar year. After the 100th day, Medicare nursing home coverage ends.

In order for Medicare to be a nursing home funding source, the facility in which care is provided must be a skilled nursing facility. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not certified by Medicare.

In addition to covering costs for skilled nursing care delivered in a skilled nursing facility, Medicare also pays for certain home health visits, providing all of the following conditions are met:

* The care must be post-institutional home health services;
* The care includes intermittent skilled nursing care, physical therapy, or speech therapy;
* The care recipient is confined at home and is under the care of a physician who determines the need for home health care;
* The home health agency providing the services to the care recipient participates in Medicare; and
* The services are provided on a visiting basis in the care recipient’s home or on an outpatient basis in a –
	+ Hospital,
	+ Skilled nursing facility, or
	+ Licensed rehabilitation center.

Because of these requirements, Medicare generally pays only about one-fifth of national annual long term care costs.

### Medicare Supplementary Insurance

Medicare supplementary insurance provides some limited benefits for paying long term care costs, depending on the plan purchased:

* Skilled nursing care (Plans C, D, F, G, K, L, M and N)
	+ These plans provide benefits for the coinsurance payment due from the insured for skilled nursing care for days 21 through 100
	+ No benefit is provided under these plans for skilled nursing care beyond day 100 nor for any custodial care at any time
* Home health care (Plans A, B, C, D, F, G, I, J, K, L, M and N) provide an at-home recovery benefit, following an illness or injury provided the follow-up care is ordered by a physician and meets other specified requirements

(It should be noted that the above explanation applies to Medicare supplement policies issued before June 1, 2010. After this date, Plans I, and J are no longer available, nor will any plan offer the at-home recovery benefit. Those who purchased their plans before this date may continue their original coverage.)

### Medicaid

Medicaid is a principal source of long term care funding and is sometimes erroneously referred to as “insurance.” However, unlike insurance which is designed to protect insureds and beneficiaries against financial catastrophe, Medicaid—because of its spend-down requirement—generally finances long term care services only after the financial catastrophe has struck and the individual has become impoverished.

It is a welfare-assistance program involving both the state and federal governments that is designed to provide healthcare benefit access for the indigent. Because of long term care’s substantial costs, Medicaid has become a principal source of funding as care recipients deplete their existing assets paying long term care costs.

The benefits provided by Medicaid vary substantially from one state to the next since each state has the task of defining the program’s eligibility and benefits that will apply in that state. In fact, because of that variability individuals in one state may obtain Medicaid benefits even though an individual in another state in exactly the same situation may be denied them.

Despite the variation in Medicaid long term care eligibility and benefits from state to state, Medicaid nonetheless pays the lion’s share of long term care costs nationwide, paying 41% of such costs. According to The Kaiser Commission on Medicaid and the Uninsured, “[n]early 60 percent of those in nursing homes have Medicaid as their primary source of payment.”

Self-payment is often a source of funding for long term care, at least until the care recipient becomes impoverished and Medicaid takes over payment responsibility.

### Long Term Care Payer by Type of Service

The portion of the long term care expenditure made by each of the payers varies depending on the type of long term care service provided and the setting in which it takes place. In this section we will consider the funding sources for long term care provided for the elderly receiving:

* Hospice care;
* Home health care;
* Short term institution care; and
* Nursing home care.

#### Hospice Care

You may recall that hospice care is a treatment approach that recognizes the care recipient’s impending death and involves a change in treatment focus from curative care to palliative care, i.e., the relief of pain and other uncomfortable symptoms. Although it is sometimes administered in a hospice care facility, most hospice care takes place in the care recipient’s home.

Virtually all hospice care for care recipients who have Medicare Part A (Hospital Insurance) coverage is covered by Medicare. No deductibles apply, and the beneficiary pays only small coinsurance amounts for outpatient drugs and inpatient respite care.

In order for hospice care to be covered under Medicare, three criteria must be met. The beneficiary must:

1. Be eligible for Hospital Insurance benefits provided under Medicare Part A;
2. Be certified by a doctor as terminally ill, i.e., he or she must have a life expectancy of 6 months or less; and
3. File a statement electing –
	* To waive all other Medicare coverage for hospice care from hospital programs other than the one chosen, and
	* Not to receive other services related to treatment of the terminal condition.

#### Home Health Care

In our discussion of payers for home health care, it is important not to confuse the type of care provided with homemaker or companion care. The type of care being examined is *health* care provided in the care recipient’s home. The sources of payment for home health care are:

* Medicare,
* Out-of-pocket payment by the care recipient,
* Medicaid, and
* A small percentage from other sources, including private insurance and other public programs.

 The breakdown of home health care payments is shown graphically below:

“Other sources” include private insurance, VA benefits, and other public programs.

Medicare pays for the first 100 home health visits in a home health spell of illness for a Medicare-eligible recipient. In order for Medicare to pay home health care benefits, all of the following conditions must be met:

* The care must be post-institutional home health services;
* The care must include intermittent skilled nursing care, physical therapy, or speech therapy;
* The care recipient must be confined at home;
* The care recipient must be under a physician’s care, and the physician must –
	+ Determine the need for home health care, and
	+ Set up a home health plan for the individual;
* The home health agency providing the home health care services must participate in Medicare; and
* The services must be provided on a visiting basis in the care recipient’s home or, if necessary to use equipment not readily available in the home, on an outpatient basis in a hospital, skilled nursing facility or licensed rehabilitation center.

In order for home health care to be deemed “post-institutional,” it must be furnished to the care recipient after discharge from a:

* Hospital in which the individual was an inpatient for at least 3 consecutive days before discharge; or
* Skilled nursing facility in which the individual was provided post-hospital extended care services.

Home health care services must be initiated within 14 days following the date of discharge from a hospital or skilled nursing facility in order to be covered by Medicare.

#### Short-Term Institutional Care

The category “short-term institutional care” generally refers to skilled nursing care of the type covered by Medicare. Accordingly, a large part of the payment for this care comes from Medicare. Payment sources for short-term institutional care are:

* Medicare,
* Medicaid,
* Out-of-pocket payment by the care recipient, and
* A small amount from other sources including private insurance.

Graphically, the typical breakdown of payment sources for short-term institutional care is shown below:

“Other sources” include private insurance, VA benefits, and other public programs.

For care in a skilled nursing facility to be covered by Medicare, the care recipient must meet all of the following conditions:

* The care recipient’s condition must require daily skilled nursing or skilled rehabilitative services which can only be provided in a skilled nursing facility;
* The care recipient must have been in a hospital for at least 3 consecutive days (not counting the day of discharge) before admission to the participating skilled nursing facility;
* The care recipient must be admitted to the skilled nursing facility within a “short time”[[27]](#footnote-27) after leaving the hospital;
* The care provided in the skilled nursing care facility must be for a condition that was treated in the hospital or for a condition that arose while the care recipient was being treated in the skilled nursing facility for a condition treated in the hospital; and
* A medical professional must certify that the care recipient needs and receives skilled nursing or skilled rehabilitation services on a daily basis.

#### Nursing Home Custodial Care

We noted earlier that the great bulk of nursing home care is custodial care in which care recipients receive assistance to help them meet their medical, physical and social needs in a secure environment. The services provided in these facilities normally include:

* A private or semi-private room;
* Meals;
* Medication management;
* Assistance with ADLs; and
* Social and recreational activities.

The payment sources for custodial care provided in a nursing home are:

* + Medicaid;
	+ Out-of-pocket; and
	+ Other sources, including private insurance.

You will note the conspicuous absence of Medicare in this list of payment sources for custodial care. *Medicare does not pay for custodial care unless it is provided incident to the type of care for which Medicare benefits are otherwise provided, e.g., skilled care.*

Custodial nursing home care payment sources are shown graphically below:

“Other sources” include private insurance, VA benefits, and other public programs.

We should realize that, for many care recipients, out-of-pocket payments are simply the first step in paying for nursing home custodial care. Typically, unless the individual has purchased long term care insurance, the care recipient’s funds are depleted to the point at which he or she is impoverished—a condition generally required for Medicaid to begin paying benefits—at which time Medicaid begins to pay for the care. However, since not all nursing homes accept Medicaid payments the transition from out-of-pocket payments to Medicaid payments may also signal a transition from one nursing home to another—a nursing home that accepts Medicaid.

## Summary

Most nursing home stays involve custodial care in which care recipients receive assistance in performing the activities of daily living, but a relatively small number of those nursing home stays involve skilled care. Not surprisingly, skilled care is generally the most expensive type of long term care and may exceed $500 per day. For elderly skilled care recipients whose care is provided in an institutional setting, the overwhelming majority of cost is paid by Medicare.

Unlike skilled care, custodial care involves the assistance of care recipients with their performance of the activities of daily living or providing supervision for individuals with cognitive impairments. The costs for a nursing home stay limited to custodial care varied considerably depending on the region of the U.S. in which the nursing home was located and the nature of the accommodations. The national average daily rate in 2014 for a private room in a nursing home providing custodial care was $240, and costs ranged from $104 to $954. The semi-private room daily rate for custodial care in 2014 was $212 and ranged from $94 to $800. Nursing home costs over the period from 2010 to 2014 rose by 16.5 percent for private room accommodations and 14.6 percent for a semi-private room.

The typical assisted living facility (ALF) provides residents with assistance by managing and monitoring their care and medications, helping them in their performance of ADLs and providing laundry, housekeeping, security and transportation services. In addition, they often arrange for recreational activities for residents. In 2014, the national average, private pay monthly base rate for a care recipient in an ALF was $3,500, or $42,000 each year15F Those monthly rates also ranged substantially by region from $750 to $10,412. The increase in the cost for a resident in an assisted living facility over the period 2010 – 2014 was 9.9%.

Home health care also may involve skilled or custodial care. When custodial care is supplied in the individual’s home, it is normally to provide assistance with ADLs or to provide care for an individual with dementia who wants to remain in his or her home. In addition, home care may involve the services of a homemaker or companion without healthcare training.

When skilled care is provided in the care recipient’s home, it is usually to provide care to a patient recovering from a potentially catastrophic event such as a heart attack or stroke. In 2014, the national average hourly rate for a home health aide was $20 but ranged from a low of $9 to an average high of $39. The average hourly rate for a homemaker/companion in 2014 was only slightly less at $19 and ranged from $8 to $39, depending on location.

The services provided in adult day care facilities are normally offered only on weekdays from about 7:00 in the morning to about 6:00 in the evening and are designed to enable a principal caregiver to be employed outside the home. The national average cost for adult day care facility services in 2014 was $65 per day.

Population projections published by the U.S. Census Bureau suggest that the nation’s risk of needing long term care will increase significantly based principally on the increasing size of the population cohort most at risk for requiring such care. During the period from 2010 to 2050, based on middle-series projections, the overall population is expected to grow about 27%. However, during that period the population most likely to require long term care is expected to grow at a much greater rate. The part of the population comprised of people age 55 and older is expected to grow 73%, more than twice the growth rate of the general population. In addition, the oldest segments of that age 55+ cohort are expected to grow at the fastest rates. In fact, the population segment comprised of individuals age 85 and older is expected to grow 280% over the 40-year period from 5.49 million to 20.86 million.

This anticipated population growth is likely to stretch many of the sources of funding long term care to their limits. The current long term care funding sources include Medicare, Medicare supplementary insurance, Medicaid, personal assets and long term care insurance.

Medicare provides coverage for an individual’s stay in a nursing facility only when the care required is skilled care, and that coverage is limited. Medicare also pays for certain home health visits, provided specified conditions are met. Because of the requirements imposed on Medicare funding for long term care, Medicare generally pays only about one-fifth of national annual long term care costs.

Medicare supplementary insurance provides some limited benefits for paying long term care costs, depending on the plan purchased. When the supplementary insurance covers long term care costs, its coverage is generally limited to Medicare’s deductibles and coinsurance amounts.

Medicaid, a state and federal welfare-assistance program, is a principal source of long term care funding once recipients have become impoverished. Although the eligibility for and benefits available from Medicaid vary from state to state, Medicaid pays the lion’s share of long term care costs nationwide. The Kaiser Commission on Medicaid and the Uninsured reports that almost 60% of nursing home residents have Medicaid as their primary source of payment.

The portion of the long term care expenses paid by each of the principal funders varies depending on the type of long term care service provided and the setting in which it takes place. Virtually all hospice care for care recipients who have Medicare Part A (Hospital Insurance) coverage is covered by Medicare. No deductibles apply to benefits paid for hospice care, and the beneficiary pays only small coinsurance amounts for outpatient drugs and inpatient respite care. Medicare also pays for the first 100 home health visits in a home health spell of illness for a Medicare-eligible recipient and bears about 85% of home health care costs.

## Chapter Review

1. What was the national average daily rate in 2014 for a private room in a nursing home whose services are generally limited to providing custodial care?
	1. $240
	2. $212
	3. $500
	4. $65
2. Which of the following sources generally provides the largest percentage of long term care funding overall?

A. Medicare

B. Medicaid

C. Care recipient’s out-of-pocket funds

D. Long term care insurance

1. What is the principal funding source for hospice care?

A. Medicare

B. Medicaid

C. Care recipient’s out-of-pocket funds

D. Long term care insurance

1. What is the maximum period of time that Medicare will pay for any costs associated with care delivered in a skilled nursing facility?
2. 3 days
3. 20 days
4. 30 days
5. 100 days

[See answers to chapter quiz at end of course.](#_Chapter_2)

# Chapter 3 - Long Term Care Insurance

## Key Points

* A “pool of money” approach to providing long term care insurance benefits provides additional flexibility to an insured;
* Insurers using a specified daily benefit amount in their long term care insurance policies may use an indemnity or a reimbursement provision;
* Long term care insurance policies using an indemnity approach to benefits pay the specified daily benefit regardless of the actual cost for the covered care;
* Long term care insurance policies using a reimbursement approach pay the lesser of the policy’s specified benefit or the actual cost for the care;
* Benefit triggers are those conditions that may result in the policy’s payment of a long term care insurance benefit;
* The only permitted benefit triggers in a tax-qualified long term care policy are the loss of ability to perform ADLs and an impairment in cognitive ability;
* Common ADLs are bathing, continence, dressing, eating, toileting and transferring;
* A long term care insurance policy’s benefit period is the maximum period that benefits for which the insured is eligible are paid;
* Typical benefit periods available in a long term care insurance policy are 2 years, 3 years, 4 years, 5 years, 6 years, 10 years, and lifetime;
* An elimination period in a long term care insurance policy is the period beginning with the insured’s receiving covered care and ending when long term care benefits begin to accrue;
* Long term care insurance policy elimination periods typically offered by insurance companies are 15 days, 20 days, 30 days, 60 days, 90 days 100 days, 120 days, 150 days, 180 days, and 365 days;
* The long term care insurance policy grace period applicable to premiums not paid by the due date is usually 65 days;
* The minimum free-look period applicable to a long term care insurance policy is typically 30 days;
* In order for a long term care insurance policy to be tax-qualified it must be guaranteed renewable;
* Incontestable provisions in tax-qualified long term care insurance policies are segmented into three periods: less than 6 months, at least 6 months but less than 2 years, and at least 2 years;
* A tax-qualified long term care policy must not provide coverage for skilled nursing care only or provide significantly greater coverage for skilled care than for other types of care;
* Under an alternative care benefit, the insurer may provide benefits for expenses an insured incurs for care, treatment, services and supplies not specifically covered elsewhere in the policy;
* Benefits for respite care, defined as short-term care offered by various facilities designed to provide temporary relief to an uncompensated caregiver from caregiving duties, are typically provided in long term care insurance policies;
* Care advisory services involve assessment and care planning by an appropriate agency, organization, or care manager and are normally covered in a long term care insurance policy;
* Under a bed reservation benefit in a long term care insurance policy, an insurer will continue to pay an insured’s actual nursing home or assisted living facility charges if the insured’s confinement is temporarily interrupted;
* Tax-qualified long term care insurance policies are limited to a “6 and 6” pre-existing conditions exclusion;
* Long term care insurance policy inflation protection—normally offered as an additional optional benefit—may increase benefits on a simple or compound basis;
* Purchase Option Riders offer the insured the option to purchase additional long term care insurance daily benefits on various policy anniversaries;
* The function of nonforfeiture benefits in long term care insurance policies is to preserve some of the policy benefits in the event of a lapse;
* Under the restoration of benefits additional optional benefit, the insurer will restore the policy limit, on a one-time basis provided the insured meets certain “insurability” type conditions;
* Premiums for tax-qualified long term care insurance are included in the costs of medical care for tax purposes, subject to dollar limitations based on the insured’s attained age;
* Benefits received under tax-qualified long term care insurance policies are tax-free, subject to certain *per diem* dollar limitations; and
* Alternatives for financing long term care costs include accelerated death benefits, viatical settlements, and various riders on life insurance policies and annuity contracts.

## Introduction

As discussed in Chapter 1, the risk of an individual’s requiring long term care at some time in his or her life is substantial and becomes even more substantial as the individual ages. Compared to the likelihood of an automobile accident or a house fire, the risk of needing long term care is much greater.

In Chapter 2 we looked at the costs of long term care and found that while costs vary based on the type of care received and the region in which it is provided, long term care costs are high and getting higher. For many individuals and couples, the only viable method of paying long term care costs without becoming impoverished is through the mechanism of insurance.

In this chapter we will examine long term care insurance. In our examination of the product, we will consider:

* The basic approaches insurers use in their policies to deliver long term care insurance benefits;
* The conditions that need to be met to qualify for long term care insurance benefits;
* The basic long term care policy provisions and the optional benefits offered; and
* The tax treatment given to tax-qualified long term care insurance.

HIPAA—the Health Insurance Portability and Accountability Act—in specifying required provisions in long term care insurance products qualifying for favorable income tax treatment of premiums and benefits, created two categories of long term care insurance products: tax-qualified long term care insurance and nonqualified long term care insurance. Although most long term care insurance policies sold are tax-qualified policies, some insurers continue to offer nonqualified long term care insurance policies. For that reason we will point out those provisions that are required to render the product tax-qualified and will briefly discuss alternative provisions that may appear in nonqualified long term care insurance policies.

Chapter 3 will conclude with a discussion of alternative methods of financing the substantial costs involved in purchasing long term care services. When reviewing this chapter on long-term care insurance it is important to bear in mind that insurers, as they gain additional long-term care experience, may drop or revise benefits previously offered. In addition, insurers are likely to continue to increase premiums for long-term care insurance coverage. Thus, with respect to currently-available coverage, long-term care insurance is a changing landscape.

## Chapter Learning Objectives

When you have completed this chapter, you should be able to:

* Compare the indemnity and reimbursement approaches to providing long term care insurance benefits;
* Identify the qualified and nonqualified long term care insurance policy benefit triggers;
* Recognize the basic provisions contained in a long term care insurance policy;
* Describe the tax treatment to which long term care insurance premiums and benefits are subject; and
* Identify the alternatives for paying the costs of long term care services.

## Long Term Care Insurance Approaches

The approaches insurers take in their policies’ delivery of long term care insurance benefits fall into two broad categories:

* A “pool of money” approach; and
* A specified daily benefit and benefit period approach that may provide benefits on an indemnity basis or on a reimbursement basis.

Both of these approaches have advantages. Let’s consider the “pool of money” approach first.

### Pool of Money Concept

In a long term care insurance policy employing the pool of money approach, the duration of the long term care daily benefit is not stated. Instead, the policy specifies a maximum:

* Daily benefit limit, and
* Lifetime benefit amount.

For example, a long term care insurance policy using this approach might specify a $200 maximum daily benefit amount and a lifetime benefit amount of $365,000. By doing some arithmetic we can see that this is a long term care insurance policy that provides a 5-year benefit period. ($200 x 365 days = $73,000 annually; $365,000 ÷ $73,000 = 5 years)

While that arithmetic seems fairly straightforward, it fails to highlight one of the advantages of a pool of money approach. Specifically, the pool of money approach offers a certain flexibility that may not be available under a policy providing for a set daily benefit. For example, an insured with such a long term care policy would be able to extend the availability of benefits beyond the 5-year period by finding a long term care facility that charged a daily rate of $166. Since the reduction in the remaining lifetime benefit amount is less each day than the daily maximum, the benefit will continue for a longer period. In this case, the benefit period has been increased to 6 years. ($166 x 365 days = $60,590; $365,000 ÷ $60,590 = 6.02 years)

### Specified Daily Benefit Amount & Benefit Period

The second approach to delivering long term care insurance benefits taken by insurers is to specify a daily benefit amount and a benefit period.

For example, using the same numbers in our earlier illustration, a long term care insurance policy could specify a daily benefit amount of $200 and a benefit period of 5 years. Under this second approach when five years of benefits have been paid, no further benefits are payable, even though the insured may continue to be receiving long term care services.

Insurers using a specified daily benefit amount in their long term care insurance policies may use two different types of provisions that can have a significant effect on how benefits are paid. They are:

* An indemnity provision; or
* A reimbursement provision.

#### Indemnity Provisions

In a long term care insurance policy under which benefits are paid pursuant to an indemnity provision, an insured who receives covered care would receive the specified daily benefit *regardless of the actual cost for the covered care*. For example, suppose your client’s long term care insurance policy specified a daily benefit of $200 for each day of nursing home care. The fact that the actual cost to the insured of the nursing home care was only $175 per day would have no effect on the $200 per day benefit payment: the insured would receive $200 for each day he or she received nursing home care.

#### Reimbursement Provisions

Reimbursement provisions work differently than indemnity provisions in that they pay the lesser of the specified benefit or the actual cost for the care. Thus, if the actual charges for the covered care were less than the specified daily benefit, only the actual charges would be paid. In our example just above in which an insured under a long term care insurance policy with a $200 per day benefit received care for which a $175 per day charge was made, a reimbursement provision would only have paid the actual charges, i.e., $175 per day.

Because long term care insurance policies paying benefits under an indemnity provision tend to have somewhat higher claims than policies under which benefits are paid as reimbursement, they also tend to have higher premiums and are more likely to involve rate increases. Reimbursement provisions are far more common in long term care insurance policies than indemnity provisions.

## Benefit Triggers

A *benefit trigger* is simply that condition that may result in the payment of a long term care insurance benefit. The traditional benefit triggers in a long term care insurance policy are:

* Inability to perform a specified number of activities of daily living (ADLs);
* Suffer an impairment in cognitive ability; or
* A medical necessity for long term care services, as prescribed by a physician.

Although we will examine these three benefit triggers below, the Health Insurance Portability and Accountability Act (HIPAA) effectively removed medical necessity as a benefit trigger for long term care policies issued on and after January 1, 1997 to be eligible for certain tax benefits. HIPAA defined a tax-qualified long term care policy as one having only the loss of ability to perform ADLs and impairment in cognitive ability as benefit triggers. Therefore, a long-term care insurance policy under which medical necessity is also a benefit trigger would not be a tax-qualified long-term care insurance policy.

### Inability to Perform ADLs

As we noted in earlier chapters, the most common ADLs are bathing, continence, dressing, eating, toileting and transferring. In most long term care insurance policies, these ADLs are listed and defined so there is no confusion as to their meaning.

Although some early long term care insurance policies only required that an insured be unable to perform one ADL in order to trigger a benefit, these insurers generally found that only requiring the insured be unable to perform one ADL resulted in a claims ratio far in excess of their projections. Other insurers, particularly concerned about a possible mountain of claims resulting from requiring the inability to perform only 2 ADLs, required the insured to be unable to perform 3 or more ADLs in order to trigger a benefit. However, requiring the insured to be unable to perform 3 or more ADLs wasn’t competitive with the policies of other insurers and such policies failed to sell. As a result, current long term care insurance policies generally require that the insured be unable to perform 2 or more ADLs in order to trigger a benefit.

According to insurers, the first two ADLs with which care recipients generally require assistance in most cases are dressing and bathing. Being able to dress requires an individual be fairly limber. It means the individual must be able to bend down to tie shoelaces, which is a problem for many older people. In addition, arthritis can make it impossible for an insured to button a shirt or blouse. Similarly, the slippery surface of a bathtub or shower can pose considerable danger to an already-frail individual.

### Impairment in Cognitive Ability

Alzheimer’s disease and other forms of dementia pose enormous difficulties for many older Americans. It is a disease that results in the individual’s loss of intellectual capacity and may be evidenced by a wide range of inappropriate behavior, including:

* Abusive or assaultive behavior;
* Poor judgment; and/or
* Inappropriate personal hygiene.

Although a long term care recipient who suffers from dementia may be unable to perform 2 or more ADLs from time to time, eligibility for long term care insurance benefits based on the loss of ability to perform ADLs requires that the individual *continue to be unable to perform* the ADLs. Since individuals with dementia are sometimes lucid and fully capable of performing ADLs and may be completely unable to perform them at other times, the ADL test is not an appropriate one for someone suffering from this disease. For that reason, cognitive impairment—sometimes referred to as *severe* cognitive impairment—is a separate benefit trigger and does not require that the insured be unable to perform ADLs in order to receive a long term care insurance benefit.

*Cognitive impairment* is generally defined as a condition resulting in a deficiency in the individual’s:

* Short-term or long-term memory;
* Orientation as to people, place, or time;
* Deductive or abstract reasoning; or
* Judgment as it relates to safety awareness.

### Medical Necessity

Medical necessity is the third benefit trigger that is sometimes found in a long term care insurance policy. It enables the insured to access long term care insurance benefits when an illness or injury requires him or her to use long term care services even though the insured fails to meet either the inability to perform ADLs or the cognitive impairment benefit triggers. Under this benefit trigger, only the verification of need by a physician is normally required to obtain a long term care insurance benefit.

As noted above, HIPAA effectively eliminated this third benefit trigger for any long term care insurance policy issued in 1997 or later if the insured wanted to be sure that the policy’s premiums and benefits qualified for favorable tax treatment. The tax treatment of long term care insurance policies is discussed later in this course.

## Basic Long Term Care Insurance Policy Provisions

Long term care insurance policies are similar to other insurance policies with respect to their structure. They contain basic contractual provisions that are included in every long term care policy the insurer issues and can also include additional optional benefits the policyowner may choose to include or omit.

In our examination of the basic policy provisions in a long term care insurance policy we will look at the following provisions:

* Benefit period;
* Elimination period;
* Premium payment grace period;
* Free-look period;
* Renewability;
* Lapse and reinstatement;
* Non-duplication of benefits;
* Benefit coordination;
* Incontestability;
* Shared coverage;
* Benefits, including benefits for –
	+ Long term care,
	+ Stay at home benefits,
	+ Respite care,
	+ Advisory services,
	+ Waiver of premium,
	+ Benefit extension,
	+ Return of premiums,
	+ Bed reservation, and
	+ International coverage; and
* Policy exceptions.

### Benefit Period

A long term care insurance policy’s *benefit period* is the maximum period that benefits for which the insured is eligible are paid. Except in long term care insurance policies employing a “pool of money” approach (see **Pool of Money Concept** above), the policy will specify the maximum duration for benefit payments. The typical benefit periods available in a long term care insurance policy are 2 years, 3 years, 4 years, 5 years, 6 years, 10 years, and lifetime; however, an insurer may choose to offer alternate benefit periods.

A lifetime benefit period is sometimes referred to as an “unlimited” benefit period. In a long term care insurance policy with a lifetime or unlimited benefit period, policy benefits are paid when the insured is eligible for them regardless of how long the benefits have already been paid or the total amount of benefit that has already been paid. It should be no surprise that, all other things being equal, a long term care insurance policy with a longer benefit period will require higher premiums than one with a shorter benefit period.

### Elimination Period

An *elimination period* in a long term care insurance policy is very much like an elimination period in a disability income policy. It is the period beginning with the insured’s receiving covered care and ending when long term care benefits begin to accrue. An elimination period may also be referred to as a “waiting period” or as a “deductible.”

Unlike the elimination period in a disability income policy, a long term care insurance policy’s elimination period normally needs to be met only once in the insured’s lifetime. Once the elimination period has been met, no further elimination periods usually apply. In addition, the elimination period typically need not be met with consecutive days of covered care and, in fact, may be accumulated under multiple claims.

Since long term care insurance policies provide benefits for various types of covered care—for example, care may be home health care or care in a nursing home—it adds some complexity to the elimination period provision. For example, how does an insured’s receiving home health care count towards satisfaction of the elimination period? The answer is that insurers take varying approaches when different types of long term care are accessed.

Some insurers simply state that the elimination period does not apply to home care benefits. Under such a provision:

* Home care benefits are payable as soon as the insured is eligible for and accesses home care benefits; and
* Each day for which the insurer pays home care benefits under the policy counts towards the elimination period (which applies to other policy benefits).

Other insurers take a different approach to home care benefits and may state that if the insured receives home care for one or more days during a calendar week (normally defined as Sunday through Saturday), then seven days are applied towards the elimination period. Thus, a 30-day elimination period would be reduced to 23 remaining days simply with one day of home care.

Clearly, the first approach in which the elimination period simply does not apply in the case of home care is more favorable for your client, particularly since most long term care occurs in the care recipient’s home.

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| **Important Note About Easy-to-Obtain Benefits** It is important to bear in mind that when a provision is described as being “more favorable to the client,” it generally means that obtaining a benefit is easier. However, a benefit that is easier to obtain may result in higher premiums and/or higher premium increases. |

Long term care insurance policy elimination periods typically offered by insurance companies are 15 days, 20 days, 30 days, 60 days, 90 days 100 days, 120 days, 150 days, 180 days, and 365 days. Some insurers also offer zero-day elimination periods, but the higher premium cost for shorter elimination periods tends to make a zero-day elimination period a fairly expensive option. The most common elimination period chosen is 20 days because that coincides with the 20 days of eligible skilled nursing care that is paid in full by Medicare.

The longer your client can wait for benefits to begin the smaller his or her long term care insurance policy premium will be for otherwise identical benefits. However, before suggesting an extended elimination period to a client you need to locate other fund sources your client can access—available assets, etc.—to pay for needed long term care services before benefits begin.

### Premium Payment Grace Period

As is the case with any insurance policy, premiums for a long term care insurance policy are due and payable as specified in the policy. For insurance policies other than long term care insurance policies, a grace period of 30 or 31 days applies if any premium is not paid by its due-date. During the grace period the policy remains in force, and at the conclusion of the grace period it lapses. Long term care insurance policies have a longer grace period.

In a long term care insurance policy, the grace period that applies to any premium not paid by the due date is usually 65 days. At the end of 30 days following the date the still-unpaid premium was due, the insurance company will send a notice of termination for non-payment of premiums to the insured and any person designated by the insured to receive such notice stating that the coverage will lapse in 30 days after the insured receives the notice. The termination notice is deemed to be received by the insured 5 days after it is mailed by the insurer.

### Lapse and Reinstatement of Coverage

Although long term care insurance policy coverage lapses if the premium is not paid by the end of the grace period—effectively a 65-day period—the insured may apply for reinstatement of the coverage. Reinstatement requires the insured to apply to the company to have the policy put back in force and pay all past due premiums. When the reinstatement application and past due premiums have been paid, the applicant will receive a conditional receipt.

Coverage is reinstated when approved by the company or, if not previously disapproved by the company it will be automatically reinstated on the 45th day following the date of the conditional receipt. The reinstated long term care insurance policy will cover only those expenses incurred for a covered loss beginning *after the date of reinstatement*. Long term care received by the insured during the period following lapse and before reinstatement is not covered.

Some insurers offer an automatic reinstatement within a specified period—typically five to seven months—following lapse in certain cases. For automatic reinstatement to apply, the insured must:

* Pay all unpaid premiums, and
* Submit satisfactory proof to the insurer that he or she was unable to perform at least two ADLs or was suffering from a cognitive impairment at the time the policy terminated.

In the case of such automatic reinstatement, insurers normally pay benefits just as though the lapse had never occurred.

### Free-Look Period

The free-look period provision in an insurance policy gives the policyowner a specified period of days following delivery of the policy within which to return it to the insurer for a full refund of premiums. That free-look period is designed to give the policyowner an opportunity to review the policy he or she purchased and decide on retaining or returning it. For life and disability insurance policies, the duration of that period is normally 10 days. The free-look period in the case of a long term care insurance policy may be considerably longer, depending on the regulations in the state in which the client lives and the insurance company issuing the coverage.

In many states the minimum free-look period applicable to a long term care insurance policy is 30 days. During that 30-day period—a period that begins when the policy is *delivered*—a policyowner may return the long term care insurance policy for any reason or for no reason at all and receive a complete refund of premiums.

### Renewability

The policy provision concerning the renewability of a long term care insurance policy is an important one. Generally long term care insurance policies may be:

* Noncancelable and guaranteed renewable;
* Guaranteed renewable; or
* Conditionally renewable.

Policies that are noncancelable and guaranteed renewable offer the highest level of renewability guarantees. Insurers issuing noncancelable and guaranteed renewable policies guarantee that the insurer may not:

* Cancel the policy; or
* Increase the premiums.

Policies that are guaranteed renewable (but not noncancelable) guarantee that the insurer may not:

* Cancel the policy, or
* Increase the premiums *except on a class basis*.

In order for a long term care insurance policy to be tax-qualified it must be guaranteed renewable. It may also be noncancelable, but insurers are particularly cautious about this generally new type of insurance and are unwilling to give up their right to increase premiums. Accordingly, few long term care insurance policies are of the noncancelable and guaranteed renewable variety.

Policies that are conditionally renewable give the insurer the opportunity to refuse to renew the coverage based on poor claims experience. Although the premium for conditionally renewable coverage would likely be lower than for policies providing otherwise comparable benefits but with guaranteed renewable or noncancelable and guaranteed renewable provisions, the lack of guarantee concerning renewability may result in your client’s loss of the coverage exactly when he or she needs it. In short, it is almost always not a worthwhile purchase.

### Non-Duplication of Benefits

Tax-qualified long term care insurance policies must meet several requirements. Among those requirements is that the policy must not pay benefits or reimburse expenses incurred for services to the extent the expenses are reimbursable under Title XVIII of the Social Security Act, i.e., by Medicare. Accordingly, a tax-qualified long term care insurance policy—and many other long term care insurance policies as well—will not duplicate benefits paid by Medicare, and insurers rely on a **Non-Duplication of Benefits** provision to exclude them.

A typical Non-Duplication of Benefits provision limits the policy’s payment of covered charges to those charges in excess of charges covered under:

* Medicare,
* Other governmental programs, or
* Any workers’ compensation, employer’s liability or occupational disease law.

Accordingly, the policy will not pay benefits if benefits are payable for the same covered charges by Medicare, Workers’ Compensation or other government programs.

### Coordination of Benefits

Insurers generally try to make sure that long term care insurance coverage doesn’t constitute overinsurance. They do that, in part, through coordination of benefits provisions.

Under a **Coordination of Benefits** provision, the insurer may reduce benefits payable under a long term care insurance policy if it also pays benefits for the same services under another long term care insurance policy issued by it. Benefits are reduced under the policy only when payment of the benefits would result in a total benefit amount greater than actual charges.

### Incontestability

Incontestability provisions are designed to limit the amount of time during which an insurer is able to contest payment of an insurance benefit and is designed to afford protection to insureds and their beneficiaries. Early insurance policies contained no provision limiting an insurer’s ability to contest a policy if it found the applicant had failed to answer a question truthfully, and insureds and their beneficiaries sometimes found that life insurance coverage they counted on would not be paid because of some misstatement that was made in applying for the policy. Not unexpectedly, late 19th century newspapers carried sensational stories of insurers’ denial of benefits to grief-stricken, needy widows and orphans.

The outcry that followed these disclosures amounted to a public relations disaster for the fledgling American life insurance industry. Although some life insurers voluntarily added certain consumer safeguards to their policies, such as nonforfeiture provisions and incontestability provisions, it was not until the formation of the Armstrong Committee and its investigation of insurer abuses in 1906 that such consumer protections were mandated. Not so coincidentally, the Armstrong Report marked the beginning of modern insurance regulation.

Early incontestable clauses were quite simple; they gave the insurer two years after the policy was issued to contest the policy, except for non-payment of premiums. Accordingly, such a provision read as follows:

***After two years, this policy shall be noncontestable except for the nonpayment of premiums as stipulated.***

For many insurance policies that language, or some variation of it, continues to be used.

This brief discussion of the early development of the incontestable provision is designed to provide some background on which to appreciate the far more complicated incontestable provision appearing in tax-qualified long term care insurance policies. Incontestable provisions in tax-qualified long term care insurance policies segment incontestability into three periods:

* 1. The period beginning on the policy date and ending when the policy has been in force for ***less than 6 months***;
	2. The period beginning when the policy has been in force for ***at least 6 months but less than 2 years***; and
	3. The period beginning when the policy has been in force for ***at least 2 years***.

During the first of the three segments, i.e., when the policy has been in force for less than 6 months, the insurer may rescind the policy or deny an otherwise valid long term care insurance claim by showing the applicant made a misstatement on the application for coverage and that the misstatement was material[[28]](#footnote-28) to the insurer’s acceptance of coverage. The misstatement made on the application need not pertain to the condition for which benefits are being sought.

After the policy has been in force for at least 6 months but less than 2 years, the insurer may rescind the policy or deny an otherwise valid long term care insurance claim by showing the applicant made a misstatement on the application for coverage, that the misstatement was material to the insurer’s acceptance of coverage, *and that the misstatement pertains to the condition for which benefits are sought*.

After the policy has been in force for at least 2 years, the insurer may rescind the policy or deny an otherwise valid long term care insurance claim only by showing the applicant *knowingly* and *intentionally misrepresented* relevant facts relating to the insured’s health.

### Shared Coverage

Some long term care insurance policies may insure a couple under a single policy. Such policies generally have shared coverage provisions addressing issues that would not normally be a concern in a policy insuring only one person. Among those shared coverage issues are:

* How the lifetime maximum, or benefit limit, applies in connection with multiple insureds;
* How any Waiver of Premium benefit works if only one of the insureds meets the eligibility criteria;
* The manner in which the policy operates after the death of one of the insureds; and
* The options available if the couple should divorce or separate.

Let’s briefly consider each of these coverage issues and the typical provisions that address them.

#### Lifetime Maximum is Shared

Except in the case of a policy offering unlimited or lifetime coverage, long term care insurance policies generally specify a lifetime maximum on benefits. When a long term care insurance policy covers two individuals, that lifetime maximum benefit amount is normally *shared* by the two insureds rather than being applicable to each insured. As a result, the need for long term care by one of the insureds may exhaust policy benefits before any benefits are paid to the other insured. This is not necessarily a bad provision, but if it applies in the long term care insurance policy you are recommending you need to be sure to disclose the potential impact of sharing to your clients. (See **Death of One of the Insureds** below for an explanation of the death of one of the insureds on the policy’s lifetime maximum.)

#### Shared Waiver of Premium

The Waiver of Premium benefit is discussed more fully below. However, in the case of multiple insureds the eligibility of one insured for premium waiver will generally result in the waiving of all policy premiums—even the premium attributable to the other insured who is not eligible for the waiver benefit according to the policy provisions.

#### Death of One of the Insureds

In most cases, the two individuals that constitute a “couple” die at different times. An important question is what happens to the long term care insurance policy that covers the two members of the couple when one of them dies.

In the general case, although any insurer may offer a different benefit, the effect of the death of one of the insureds is as follows:

* The surviving insured may continue the policy;
* The policy premium attributable to the surviving insured is multiplied by some factor—1.25, for example—to account for the policy administration cost that had previously been a part of the combined premium; and
* The policy’s lifetime maximum benefit is not affected.

#### Divorce or Separation of the Couple

If a couple insured under a long term care insurance policy divorce or separate, they are generally faced with a decision relating to the coverage. Some insurers give the couple the following choices. They may:

* Continue to share the coverage provided by the long term care insurance policy; or
* Request that the joint long term care insurance policy be converted to separate individual long term care insurance policies.

Certain conditions apply to the limited right of divorced or separated couples to convert their long term care insurance policies. The conditions that normally apply are:

* Both insureds must request the conversion to separate long term care insurance policies in writing;
* Neither insured is eligible at the time of requested conversion for any benefit payments; and
* Neither the Waiver of Premium nor Nonforfeiture Benefit is in effect on the joint policy.

The policy issued to each of the insureds upon conversion will usually be as follows:

* One-half the lifetime maximum benefit that applied on the joint long term care insurance policy will apply to each of the policies issued upon conversion;
* One-half of all non-restored benefits paid under the joint long term care insurance policy will be deemed to have been paid under each of the policies issued upon conversion; and
* Premiums for each of the policies issued upon conversion are based on the insured’s issue age and underwriting classification as shown in the joint long term care insurance policy.

### Basic Policy Benefits

Basic long term care insurance policy benefits are those normally provided by the base long term care insurance policy as distinct from any benefits added by rider to the policy. Although not every long term care insurance policy is likely to contain every benefit, the products that contain the most competitive benefit array will normally include:

* Long term care benefits;
* Alternative care benefits;
* Respite care benefits;
* Care advisory service benefits;
* Waiver of Premium benefits;
* Extension of Benefits provisions;
* Return of Premiums benefits;
* Bed Reservation benefits; and
* International coverage.

We will examine each of these basic long term care insurance policy benefits below.

#### Long Term Care Benefits

Although a long term care insurance policy may generally limit long term care benefits to skilled nursing care or to some other type of long term care—custodial care or home care, for example—a tax-qualified long term care policy must not provide coverage for skilled nursing care only or provide significantly greater coverage for skilled care than for other types of care.

Recognizing that broader coverage generally translates to higher premiums for your clients, comprehensive coverage is, nonetheless, the most desirable. It gives your clients the greatest possible flexibility in determining the level of long term care and the setting in which the care is delivered.

In a comprehensive long term care insurance policy, long term care benefits are paid for the following care and services:

* Confinement in a nursing home or assisted living facility for the insured’s room, board and care. Covered care includes –
	+ Nursing care,
	+ Custodial care, and
	+ Hospice care;
* Home care, hospice care, respite care; and
* Adult day care provided in an adult day care facility.

#### Alternative Care Benefits

Sometimes, no matter how much thought and creativity has gone into developing a long term care insurance policy, a type of care other than that specified in the policy may be more appropriate for a particular insured. That care may be covered in a long term care insurance policy under its alternative care benefit.

Under an alternative care benefit, the insurer may provide benefits for expenses an insured incurs for care, treatment, services and supplies not specifically covered elsewhere in the policy. Normally, in order to access alternative care benefits, several conditions must be met. Typical conditions that must be met include the following:

* The care, treatment, services or supplies must be specified in the insured’s plan of care (see box below);
* The insured, the insured’s physician and the insurer must mutually agree that the alternative care specified is a cost-effective alternative to other benefits specified in the policy; and
* The expenses for the alternative care benefits must be incurred while the mutual agreement is in effect and the long term care insurance policy is in force.

Tax-qualified long term care insurance policies are permitted to provide benefits only for qualified long term care services. As a result, tax-qualified long term care insurance policies would also require that the expenses for which alternative care benefits are provided must be for qualified long term care services as defined in the Internal Revenue Code.

Examples of expenses that could qualify for benefits under the alternative care benefit include, but are not limited to, the following:

* Safety devices for use in the insured’s home or other home modifications;
* Equipment in the insured’s home whose expense is not otherwise covered in the long term care insurance policy, such as emergency medical response systems;
* Community-based services that provide disabled individuals with meals in their home; and
* Other services or devices that enable the insured to remain at home rather than be confined in a nursing home or other covered facility.

The alternative care benefit is broad and is sometimes viewed as a “catch-all” provision. However, it is important to realize that a broad benefit typically requires the agreement of the insurer before benefits can be paid. Other insurers may offer a somewhat similar benefit which, although not as broad as the one described, does not require the insurer’s agreement for benefits to be payable.

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|  **Plan of Care**A plan of care is a written plan for long term care services that is designed specifically for an individual as a result of an assessment and which changes as required to reflect the individual’s needs. It specifies the type, cost, frequency and providers of the required services and must be in accordance with accepted medical and nursing practice standards. |

#### Respite Care Benefit

We defined respite care earlier as “… short-term care offered by various facilities that is designed to provide temporary relief to an uncompensated caregiver from caregiving duties.” Respite care benefits provided under long term care insurance policies pay for an insured’s care in:

* A nursing home;
* An assisted care facility;
* An adult day care facility;
* The insured’s home; or
* A community-based program.

Benefits for respite care are generally available without the need to satisfy the long term care insurance policy’s elimination period. However, depending on the respite care provision, benefits paid during the policy’s elimination period may be limited to no more than a specified number of days, such as 21 days, in any calendar year and may require that certain conditions be met, including the following:

* The policy must be in force;
* The insured must meet the eligibility requirements; and
* The insurer must be given written proof the uncompensated caregiver is taking a temporary leave of absence.

Payment of the respite care benefit is subject to the policy’s various limits, including the lifetime maximum benefit.

#### Care Advisory Services Benefit

A long term care insurance policy may pay benefits for care advisory services (see box below) provided certain conditions are met. The typical conditions that must be met include:

* The insured is actually receiving care advisory services;
* The provider of care advisory services submits a written record to the insurer specifying its recommendations;
* The provider of care advisory services submits a written assessment and itemized bill to the insurer; and
* The insured is eligible for benefits under the policy.

|  |
| --- |
| **Care Advisory Services**Care advisory services involve assessment and care planning by an appropriate agency, organization, or care manager and include:* Assessment of an individual’s need for long term care services;
* Developing a recommendation for long term care services consistent with the individual’s care needs determined as a result of assessment;
* Coordinating delivery of long term care and services; and
* Monitoring long term care and services delivered.
 |

Insurers generally pay the actual charges for care advisory services up to the amount specified in the policy for such services. The long term care insurance policy’s elimination period does not have to be satisfied for care advisory services benefits to be paid.

#### Waiver of Premium

Under a Waiver of Premium benefit, the insurer agrees to forgo premium payments provided certain conditions are met. The conditions that must usually be met for premiums to be waived under the benefit are:

* The insured must be receiving care or services for which benefits are payable under the long term care benefit; and
* The policy’s elimination period, if any elimination period applies, must be satisfied.

Premiums begin to be waived as soon as the elimination period has been satisfied and continue to be waived as long as benefits are payable. When long term care benefits cease, the Waiver of Premium benefit stops. Premiums paid for a period for which they are waived are refunded.

#### Extension of Benefits

Benefits under a long term care insurance policy may be paid even after the policy lapses. If a long term care insurance policy lapses while the insured is continuously confined in a nursing home, the policy’s long term care benefit will continue to be paid. Payment of the long term care benefit will end on the earliest of the following dates:

* The date the insured is discharged from the nursing home;
* The date the maximum benefits have been paid; or
* The date the insured dies.

An example of a situation in which the extension of benefits could become operative is one in which a nursing home-confined insured fails to pay a premium due during the elimination period, resulting in a lapse of the policy.

#### Return of Premium Benefit

Some insurers offering long term care insurance policies provide a return of premium benefit as one of their basic policy benefits. When included as a basic policy benefit, the return of premium benefit generally pays a benefit *only if the insured dies before age 65*. If the insured dies after age 65 no return of premium benefit is payable.

The return of premium benefit typically pays a benefit equal to the total premiums paid (without interest) less any claims paid. So, if an insured purchased a long term care policy at age 50 with annual premiums of $2,000 and died 14 years later at age 64 after having received $10,000 in long term care policy benefits, his or her return of premium benefit would be $18,000. ($2,000 x 14 = $28,000 - $10,000 = $18,000)

In order for a long term care insurance policy to be considered a tax-qualified long term care insurance policy, any refund of premiums on the death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(Note: Some insurers may offer an additional optional benefit by rider under which premiums may be returned at any age. See **Optional Benefits** below.)

#### Bed Reservation Benefit

Some insurers provide a *bed reservation benefit* under which they will continue to pay the actual nursing home or assisted living facility charges—usually, but not always, limited to a specified number of days—if the insured’s confinement in a nursing home or assisted living facility is temporarily interrupted.

Such temporary interruption may be for *any reason* including the insured’s:

* Hospital confinement; or
* Visits home to spend time with family.

#### Survivorship Benefit

Some insurers provide a survivorship benefit as part of their basic policy benefits when long term care insurance policies are issued to couples. Under a typical *survivorship benefit,* long term care insurance policy premiums are waived for a surviving insured upon an insured’s death as long as certain conditions are met.

The conditions that must be met for such premiums to be waived are:

* Both the decedent and the surviving insured must have been insured under a joint long term care insurance policy or under separate long term care insurance policies issued by the insurer continuously for at least 10 years at the time of death;
* The joint long term care insurance policy (or the individual long term care insurance policies if the couple is insured under separate policies) must contain a survivorship benefit; and
* No long term care benefits were paid or payable for either insured for the first 10 years of coverage under the policy or policies.

(Note: Some insurers offer optional survivorship benefits by rider. See **Optional Benefits** below.)

#### International Coverage Benefit

If long term care is received by an insured outside the United States, a long term care insurance policy may provide limited benefits. Depending on the insurer, the long term care services that are normally eligible for payment under the international coverage benefit may be limited to confinement in a nursing home only or may also include:

* Confinement in an assisted living facility;
* Home health care;
* Adult day care; and
* Hospice care.

Benefits for alternative care, respite care, or for care advisory services—benefits that could be payable if care had been provided in the U.S.—are not usually available under the international coverage benefit. Furthermore, depending on the insurer, total benefits payable under the international coverage benefit may be equal to the long term care insurance policy benefits that would otherwise be payable for confinement in the U.S. or may be limited to a shorter period, such as no longer than 365 days.

### Exceptions and Exclusions

Not all claims presented to an insurer are eligible for benefit payments, regardless of the type of insurance coverage involved. To ensure the policy only covers those claims envisioned by the insurer at the time it priced the coverage, the policy—including a long term care insurance policy—normally excludes losses resulting from certain conditions or causes in the section of the policy titled *Exceptions* or *Exclusions*.

The exclusions that are normally contained in a long term care insurance policy, and for which no payment is made, include charges or treatments:

* For injuries that are self-inflicted;
* Required because of the insured’s participation in a riot, felony, or insurrection;
* Required due to declared or undeclared war, any act of war, or the insured’s service in the Armed Forces or auxiliary units;
* For alcoholism or drug addiction (unless drug addiction resulted from administration of drugs as part of treatment by a physician);
* Not normally made in the absence of insurance;
* Provided by a member of the insured’s immediate family, unless –
	+ The family member is one of specified professionals that include a licensed registered nurse, practical nurse, or vocational nurse, a licensed social worker, or a speech, respiratory, physical, or occupational therapist;
	+ The family member is a regular employee of the organization providing the services;
	+ The organization receives payment for the services provided; and
	+ The family member providing the services receives no compensation other than the normal compensation for employees in such member’s job category; and
* Provided outside the U.S., except as explained under the policy’s International Coverage Benefit.

Many insurance policies—other than tax-qualified long term care insurance policies—also exclude coverage for pre-existing conditions. However, tax-qualified long term care insurance policies are limited to a “6 and 6 pre-existing conditions exclusion” under which they may exclude pre-existing conditions occurring within 6 months following the policy’s effective date. Furthermore, a *pre-existing condition* for purposes of a tax-qualified long term care insurance policy is defined as a “…condition for which advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.”[[29]](#footnote-29)

### Optional Benefits

In addition to basic long term care insurance policy benefits, insureds may add optional benefits to the policy by purchasing one or more additional benefit riders. In this section we will examine many of those optional benefits including:

* Inflation coverage benefits;
* Purchase option benefits;
* Nonforfeiture benefits;
* Partner benefits;
* Family care benefits;
* Restoration of benefits;
* Survivorship and Waiver of Premium benefits;
* Waiver of home care elimination period benefits;
* Additional cash benefits;
* Enhanced return of premium benefits; and
* Double coverage for accident benefits.

#### Inflation Coverage Benefits

Inflation is a fact of life. Bread, milk, rent, automobiles and gasoline—just to name a few important commodities—all cost more today than they did ten years ago. Inflation increases the prices of long term care as well.

We noted in Chapter 2 that over the period from 2010 to 2014, the national average per-day private room nursing home charge had increased 16.5 percent and the semi-private average rate had increased 14.6 percent. The overall U.S. inflation rate during this period22F[[30]](#footnote-30) was 7.95 percent.

Nobody knows if the increases in long-term care costs will continue to outpace the overall inflation rate in the years ahead, but it is prudent to build in some level of benefit increases to any long-term care insurance protection. To do that, insurers offer riders that increase benefits annually either on a simple basis or compound basis.

The usual inflation protection optional benefits offered in a long term care insurance policy increase policy benefits *without any increase in premium* by:

* 5% of the original benefit each year (a simple inflation protection approach); or
* 5% of the previous year’s benefit each year (a compound inflation protection approach).

Unlike the inflation protection generally provided in disability income insurance policies, an inflation protection that increases the disability income benefit only *while the insured is receiving disability benefits* based on the consumer price index (CPI), the inflation protection benefits provided on long term care insurance policies:

* Increase the benefit each year *without reference to an external index*, such as the CPI; and
* Increase the policy benefit each year *regardless of whether or not the insured is on claim*.

The long term care insurance policy benefits increased by virtue of the inflation protection riders are the:

* Daily or monthly benefit amount; and
* Maximum policy benefit.

Although maximum policy benefits are increased by the inflation protection rider each year, there is an important difference between inflation protection riders. That difference relates to their effect on the maximum policy benefit.

Under some inflation protection riders, the entire maximum benefit specified in the policy is increased each year, whether or not the insured has used up any of those benefits. Under other inflation protection riders, however, only the *remaining portion* of the maximum benefit is increased each year.

Although that difference in how the inflation protection rider impacts the maximum policy benefit is irrelevant if the insured is not currently, and has not been, on claim, it could make a significant difference in the policy’s maximum benefit depending on the insured’s current and/or previous claims access. There is little question but that an inflation protection rider which increases the entire maximum benefit specified in the policy each year is superior to one that applies the increase percentage only to the remaining portion of the maximum benefit.

The chart below compares a $200 daily long term care insurance policy benefit increased annually by 5% under a simple inflation protection rider with the same daily benefit increased annually by 5% under a compound inflation protection rider.

A simple inflation protection rider will increase the daily benefit amount $40 by year 5, while the compound inflation protection rider will only increase the daily benefit by $43 in the same year—a relatively insignificant difference. By policy year 10, the simple inflation protection rider will have increased the daily benefit by $90 per day, and the compound inflation protection rider by $310.

Although both inflation protection riders significantly increase the original daily benefit amount, the compound inflation protection rider doesn’t really begin to make a big difference until the 15th year, when the difference is $56 per day. The point of the comparison is twofold:

* To demonstrate the need for inflation protection of some sort; and
* To demonstrate that the significant difference between the simple inflation protection rider and the compound inflation protection rider begins at about 15 policy years.

The breakdown between benefit amounts with no inflation protection and with each of these riders is shown below, again assuming an initial $200 per day benefit and a 5% rider:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year | No Inflation Protection | Simple Inflation Protection | Difference  | Compound Inflation Protection | Difference |
| 1 | $200 | $200 | $0 | $200 | $0 |
| 5 | $200 | $240 | $40 | $243 | $43 |
| 10 | $200 | $290 | $90 | $310 | $110 |
| 15 | $200 | $340 | $140 | $396 | $196 |
| 20 | $200 | $390 | $190 | $505 | $305 |
| 25 | $200 | $440 | $240 | $645 | $445 |
| 30 | $200 | $490 | $290 | $823 | $623 |

There seems to be little question that inflation protection can be very meaningful with respect to maintaining the purchasing power of a long term care insurance benefit. However, the fact that a significant difference between the simple and compound inflation protection riders does not begin until 10 to 15 years have passed after policy issue suggests that, if premium is a concern, applicants older than 65 may be able to obtain sufficient inflation protection with a simple inflation protection rider. The obvious choice for younger long term care insurance applicants—individuals who are likely to avoid the need for long term care for a greater number of years—is to purchase a compound inflation protection rider.

When we consider the premium cost of these riders, this conclusion becomes even more obvious. A simple inflation protection rider generally increases the premium by 20% - 30%. A compound inflation protection rider is likely to be double the premium for a simple inflation protection rider.

#### Purchase Option Rider

Purchase Option Riders are sometimes called Guaranteed Insurability Option or Guaranteed Purchase Option riders. Regardless of their name, they offer the insured the option to purchase additional long term care insurance daily benefits on various policy anniversaries.

The amount of the additional daily benefit that may be purchased on an option date may be 5%, 10% or 15% of the original amount of daily benefit in the policy, depending on the insured’s choice. Although no additional underwriting is done by the insurer when an insured elects an option under the rider—which means that the insured’s underwriting classification at the time of original policy issue will apply—the option to purchase additional daily benefits is not available if the insured has received any benefits under the policy during the two years preceding the option date. Generally, the insured may choose not to elect to exercise the option on an option date without affecting any future options.

When the policy is issued, the premium for the additional daily benefit will be based on:

* The insured’s age at the time the option is exercised; and
* The insurer’s rates in effect on the date of exercise.

At the time the additional daily benefit is issued, the daily benefit will be increased by the appropriate amount, and any remaining policy limit will also be increased by the same percentage. For example, assume an insured with a $200 per day long term care insurance benefit and a $365,000 remaining policy limit exercised an option for a 15% increase. When the increase became effective the daily benefit would be increased to $230 ($200 x 15% = $30 + $200 = $230), and the policy limit would be increased to $419,750. ($365,000 x 15% = $54,750 + $365,000 = $419,750)

Option dates on which an insured may elect to purchase additional daily long term care insurance benefits generally fall on policy anniversaries. A typical purchase option rider gives an insured the option to purchase additional benefits on the 3rd policy anniversary and on any third policy anniversary thereafter. Hence, insureds under such a rider could add coverage (if eligible) on the 3rd, 6th, 9th, 12th, 15th, etc. policy anniversary.

Some advisers see the purchase option rider as an acceptable alternative to the inflation protection riders discussed in the previous section. The answer to whether that is so for a particular client needs to be given by the client after first disclosing to him or her all of the material facts.

It is important for both the adviser and the client to realize, however, in determining whether to attempt to offset the erosion of long term care insurance benefits through an inflation protection rider or a purchase option rider that:

* Purchase Option Riders are generally much less expensive than inflation protection riders;
* No premium increase occurs when long term care insurance policy benefits are increased pursuant to an inflation protection rider, but attained age premiums at the insurer’s then-current rate apply to any increase in daily benefits purchased under the purchase option rider; and
* If an insured has received benefits under the long term care insurance policy in the two-year period preceding the option date, the option may not be available to him or her.

#### Nonforfeiture Benefit

The function of nonforfeiture benefits in long term care insurance policies is essentially identical to their function in life insurance policies: they preserve some of the policy benefits in the event of a lapse. Long term care insurance nonforfeiture benefits are generally available in two forms:

* A “regular” nonforfeiture benefit that provides a paid-up long term care policy with a shortened policy limit; and
* A contingent nonforfeiture benefit under which insureds may decrease policy benefits in the event of a substantial premium increase.

Under the *regular nonforfeiture benefit* available as an optional additional benefit on a long term care insurance policy, the insurer must make the long term care insurance policy paid-up if the policy lapses because the premium is not paid when due provided certain conditions are met. The conditions that must be met are that the policy has been in force for at least 3 years (for at least 1 year if the policy premium is being paid under a limited payment option).

The policy limit under the paid-up long term care insurance policy will be equal to the greater of:

* The total policy premiums paid; or
* Thirty (30) times the policy’s nursing home daily benefit in force at the time of lapse.

The daily long term care benefit amount under the paid-up long term care insurance policy will be the amount of the benefit in effect on the date of policy lapse.

If the policy has been in force for fewer than 3 years at the time of lapse (or for fewer than 1 year if premiums are being paid under a limited payment option), the policy will terminate for non-payment of premiums. In such a case, no nonforfeiture benefit is payable.

Under the *contingent nonforfeiture benefit* available as an optional additional benefit on a long term care insurance policy, the insurer agrees to:

* Reduce the policy benefits without any underwriting, so that policy premiums are not increased if cumulative policy increases since issue have exceeded a specified percentage based on issue age; or
* Change the policy to a reduced paid-up long term care insurance policy.

The insurer’s agreement to reduce the policy benefits without underwriting or change the policy to reduced paid-up insurance in order to enable the insured to avoid a premium increase is only available if the total premium increases made by the insurer since issue exceed a specified percentage of the initial premium; that percentage is based on the insured’s age on the date the policy was issued. The three-year in-force requirement applicable to the regular nonforfeiture benefit does not apply to the contingent nonforfeiture benefit.

Under a typical contingent nonforfeiture benefit, the cumulative premium increases must be at least the following percent of the initial premium for the issue ages shown:

|  |  |
| --- | --- |
| Issue Age | Cumulative Premium Increase Trigger |
| 30 | 190% |
| 40 | 150% |
| 50 | 110% |
| 60 | 70% |
| 65 | 50% |
| 70 | 40% |
| 75 | 30% |
| 80 | 20% |

The policy limit under the paid-up long term care insurance policy, if that option is elected by the insured, will be equal to the greater of:

* The total policy premiums paid; or
* Thirty (30) times the policy’s nursing home daily benefit in force at the time of lapse.

The daily long term care benefit amount under the paid-up long term care insurance policy will be equal to the amount of the benefit in effect on the date of the insured’s election.

When the long term care insurance policy becomes paid-up under either of the nonforfeiture benefits, all optional benefit riders automatically terminate.

Adding optional nonforfeiture benefits may add up to 40% to a basic long term care insurance policy premium.

#### Shared Partner Benefit

A shared partner optional benefit enables a partner designated in an insured’s long term care insurance policy to access policy benefits, provided certain conditions are met. The conditions that must be met are:

* The partner named in the long term care insurance policy must also own a long term care insurance policy issued by the insurer;
* The partner’s long term care insurance policy must contain a shared partner benefit under which the insured is named as the covered person; and
* The partner’s long term care insurance policy benefits under his or her policy have been exhausted.

If the insured’s partner meets these conditions, he or she may receive long term care insurance benefits under the insured’s policy. The daily benefit available to the insured’s partner under the insured’s long term care insurance policy is equal to the partner’s daily benefit under the partner’s policy prior to termination. Both the insured and his or her partner may receive benefits under the insured’s long term care insurance policy at the same time. The insurer will not pay a total benefit under this option that exceeds the maximum policy benefits under both policies combined.

Upon the death of the insured or partner, the survivor’s policy limit is increased by any remaining policy limit under the decedent’s long term care insurance policy.

If the insured’s partner exhausts the insured’s long term care insurance policy benefits, no further benefits are payable to the partner. However, the insured may purchase two additional years of benefits if he or she meets the following conditions:

* The insured has not been eligible to receive long term care insurance policy benefits for the two-year period preceding the date the policy limit was exhausted; and
* The insured had not yet reached his or her 91st birthday on the date the policy limits were exhausted.

The shared partner optional benefit is sometimes considered an alternative to purchasing lifetime long term care insurance coverage and is seen as a more economical method of increasing the potential coverage for both insureds than purchasing lifetime coverage.

#### Family Care Optional Benefit

The family care benefit has some similarity to the shared partner benefit that we just discussed to the extent that it permits certain additional specified persons to access the insured’s long term care insurance benefits. Under this optional benefit, the insured must designate no more than three family members as covered persons under the policy. By being so designated, the family members are able to access benefits under the insured’s policy.

The benefits available to the designated members of the insured’s family include the policy’s:

* Long term care benefit;
* Alternative care benefit;
* Respite care benefit; and
* Care advisory services benefit.

In order to be eligible to receive the above benefits, the family member must be receiving care or services within the United States and must require substantial assistance to:

* Perform at least two ADLs; or
* Protect him- or herself from threats to health and safety due to the presence of a cognitive impairment

The insured and his or her family members may access the policy’s long term care benefits at the same time. However, no benefits are paid for charges in excess of the policy’s various limits

#### Restoration of Benefits

Under the restoration of benefits additional optional benefit, the insurer will restore the policy limit, on a one-time basis provided the insured meets certain “insurability” type conditions. The conditions that must be met for such benefit restoration are that the insured, for a period of 180 consecutive days did not need substantial assistance to:

* Perform at least two ADLs; or
* Protect him- or herself from threats to health and safety due to the presence of a cognitive impairment.

The insurer may perform an on-site nursing or functional/cognitive assessment or require a physical examination to confirm that the above criteria were met. The restoration of benefits benefit does not extend to policy benefits accessed by the insured’s partner.

#### Survivorship & Waiver of Premium Benefit

The Survivorship & Waiver of Premium benefit provides two benefits for an insured whose partner dies or goes on claim, provided certain conditions are met. The rider benefits are:

* A survivorship benefit under which the insured’s long term care insurance policy is paid-up and no further premiums are due if the insured’s partner dies; and
* A waiver of premiums for the insured’s long term care insurance policy if the premiums on the partner’s policy are waived.

The conditions that must be met for the insured’s long term care insurance policy to become paid-up or to have its premiums waived are the following:

* No benefits, except for advisory services, were paid under either policy for the first 10 years they were in force;
* On the date of the insured’s partner’s death (or commencement of premium waiver), both the insured and his or her partner were insured under individual long term care insurance policies issued by the insurer for 10 consecutive years; and
* On the date of the insured’s partner’s death (or commencement of premium waiver), the Survivorship & Waiver of Premium rider had been in force for a period of no less than 10 years.

#### Waiver of Elimination Period for Home Care Benefit

Although some insurers do not require that an insured satisfy an elimination period in order to receive home care or certain other benefits for which he or she is eligible, some insurers impose an elimination period in such cases. This rider benefit is designed to eliminate that requirement.

Under the Waiver of Elimination Period benefit, the insurer agrees to waive the elimination period requirement before receiving benefits if the insured is:

* Eligible for the payment of policy benefits; and
* Receiving the following types of care –
	+ Home health care in his or her home,
	+ Hospice care, or
	+ Adult day care in an adult day care facility.

The insured must still satisfy the policy’s elimination period before policy premiums are waived or the policy will pay any benefits for confinement in:

* + - A nursing home; or
		- An assisted living facility.

#### Additional Cash Benefit

The additional cash benefit is designed to provide the insured client with extra funds that will enable him or her to remain at home while receiving needed long term care. This extra cash may be used for any purpose by the client but may be subject to income tax liability.

Under the Additional Cash Benefit rider, the benefit—an amount specified in the policy—is paid to the insured each month provided the insured:

* Requires substantial assistance to –
	+ Perform at least 2 ADLs, or
	+ Protect him- or herself from threats to health and safety due to the presence of a cognitive impairment;
* Has satisfied the policy’s elimination period;
* Has not been confined in a nursing home or assisted living facility for any part of the calendar month; and
* Has received home health care for at least one day during the calendar month.

#### Return of Premium Benefit

Return of premium benefits have long been available (depending on various state regulations) on disability income policies. The Return of Premium Benefit is a similar benefit applied to a long term care insurance policy.

Insurers take various approaches to this benefit. Under some riders, the benefit is paid only upon the insured’s death while other insurers pay the benefit upon the insured’s death or surrender of the policy. Regardless of the approach taken, the payment of the return of premium benefit may result in income tax liability.

In addition to the variation in this benefit with respect to *when* it is payable, i.e., on death only or also on surrender, it may also vary as to the *method used* to determine the amount payable. The methods that insurers may use to determine the amount payable are:

* Refund the entire premium paid;
* Refund the difference between the premium paid and any claims paid; or
* Refund some percentage of the difference between the premium paid and any claims paid.

Depending on the approach used by the insurer to determine how much is paid under the benefit and the circumstances prompting payment, the premium for the rider can vary considerably. The premium for this benefit alone may be 50% to 100% of the premium cost for the base policy. Some advisers have suggested the client may be better served by investing the additional premium in a financial product that will pay interest—an annuity, for example—since the annuity benefit is paid regardless of the amount of any claims.

## Tax Treatment of Long Term Care Insurance

In addition to using taxes to fund the various operations of government, Congress historically has used the tax laws to affect the behavior of U.S. citizens either by heavily taxing a behavior it wants to curb or by providing tax incentives for a behavior it wants to encourage. That approach is evident in many areas.

For example, we can see it in the:

* Tax-deductibility of most traditional individual retirement account contributions; and
* Premature distribution tax penalties that attach to most distributions from individual retirement accounts before the individual attains age 59½.

Congress has used a similar method to encourage the purchase of long term care insurance—in this case offering tax-deductible premiums and tax-free benefits—in anticipation of the aging of the enormous baby boom demographic bubble we looked at earlier in this course. By providing tax incentives to encourage individuals to buy long term care insurance, Congress is attempting to shift the burden of paying for long term care from Medicaid to the private sector. These income tax incentives are not without limit or requirements, however, and we will examine them next.

### HIPAA Clarifies Tax Treatment for Tax-Qualified Policies

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), in addition to affecting many other areas, constituted an attempt by Congress to satisfy several objectives with respect to long term care. Those objectives include:

* Classifying long term care costs as a medical expense to give taxpayers burdened with such expenses some tax relief;
* Categorizing long term care insurance as accident & health insurance to clarify its tax treatment of premiums and benefits; and
* Giving the public an incentive to buy long term care insurance.

In order to ensure that these tax benefits apply only to long term care and long term care insurance, HIPAA defined various terms. Principal among those defined terms are:

* A “chronically-ill” trigger that must be met to qualify for long term care benefits whose costs would be considered medical expenses for tax purposes; and
* The content of various long term care insurance provisions in order to qualify as long term care insurance.

#### Favorable Tax Treatment only for Chronically-Ill

In order for long term care services to receive favorable tax treatment, the individual receiving them must meet the “chronically-ill” definition included in HIPAA. A *chronically-ill individual* is defined as follows in the legislation:

***A chronically ill individual must be certified by a licensed health care practitioner within the previous 12 months as one of the following:***

***The insured is unable, for at least 90 days, to perform at least two activities of daily living (ADLs) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.***

***The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.***

Because of this definition of chronically-ill that limits favorable long term care expense tax treatment only to an individual who has been certified as requiring assistance with two or more ADLs or has a severe cognitive impairment, the third benefit trigger in some long term care insurance policies—medical necessity—cannot be a benefit trigger in a long term care insurance policy that is considered tax-qualified. Hence, long term care insurance policies that provide a medical necessity trigger for benefit eligibility are considered *nonqualified* long term care insurance policies.

Prior to the passage of HIPAA, long term care insurance policies normally contained all three benefit triggers. Recognizing that many long term care insurance policies issued prior to HIPAA would not meet HIPAA’s requirements, such long term care insurance policies issued before January 1, 1997 are grandfathered[[31]](#footnote-31) for the purposes of tax qualification, provided they:

* Meet the long term care insurance requirements in the state in which they were issued; and
* Do not undergo a “material change.”

Final regulations issued by the Department of the Treasury in December 1998 indicate that the following would be considered “material changes” and cause a grandfathered long term care insurance policy to lose its favorable tax status:

* A change in the contract terms altering the amount or timing of an item payable by the policyholder, the insured, or the insurer;
* A substitution of the insured under an individual contract; and
* A change (other than an immaterial change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract.

### Tax-Qualified Long Term Care Premiums Deductible within Limits

Premiums paid for tax-qualified long term care insurance may be deductible. Tax-qualified long term care insurance policy premiums are included in the definition of “medical care” and are, therefore, eligible for income tax deduction within certain limits.

For *individuals* younger than age 65 at the end of the year who itemize deductions the amounts paid for medical care, including tax-qualified long term care insurance premiums not exceeding the dollar limitations discussed below, are deductible to the extent such amounts exceed 10% of the taxpayer’s adjusted gross income (AGI). Although the medical expense deduction threshold is increased generally beginning in 2013 from 7.5% to 10%, the increase in the threshold is waived for taxpayers age 65 and older for tax years 2013 through 2016. Beginning in 2017, the 10% of AGI threshold on the deduction of unreimbursed medical expenses for taxpayers who itemize deductions applies to all taxpayers regardless of age. *Self-employed persons*[[32]](#footnote-32) may also deduct such premiums not in excess of the dollar limitations without the need for medical care to exceed an AGI threshold. In short, tax-qualified long term care insurance policy premiums are 100% tax-deductible to the extent they don’t exceed the dollar limits.

The amount of any long term care insurance premium that may be included in medical care, however, is further limited by certain dollar maximums that are indexed for inflation and which change as the insured’s attained age changes. The dollar limitations applicable to tax-qualified long term care premiums in 2015 are:

|  |  |
| --- | --- |
| Attained Age BeforeClose of Tax Year | Limitation on Premium\* |
| 40 or younger | $380 |
| 41 to 50 | $710 |
| 51 to 60 | $1,430 |
| 61 to 70 | $3,800 |
| Older than 70 | $4,750 |
| *\* Indexed for inflation* |

### Tax-Qualified Long Term Care Benefits Tax-Free within Limits

Just as the treatment of a tax-qualified long term care insurance policy as an accident & health insurance contract results in the tax-deductibility of premiums within certain limits, it also affects the tax treatment of benefits. Benefits, other than dividends or premium refunds, received under a tax-qualified long term care insurance policy are treated as reimbursements for expenses incurred for medical care and are generally not included in the recipient’s income. Also similar to the tax treatment of premiums, the benefits from a tax-qualified long term care insurance policy that may avoid inclusion in the recipient’s income are limited by certain dollar maximums.

Benefits received under tax-qualified long term care insurance policies that may be excluded from income are those benefits not exceeding the greater of:

* The applicable *per diem* limitation for the year; or
* The costs incurred for qualified long term care services provided for the insured.

The applicable *per diem* limitation for 2015 is $330. The *per diem* limitation amount is adjusted each year for inflation.

### Tax Treatment of Nonqualified Long Term Care Insurance Policies

The discussion of the tax treatment of tax-qualified long term care insurance should cause any reader to wonder about the tax treatment of nonqualified long term care insurance policies that were not grandfathered. The Internal Revenue Code does not address the tax treatment of premiums for, or benefits from, long term care insurance policies that do not meet the criteria for tax-qualified policies. Accordingly, any definitive answer on their tax treatment is little more than speculation.

Some observers have suggested that the favorable income tax treatment given by Congress to tax-qualified long term care insurance policies indicates that nonqualified long term care insurance policies will not receive favorable tax treatment. At present there is no clear answer. For any agent or other adviser who recommends a nonqualified long term care insurance policy to a client, one thing is clear: be sure to recommend that your client consult with his or her tax adviser before making a decision.

## Alternatives for Paying Long Term Care Costs

Despite the overpowering logic behind the purchase of long term care insurance—the risk of needing long term care is high and its cost is significant—sales results have been disappointing. The principal reason for those disappointing sales appears to be the high cost for long term care insurance. In light of that concern on the part of would-be long term care insurance purchasers, this section will examine some alternatives that may be available for paying the costs of long term care. Accordingly, we will look at:

* Accelerated death benefits payable under life insurance policies;
* Viatical settlements; and
* Long term care riders and other provisions on life insurance policies and annuity contracts.

### Accelerated Death Benefits

Until the decade of the 1990s, life insurance policyowners who needed cash and looked to their life insurance policies to provide it were able to access any cash value through policy loans or—in the case of universal life insurance policies—through cash value withdrawals. In order for the death benefit or any part of it to be paid, regardless of the reason, the insured must have died.

In the early 1990s, some insurers began to offer to pay death benefits to terminally-ill insureds during their lifetime rather than waiting until the insured died. Insurers that elected to make such accelerated death benefits available took varying approaches to it.

Some insurers:

* Paid an amount equal to the entire death benefit;
* Paid an amount equal to some percentage of the death benefit, such as 50% or 75%;
* Paid a portion of the death benefit and deducted interest on the amount paid from the balance of the death benefit.

The popularity and accessing of accelerated death benefits has grown substantially since the concept was introduced. The policyowner is able to use the accelerated death benefit funds for any purpose, including payment for long term care services.

One of the concerns with respect to payment of these accelerated death benefits was their taxability. The Health Insurance Portability and Accountability Act of 1996—generally referred to simply as HIPAA—resolved that issue by generally ensuring that accelerated death benefits used to fund long term care are income tax-free.

Although this source of funds may be an appropriate place from which to obtain the needed cash to pay for long term care benefits, it also has certain drawbacks. One of the most obvious drawbacks to taking accelerated death benefits from an existing life insurance policy is that the original use of the death benefits—to provide income for a surviving spouse, for example—may still apply. Specifically, the terminally-ill insured needing long term care may leave a widow or widower whose income depends on the death benefits. If the death benefits are accelerated there may be little remaining for the surviving spouse.

The other potential drawback to using accelerated death benefits for the payment of long term care costs relates to the triggering event required before accelerated death benefits are payable. Some insurers will pay accelerated death benefits only if the insured is terminally ill, although other insurers may pay if the insured is:

* Terminally ill, or
* Chronically ill.

If the insurer only pays accelerated death benefits for terminally-ill insureds and defines “terminally-ill” as having a life expectancy of 6 months or less, such accelerated death benefits may be of little use to an insured.

### Viatical Settlements

An alternative to accelerated death benefits as a means of paying for long term care is a viatical settlement. A viatical settlement allows a policyowner to receive payment of a portion of a life insurance policy’s death benefit that is often far in excess of its cash valueduring the insured’s lifetime*.* It involves the sale of a life insurance policy to a third party:

* In return for a percentage of the policy’s death benefit
* By an individual who has a life-threatening illness.

Viatical settlements normally involve insureds suffering from a terminal illness who have a life expectancy not exceeding 48 months. However, *tax-free* viatical settlements are limited to such settlements involving terminally-ill or chronically-ill individuals as those terms are defined by the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA defines:

* A *terminally-ill* person as an individual with a life expectancy of 24 months or less; and
* A *chronically-ill* individual as someone who –
	+ Is incapable of at least two activities of daily living, such as eating, bathing and toileting and
	+ Requires substantial supervision.

The process of obtaining a viatical settlement involves completing an application, which is sent to a viatical settlement broker, and providing a medical release to the policyowner’s physician allowing the release of medical information. The broker normally presents the information thus obtained to several potential buyers of the policy and solicits offers. The offers made are presented to the policyowner for a decision.

Viatical experts suggest that any policyowner interested in considering a viatical settlement follow the steps shown below:

* Discuss the insured’s life expectancy with a physician;
* Get no fewer than five bids from viatical settlement companies;
* Obtain competent legal and financial advice to evaluate bids;
* Weigh the immediate need for cash against the future needs of beneficiaries;
* Ask the insurance company to split a large policy into several smaller policies so that they may be sold as needed; and
* Find out how often the viatical settlement company will make contact with the insured to track its investment and the method it plans to use to make contact.

Although viatical settlement companies normally pay between 60% and 80% of a policy’s death benefit, the amount a life insurance policyowner can expect to obtain for the policy when sold depends upon several factors:

* The insured’s life expectancy;
* The amount of the annual premium;
* The financial rating of the insurer;
* The type of policy;
* The market rate available on other similar investments; and
* Whether the policy is beyond the contestability period.

Even though viatical settlements are *negotiated* between the viatical settlement company and the policyowner, the Viatical Settlements Model Act offers certain standards for viatical settlements that are adjusted slightly downward for lower-rated life insurers. Those suggested standards are as shown in the chart below:

|  |  |
| --- | --- |
| ***Insured’s Life Expectancy*** | ***Minimum Percent of Death Benefit Less Loans Received by Policyowner*** |
| Less than 6 months | 80% |
| At least 6 but less than 12 months | 70% |
| At least 12 but less than 18 months | 65% |
| At least 18 but less than 24 months | 60% |
| Twenty-four months or more | 50% |

The principal drawback to selling a life insurance policy to a viatical company is the same as we noted with respect to accelerated death benefits: those benefits will no longer be available to the policy’s original beneficiary. However, if that need to provide funds at death is no longer present, the use of accelerated death benefits or a viatical settlement as a way to finance long term care may be appropriate.

### Long Term Care Funds from Annuity Contracts

Long term care may be financed by a rider added to an annuity contract. In fact, a motive for many nonqualified annuity purchases is to accumulate funds that may be used to provide long term care. So, the combining of long term care insurance benefits with annuity benefits would likely further the objectives of many annuity purchasers. There are two approaches that are normally taken with respect to annuities and long term care:

* + - * A crisis waiver; or
			* A long term care insurance benefit.

#### Crisis Waivers

Crisis waivers permit an annuity contract owner to withdraw funds in specified circumstances from the contract during the contract’s surrender charge period without incurring any surrender charge penalty. They are called *crisis waivers* because they apply during what might easily be termed crisis periods in the contract owner’s life. Although these crisis waivers enable the contract owner to avoid surrender charges, they provide no additional benefits to pay for long term care.

Waiving surrender charges under these crisis waivers requires that a specified crisis condition exist. Conditions under which insurers may waive surrender charges include:

* + - * Nursing home admission;
			* Suffering a terminal illness;
			* Unemployment; and
			* Disability.

Annuity contract crisis waiver provisions vary. Some require that the contract have been in force for a minimum period; others require that the crisis occur before the owner reaches a specified age. There is also variation with respect to cost: some insurers charge an additional premium for the waiver; other insurers do not.

#### Long Term Care Insurance Riders on Annuity Contracts

In some cases, long term care insurance benefits can be added to annuity contracts by rider. These riders can provide some or all of the long term care insurance benefits normally provided in a stand-alone long term care insurance policy. Unlike annuity crisis waivers or integrated long-term care/annuity benefits (see below), long term care benefits under this type of arrangement are payable without any impact on the annuity’s accumulated value. One of the practical problems of long term care insurance riders, however, is their need for ongoing premium payments.

An approach to paying long term care insurance rider premiums is through a charge against the cash value of an underlying annuity contract. For tax years beginning after 2009, such a charge from an annuity for purposes of paying the premium for a long term care insurance rider attached to the contract will not be includible in the contract owner’s gross income. Instead, the charge will simply reduce the contract’s cost basis.

#### Integrated Long Term Care/Annuity Benefits

Another long term care-annuity arrangement that can reduce long term care insurance costs—a design that has become very popular—integrates the annuity’s cash value with long term care protection. Such annuity contracts are generally referred to as hybrid contracts.

Three design approaches are used by insurers in fixed annuity/LTC hybrid products. These approaches are referred to as the:

* Tail design;
* Coinsurance design; and
* Pool design.

Benefits for long term care in all three product designs normally involve the payment of both the annuity’s cash value and an independent insurance benefit. The principal difference between the three approaches relates to the point at which the independent benefit is payable.

Under a tail design, long term care benefits are paid out of the annuity’s cash value—and deplete the cash value on a dollar-for-dollar basis—until the cash value is exhausted. At that time, independent benefits begin, and long term care benefits continue at the same monthly amount for the period specified in the long term care provisions of the annuity contract or rider.

Under a coinsurance design, long term care benefits are immediately comprised of part cash value withdrawal and part independent insurance benefits. Thus, each monthly long term care benefit contains part cash value withdrawal and part independent insurance benefit until the maximum benefit limit is reached.

Under a pool design, a pool amount is created when the annuity is issued. The pool amount is applied for on the application for the annuity/LTC hybrid contract and is the maximum amount available to pay long term care expenses; the pool amount and the annuity cash value need have no relationship. As benefits are paid, the remaining pool and the annuity’s cash value are each reduced in an amount equal to the paid benefits. When the cash value is exhausted, all remaining monthly long term care benefits are independent insurance benefits.

### Long Term Care Funds from Life Insurance Policies

Life insurance policies may also provide long term care funds. The approaches that may be employed using a life insurance policy include:

* An integrated life insurance-based long term care product; and
* A simple long term care insurance rider added to a life insurance policy.

#### Integrated Life Insurance-Based Long Term Care

An integrated life insurance-based approach involves the purchase of a life insurance policy, usually on a single premium basis, to which a long-term care benefit provision has been added. Typically, that design produces an additional potential fund equal to twice the policy’s death benefit.

In such a case, a client might allocate $100,000 that is languishing in a low-interest account to purchase a $150,000 single premium life insurance policy that provides a $300,000 long term care benefit. The funds used to purchase the single premium life insurance policy earn interest at the insurer’s declared rate and may be accessed by the policyowner.

If the insured policyowner dies without ever having used the long term care benefit, a minimum of $150,000 would be payable as a death benefit. However, if the insured policyowner requires long term care he or she may accelerate the death benefit to pay for care. When the death benefit has been entirely depleted, the insured may access the long term care benefit for an amount up to some multiple of the policy’s death benefit. If the insured policyowner uses the entire amount of the long term care benefit no further long term care benefits of any type are available. This approach has the advantage of avoiding the possibility the insured will have paid significant long term care premiums that are lost when he or she dies without needing such care.

For example, under a hybrid long-term care life insurance policy, the insured may have a monthly long term care benefit equal to the initial death benefit divided by 24. Thus, each month after initially satisfying an elimination period—typically 90 days—the insured may access 1/24th of the death benefit to pay for long term care. When the death benefit has been depleted, the long-term care component of the hybrid policy begins to pay long-term care benefits of the same monthly amount. Those additional long-term care benefits—paid under a rider that is normally referred to as an “Extension of Benefits Rider”—may continue for an additional two to four years, depending on the selection made by the policyowner at the time of application for the coverage.

So, suppose an insured purchased a $100,000 hybrid life insurance/LTC policy and subsequently met the criteria for long-term care benefits to be payable. After the elimination period, the insured could accelerate up to $4,166 each month to pay for long-term care. At the end of 24 months, his or her death benefit—except for a 10% residual death benefit—would be gone, and monthly long-term care benefits of $4,166 would be paid under the Extension of Benefits Rider.

#### Long Term Care Insurance Riders on Life Insurance Policies

Just as we discussed in connection with annuity contracts, non-integrated long term care insurance benefits can be added to life insurance policies by rider. These riders provide long term care insurance benefits without affecting the life insurance policy’s cash value.

Long term care insurance rider premiums may be paid by a charge against the policy’s cash value. Similar to the treatment of charges against an annuity contract’s cash value to pay long term care rider premiums after 2009, a charge against the life insurance cash value to pay long term care rider premiums will not be includible in the policyowner’s gross income even if the total of such charges exceeds the owner’s cost basis. Instead, the aggregate charges to pay such premiums will simply reduce the policyowner’s cost basis.

## Summary

Insurers take two approaches in their delivery of long term care insurance benefits: a “pool of money” approach; and a specified daily benefit and benefit period approach. In a long term care insurance policy employing the pool of money approach, the duration of the long term care daily benefit is not stated. Instead, the policy specifies a maximum daily benefit limit, and a lifetime benefit amount. The second approach to delivering long term care insurance benefits taken by insurers is to specify a daily benefit amount and a benefit period.

Insurers using a specified daily benefit amount in their long term care insurance policies may pay benefits under an indemnity provision or a reimbursement provision. When benefits are paid under an indemnity provision, the specified daily benefit is paid regardless of the actual cost for the covered care. Under a reimbursement provision the benefit payable is equal to the lesser of the actual charges for the care or the specified daily benefit. In other words, the benefit would not exceed the actual charges incurred.

Long term care insurance benefits become payable when the insured satisfies a benefit trigger. A benefit trigger is a condition specified in the policy that may result in the payment of a long term care insurance benefit. The traditional benefit triggers in a long term care insurance policy are the insured’s inability to perform a specified number of activities of daily living, the insured’s having an impairment in cognitive ability or a physician’s finding that receiving long term care services is a medical necessity for the insured.

The Health Insurance Portability and Accountability Act (HIPAA) removed medical necessity as a benefit trigger in tax-qualified long term care policies issued on and after January 1, 1997. Thus, HIPAA defined a tax-qualified long term care policy as one having only the loss of ability to perform ADLs and impairment in cognitive ability as benefit triggers. Current long term care insurance policies generally require that the insured be unable to perform 2 or more ADLs in order to trigger a benefit or have a cognitive impairment.

Cognitive impairment is a separate benefit trigger unrelated to the inability to perform ADLs and does not require that the insured be unable to perform any particular function in order to receive a long term care insurance benefit. It is generally defined as a condition resulting in a deficiency in the individual’s memory, orientation as to people, place, or time, reasoning or judgment as it relates to safety awareness.

Like other insurance policies, long term care insurance policies contain a large number of provisions that define and limit the risk being insured and the benefit payable. While any policy provision may affect the benefit received by a particular insured, some of the provisions affect a large number of insureds and will be briefly summarized.

An elimination period or waiting period in a long term care insurance policy is the period of time beginning with the insured’s receipt of covered long term care and ending when long term care benefits begin to accrue. An insured normally needs to meet the elimination period only once in his or her lifetime. Long term care insurance policy elimination periods typically offered by insurance companies are 15 days, 20 days, 30 days, 60 days, 90 days 100 days, 120 days, 150 days, 180 days, and 365 days. The most common elimination period chosen is 20 days, apparently because it coincides with the 20 days of eligible skilled nursing care that is paid in full by Medicare.

A grace period is the length of time following the date a premium is due during which the insured may pay the premium without the policy lapsing for nonpayment. In a long term care insurance policy, the grace period that applies to any premium not paid by the due date is usually 65 days.

Lapsed long term care insurance coverage may be reinstated. Coverage is reinstated when approved by the company or, if not previously disapproved by the company it will be automatically reinstated on the 45th day following the date of the conditional receipt given to the insured. The reinstated long term care insurance policy will cover only those expenses incurred for a covered loss beginning after the date of reinstatement.

A free-look period is the period of time the insured has following delivery of a policy to return it to the insurer for a complete premium refund. The free-look period in the case of a long term care insurance policy may be considerably longer than normally found in connection with other insurance types, depending on the regulations in the state in which the insured lives and the insurance company issuing the coverage. In many states the minimum free-look period applicable to a long term care insurance policy is 30 days.

A policy’s renewability provision is the provision that enables the insured to continue the policy in force. In order for a long term care insurance policy to be tax-qualified it must be guaranteed renewable, i.e. the insurer cannot cancel the policy and has the right to increase premiums for the coverage only on a class basis.

Long term care insurance policies may be rescinded by an insurer only specified requirements are met. When the policy has been in force for less than 6 months, the insurer may rescind the policy or deny an otherwise valid long term care insurance claim by showing the applicant made a misstatement on the application for coverage and that the misstatement was material to the insurer’s acceptance of coverage. After the policy has been in force for at least 6 months but less than 2 years, the insurer may rescind the policy or deny an otherwise valid long term care insurance claim by showing the applicant made a misstatement on the application for coverage, that the misstatement was material to the insurer’s acceptance of coverage, and that the misstatement pertains to the condition for which benefits are sought. After the policy has been in force for at least 2 years, the insurer may rescind the policy or deny an otherwise valid long term care insurance claim only by showing the applicant knowingly and intentionally misrepresented relevant facts relating to the insured’s health.

Long term care policies contain exclusions that specify conditions for which a benefit would not be payable. The exclusions that are normally contained in a long term care insurance policy, and for which no payment is made, include charges or treatments a) for self-inflicted injuries, b) required because of the insured’s participation in a riot, felony, or insurrection, c) required due to war, d) for alcoholism or drug addiction, e) not normally made in the absence of insurance, f) provided by a member of the insured’s immediate family, unless specified requirements are met, or g) provided outside the U.S. except as provided under an International Coverage Benefit.

Pre-existing condition exclusions are exclusions that enable the insurer to avoid payment for conditions the insured had at the time of applying for a long term care insurance policy. Tax-qualified long term care insurance policies are limited to a “6 and 6 pre-existing conditions exclusion” under which they may exclude pre-existing conditions occurring within 6 months following the policy’s effective date and which defines a pre-existing condition as a condition for which advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage.

Inflation protection provisions generally increase the long term care insurance benefit to offset the rising cost of care resulting from inflation. The usual inflation protection optional benefits offered in a long term care insurance policy increase policy benefits without any increase in premium by a) 5% of the original benefit each year (a simple inflation protection approach), or b) 5% of the previous year’s benefit each year (a compound inflation protection approach).

The inflation protection benefits provided on long term care insurance policies a) increase the benefit each year without reference to an external index, such as the CPI, and b) increase the policy benefit each year regardless of whether or not the insured is on claim.

In order for long term care services to receive favorable tax treatment, the individual receiving them must meet the “chronically-ill” definition included in HIPAA. HIPAA defines a chronically-ill individual as one who is unable to perform at least two ADLs without assistance or who requires substantial supervision to be protected from threats to health and safety due to a severe cognitive impairment.

Tax-qualified long term care insurance policy premiums not exceeding certain limits based on the insured’s age are included in the definition of “medical care” and are, therefore, eligible for income tax deduction to the extent such medical care expenses exceed the applicable AGI threshold. The amount of paid long term care insurance premiums that may be deducted as a medical expense generally increases as the taxpayer becomes older.

In addition to premiums that receive favorable tax treatment, benefits received under tax-qualified long term care insurance policies may be excluded from income to the extent not exceeding the greater of a *per diem* limitation and the costs incurred for the long term care services. The *per diem* amount is adjusted annually for inflation.

Although the risk of needing long term care services is great and the cost for obtaining those services is high, sales of long term care insurance have generally been disappointing due principally to the high cost of coverage. As alternatives to stand-alone long term care insurance, individuals may be able to fund some or all of their care through the use of a) accelerated death benefits payable under life insurance policies, b) viatical settlements in which existing life insurance policies are sold in a secondary market to a viatical provider, c) or long term care riders and other provisions on life insurance policies and annuity contracts.

## Chapter Review

* + - 1. John has a long term care insurance policy that provides a daily benefit of $200 and pays benefits under an indemnity provision. What benefit would be paid if the charges for his covered care were $175, assuming the elimination period had been satisfied?
	1. $0
	2. $200
	3. $175
	4. $375
		+ 1. What is the grace period in a long term care insurance policy that normally applies to a premium not paid by the due-date?
	5. 5 days
	6. 10 days
	7. 30 days
	8. 65 days
		+ 1. All tax-qualified long term care insurance policies must have a/an \_\_\_\_\_\_\_ renewability provision.
	9. conditional
	10. noncancelable
	11. optional
	12. guaranteed renewable
1. Arthur is a 62 year-old self-employed taxpayer whose adjusted gross income last year was $100,000. If he paid tax-qualified long term care insurance premiums of $6,000 and had other medical expenses of $4,500, what is his maximum tax deduction for long term care insurance premiums assuming the premiums do not exceed the applicable dollar limit?
2. $0
3. $500
4. $2,500
5. $6,000

[See answers to chapter quiz at end of course.](#_Chapter_3)

# Chapter 4 - Suitability & Ethical Issues

## Key Points

* A long term care insurance policy is not suitable for a client if paying for it can be expected to adversely affect his or her ability to meet monthly bills;
* Medicaid is not accepted by all long term care facilities;
* In order to properly assess suitability of long term care insurance for a client, an agent must be aware of the client’s financial status, personal situation, and health history;
* In general, a cogent argument can be made in favor of self-funding any long term care need for clients with investable assets in excess of $1.5 million;
* Since many diseases appear to have a genetic component, understanding a client’s health history and that of his or her family can help in estimating the likelihood the client may eventually require long term care;
* Proposed long term care insurance coverage and the insurer providing it must be investigated to help assess suitability;
* An insurer’s ability to pay long term care insurance benefits depends on its financial condition and stability;
* Clients should not ordinarily choose an insurer for long term care insurance coverage with an A.M. Best or Moody’s rating that is B or below—or a Weiss rating of less than B+;
* An insurance company’s past history of long term care insurance premium rate increases may indicate the likelihood the insurer will seek such rate increases in the future;
* The length of time an insurer has been selling long term care insurance may be a good indication of its ability to appropriate underwrite coverage and administer claims properly;
* An agent recommending long term care insurance is ethically required to provide all the material facts needed by the client to make an informed decision concerning the recommendation; and
* If a client does not benefit by a long term care insurance policy replacement, it should not take place.

## Introduction

As we saw in Chapter 2, long term care is expensive and the likelihood of requiring it is fairly great. Because of those factors, purchasing comprehensive long term care insurance in an amount sufficient to meet clients’ needs is likely to require their allocation of substantial funds to pay premiums. The important question you and your client need to ask is whether buying long term care insurance is right for him or her. In this chapter we will discuss this important suitability issue.

In addition to the consideration of the suitability of any long term care insurance policy recommendation and sale, we will also look at the long term care insurance sales process. And, in reviewing that process we will examine the important ethical issues agents are likely to encounter.

## Chapter Learning Objectives

When you have completed this chapter, you should be able to:

* Identify the factors that affect the suitability of long term care insurance for an individual client;
* Recognize the client disclosures that should be made in any ethical long term care insurance recommendation; and
* Describe the special suitability and disclosure requirements applicable to the replacement of a long term care insurance policy.

## Suitability

The purchase of long term care insurance isn’t appropriate for every client. The function of suitability analysis is to determine whether a specific long term care insurance policy is right for your client. Whether or not a long term care insurance policy is suitable for the client and, if so, whether a particular product offering is desirable, is a decision the client and adviser should arrive at after careful evaluation. In making that evaluation, keeping certain benchmarks and concepts in mind may be helpful.

### Long Term Care Suitability Considerations

It would be so much simpler to make the suitability decision if the parameters were obvious and unchanging—if, for example, we could simply total the client’s assets and come to the right answer. With a single exception, the job is more complex.

Let’s deal with that single exception first. We can determine that purchasing a long term care insurance policy is not suitable for a client if paying for it can be expected to adversely affect his or her ability to meet monthly bills. The client who would need to reduce expenditures for food, prescription drugs or other essentials in order to afford to pay a long term care insurance policy premium is clearly unsuitable. For other clients, the answer often is not so simple or so clear. To effectively work with those other clients in determining suitability, we can turn to some basic concepts.

#### NAIC Suitability Tests

The National Association of Insurance Commissioners (NAIC) has suggested that clients should be discouraged from purchasing long term care insurance if their assets fail to meet certain minimum levels or if the policy’s premium exceeds a specified percentage of income. Under the suggested income and assets tests, a decision that a long term care insurance policy is unsuitable if either of the following applies:

* The client’s financial assets are less than $35,000; or
* The long term care insurance policy’s annual premium exceeds 7% of the client’s annual income.

The thinking behind these suggested criteria is that if the client’s financial assets are so modest, he or she has little to protect from the required Medicaid spend-down with long term care insurance. If such a client requires long term care services or treatment, Medicaid will fund them. Furthermore, if policy premiums exceed 7% of income the client would be required to forgo other essential purchases.

The NAIC’s suggested assets and income tests may provide some benchmarks to help arrive at an appropriate decision as to suitability. It is important, however, to view them only as benchmarks rather than as strict criteria on which to judge whether long term care insurance is suitable for a specific client. We can see why slavishly following the suggested criteria might result in a wrong decision by looking behind them and questioning the reasoning.

With respect to financial assets, the rationale is that having few assets to protect or pass on to heirs means that long term care insurance shouldn’t be purchased. If the adviser and client accept that reasoning, they may overlook other reasons to consider purchasing a long term care insurance policy—reasons such as to help maintain independence and dignity, and to avoid being “warehoused.”

The usual alternative for clients with few financial assets and no long term care insurance who require long term care is Medicaid. Medicaid, however, is not accepted by all long term care facilities. In some locations nursing homes that accept Medicaid are generally considered among the least desirable. Furthermore, nursing home residents whose care is being financed by insurance rather than under a program for the indigent have more options—they can move to another facility—and, provided they are aware, they may be better able to maintain a sense of personal dignity while coping with the infirmities and indignities that may accompany advanced age.

The same argument may be made with respect to the client’s income relative to the long term care insurance policy’s premium. Bearing in mind that a client who must decide between paying a premium and filling a prescription is not suitable, we can, nonetheless, identify older clients for whom the suggested income test might not apply. Some of these clients may be able to easily cut back on discretionary expenditures to be able to better afford needed long term care insurance protection. It is not necessary to spend two months in Europe each year or to purchase a luxury car every two years if doing so means that needed long term care insurance coverage is forgone.

The point behind each of these arguments in defense of a long term care insurance policy purchase is that these NAIC criteria should be seen as reference points on a map that brings you and your client to the proper suitability decision rather than as hard and fast tests that should be applied in every case.

The answer to the question of suitability for any specific client lies in an evaluation that takes account of:

* Your client’s financial and personal situation;
* The coverage to be recommended; and
* The insurer offering the coverage.

In short, you need to know both your customer and your coverage.

#### Evaluating the Client’s Financial and Personal Situation

Knowing your customer obviously means more than being acquainted with him or her. Rather, it requires that you understand the client’s:

* Financial status;
* Personal situation; and
* Health history.

That level of client knowledge demands that you, as the agent or adviser, perform a thoroughgoing data-gathering with the client to obtain that information.

Although we suggested earlier that the NAIC income and asset suitability guidelines be reference points along the path towards a suitability determination rather than definitive criteria, the fact is that the client’s financial status plays an important role in the suitability calculus. The most important financial issue with respect to suitability is affordability of appropriate long term care insurance coverage. If it cannot be purchased without requiring the client forgo essentials to afford the coverage, it is unsuitable.

The client’s assets need to be considered in determining suitability. In general, for clients with investable assets in excess of $1.5 million, a cogent argument can be made in favor of self-funding any long term care need. That does not mean that a client with more than $1.5 million in investable assets should not purchase long term care insurance. It means only that the assets and the income those assets produce need to be considered.

The client’s personal situation also must be thoroughly considered. In evaluating a client’s personal situation it is important to understand if other needs have been provided for. For example, does the client have other people who depend on him or her? Those others might be a:

* Spouse, or
* Child or grandchild with special physical, emotional or mental health needs.

If the client must make financial provision for others, that requirement must be taken into consideration in determining suitability.

Long term care is often required because the client has suffered some type of debilitating disease. Since many diseases appear to have a genetic component, an understanding of the individual’s health history and that of his or her family can help the adviser and client to better estimate the likelihood the client may eventually require long term care. Since longevity is often a family characteristic—and individuals likely to live to be very old are at greater risk of needing long term care—the age of ancestors is an important piece of information.

Among the conditions that ordinarily signal a need for eventual long term care are:

* Alzheimer’s Disease,
* Multiple Sclerosis,
* Heart Disease,
* Parkinson’s Disease, and
* Stroke.

#### Evaluating the Coverage

When a complete evaluation of the client and his or her situation has led you to the conclusion that the client is a suitable prospect for long term care insurance coverage the focus of the suitability determination turns to an evaluation of the long term care insurance policy. Is the coverage right for the client?

Knowing that many long term care services can be offered in various settings—some of which are likely to be more attractive to your client than others—you and the client need to ask certain questions relative to the coverage. For example, it is important to know whether long term care services:

* Are covered in all of the settings; and
* Include companion and homemaker services as covered services.

It is vitally important to understand the benefit triggers that apply in any long term care insurance policy being recommended.

* Does the policy require the client to be unable to perform 2 or more ADLs or have a cognitive impairment as benefit triggers?
* How stringent is the testing required under the policy to determine an insured has a cognitive impairment?

With respect to benefits:

* Does the policy specify a daily benefit and benefit period, or does it provide the additional flexibility of a pool of money approach?
* Is policy payment made on a reimbursement or indemnity basis?
* What are the client’s choices with respect to –
	+ Daily maximum,
	+ Lifetime maximum,
	+ Elimination periods, and
	+ Inflation protection.
* Can the client hire anyone—family members included—to provide personal care and homemaker services under the policy?

The policy’s elimination period must be satisfied before long term care insurance benefits begin. With respect to the elimination period:

* What, if any, benefits under the policy are not subject to the elimination period?
* Does the client’s receipt of home care services count towards any elimination period? If so, on what basis?
* Does the elimination period need to be satisfied for every period of required long term care, or may it be satisfied only once?

Does the policy:

* Impose limitations on benefits for pre-existing conditions?
* Provide a bed-holding benefit so the client can visit family, be admitted to a hospital, etc. without losing his or her long-term care services?
* Pay for home modifications, medical equipment and caregiver training, if needed, to enable the client to receive long term care services at home?

#### Evaluating the Insurer

Long term care insurance benefits are secured by the general assets of the insurer. That is another way of expressing that the insurer’s ability to pay long term care insurance benefits depends on its financial condition and stability. For that and for other reasons, the insurer offering the product needs to be considered.

Several rating agencies provide financial and claims-paying ratings for insurance companies. Among those agencies are:

* Standard and Poor’s;
* Weiss;
* A.M. Best; and
* Moody’s.

Although any of these rating organizations can provide meaningful information on the insurer and its management, clients are generally cautioned to select an insurer with strong financials. Accordingly, clients should not ordinarily choose an insurer for long term care insurance coverage with an A.M. Best or Moody’s rating that is B or below—or a Weiss rating of less than B+.

The cost and utilization of long term care services are expected to increase in the future, and that may mean your client’s premium for long term care insurance coverage may also increase and become unaffordable. Since insurers are not permitted to increase long term care insurance rates without seeking insurance department approval, every time an insurer seeks to hike its rates in a particular state the regulators know about it. Information about those increases is generally available and should be obtained; you and your client will want to know the company’s history of premium rate increases.

Gaining expertise in any field is usually a result of long experience. That applies to insurers as well as it does to any other individual or firm. The ability to appropriately underwrite and administer claims for long term care insurance is likely to improve the longer the company remains in the long term care insurance business. Accordingly, you and the client should know how long the insurer has been selling long term care insurance. Generally, the longer the insurer has been in the long term care insurance business the greater the likelihood it will do the job well.

It is also important to understand the insurer’s commitment to meeting policyholders’ long term care needs. Accordingly, you should determine if the insurer offers your clients certain long term care advisory and other services without charge? Such services could include:

* Advice concerning the sources of caregiving in your client’s community;
* Negotiated discounts on caregiver services;
* Assistance with filing claims;
* Information about the quality of care provided by various nursing homes, ALFs, and home health care providers; or
* Care advocates that may help identify providers of long term care services that are appropriate for your client.

## Ethical Issues

Important ethical issues that involve long term care insurance often involve disclosure and replacement. In this section we will briefly review these concerns.

### Disclosure

In the final analysis, the determination of the appropriateness of a recommendation for long term care insurance is one that needs to be made by the client. As an agent and adviser to the client, your task with respect to disclosure must be to provide all the material facts needed by the client to make an ***informed decision*** concerning the recommendation. At the very minimum, that means informing the client about:

* Medicaid as a source of long term care funding and the requirements the client would be required to meet to obtain it;
* The coverage provided by the recommended long term care insurance policy and the settings in which such coverage is not provided;
* What is required (inability to perform 2 ADLs, cognitive impairment, etc.) to obtain benefits under the proposed policy;
* The type of approach used by the insurer in paying benefits, i.e. pool of money or specified daily benefit and benefit period;
* Whether the policy pays benefits on a reimbursement or indemnity basis and what that means to the client;
* The availability of an extended Free-Look period to enable the client to review the coverage;
* How, and how frequently, the client will be expected to satisfy the policy’s elimination period; and
* Limitations on benefits for pre-existing conditions.

 With respect to the insurer, the agent should disclose to the client:

* The insurer’s history of long term care premium rate hike requests;
* The insurer’s financial strength and rating; and
* How long the insurer has been in the long term care insurance market.

### Replacement

Insurers tend to improve coverage over time in order to provide needed benefits and improve their competitive position. So, it is possible that a long term care insurance policy purchased years ago may not contain some of the benefits routinely provided on more recent product offerings.

An ethical replacement requires that the client be benefited by the change in his or her long term care insurance coverage. If the client does not benefit, the replacement should not take place. In addition, if the client’s long term care policy was issued before January 1, 1997 its replacement would cause the client to lose the benefit of the grandfathered tax treatment.

Beginning in 2010, IRC §1035—the provision of the tax code that permits tax-free exchanges of life insurance, endowments and annuities—has been broadened to facilitate exchanges of such products containing long-term care provisions. Thus, under the broadened exchange provision, a client may make the following tax-free exchanges, ***regardless of whether the policy or contract involved in the exchange contains a qualified long-term care contract*:**

|  |  |
| --- | --- |
| ***Exchange may be made from…*** | ***Exchange may be made to…*** |
| A life insurance policy | A life insurance policyAn endowment contractAn annuity contractA qualified long term care insurance contract |
| An endowment contract | An endowment contractAn annuity contractA qualified long term care insurance contract |
| An annuity contract | An annuity contractA qualified long term care insurance contract |
| A qualified long term care insurance contract | A qualified long term care insurance contract |

#### Replacement Suitability

Changes in the tax law facilitating and broadening the rules governing tax-free exchanges may cause clients to be more willing to consider replacing existing life insurance policies and annuities for new contracts providing long-term care benefits. While such exchanges offering clients expanded coverage may be appropriate, they must be suitable for the client.

The guiding ethical principle with respect to any such exchange is that it must be in the best interest of the policyowner when considered in its entirety. If it is not in the client’s best interest, it should not be recommended.

The suitability analysis made before recommending an exchange or replacement should consider, at the very least:

* In the case of a life insurance policy or annuity contract replaced by a hybrid long term care insurance product, the surrender charges imposed on surrender of the existing contract and the surrender charges to which the policyowner will be subject under the new contract;
* That the incontestable and suicide clauses will begin anew under the new hybrid product;
* Any grandfathered benefits under the existing contract that may be lost under the new contract;
* The expenses and fees under the existing and the proposed replacement contracts; and
* Any tax consequences.

#### Replacement Disclosure

As in the case of any long term care insurance recommendation, complete disclosure of all material facts should be made. In the case of a recommended replacement, complete disclosure requires an explanation of the relative advantages of the existing and replacement policies with respect to:

* The insurer’s financial and claims-paying rating;
* The daily benefit and maximum benefit period;
* The benefits provided;
* The long term care benefits not provided;
* The settings in which long term care benefits may be accessed;
* The settings in which long term care benefits are not available;
* The duration of the elimination period;
* How the elimination period may be satisfied;
* The benefits not subject to an elimination period;
* The benefit triggers;
* Any institutional stays required before other benefits are payable;
* The duration of any limitation on benefits for pre-existing conditions;
* Inflation protection;
* Nonforfeiture benefits; and
* Any return of premium benefits.

## Summary

A long term care insurance policy may or may not be suitable for a particular client, and a determination of its suitability should be arrived at only after careful evaluation. While purchasing a long term care insurance policy would be unsuitable for a client who would need to reduce expenditures for food, prescription drugs or other essentials in order to afford to pay for it, a long term care insurance policy also would be unsuitable for a client whose financial assets are less than $35,000 or the policy’s annual premium exceeds 7% of the client’s annual income.

The answer to the question of suitability for any specific client lies in an evaluation that takes account of the individual’s financial and personal situation, the coverage to be recommended and the insurer offering the coverage. Accordingly, an adviser evaluating the suitability of long term care insurance should be thoroughly familiar with the individual’s financial status, personal situation and health history.

In general, for clients with investable assets in excess of $1.5 million, a cogent argument can be made in favor of self-funding any long term care need. In evaluating a client’s personal situation it is important to understand if other family needs have been provided for.

Since long term care is often required because the individual has suffered some type of debilitating disease. Since many diseases appear to have a genetic component, an understanding of the individual’s health history and that of his or her family can help the adviser and client to better estimate the risk of needing long term care. Since longevity is often a family characteristic—and individuals likely to live to be very old are at greater risk of needing long term care—the age of ancestors is an important piece of information.

In light of the fact many long term care services can be offered in multiple settings—some of which are likely to be more attractive to the individual than others—the adviser needs to ask certain questions relative to whether long term care services are covered in all of the settings, and whether the coverage pays for companion and homemaker services.

The benefit triggers in the long term care insurance policy being recommended must be considered to determine a) if the policy requires the client to be unable to perform 2 or more ADLs or have a cognitive impairment in order to pay benefits, and b) how stringent the testing required under the policy to determine if the insured has a cognitive impairment. The policy’s method of determining benefits, its elimination period and applicable exclusions must be evaluated to ensure they meet the client’s needs. The insurer should be chosen only from insurers that are considered financially stable and capable of paying benefits for covered services.

Certain disclosures should be made to the individual at the time of any long term care insurance recommendation. Those disclosures should inform the client about a) Medicaid as a source of long term care funding and its requirements, b) the coverage provided and the settings in which coverage is not provided, c) the benefit triggers, d) the insurer’s benefit payment approach, and e) limitations on benefits for pre-existing conditions.

With respect to the insurer, the client should be informed concerning a) the insurer’s history of long term care premium increases, b) the insurer’s financial strength and rating, and c) how long the insurer has been in the long term care insurance market.

Like a long term care insurance policy, a replacement of one long term care insurance policy by another may or may not be appropriate. The guiding ethical principle with respect to any such exchange is that it must be in the best interest of the policyowner when considered in its entirety. If it is not in the client’s best interest, it should not be recommended. In addition, the suitability analysis made before recommending an exchange or replacement should consider a) any charges imposed, b) in the case of a hybrid product that the incontestable and suicide clauses will begin anew, c) any grandfathered benefits under the existing contract that may be lost under the new contract, d) the expenses and fees under the existing and the proposed replacement contracts, and e) any tax consequences resulting from the replacement.

Complete disclosure of all material facts should be made in the case of a recommended replacement. Thus, an adviser should explain the relative advantages of the existing and replacement policies with respect to a) the insurer’s financial and claims-paying rating, b) the daily benefit and maximum benefit period, c) the benefits provided or not provided, d) the settings in which long term care benefits may be accessed, e) the duration of the elimination period, how it may be satisfied and whether any benefits are not subject to it, f) the benefit triggers, g) any institutional stays required before other benefits are payable, h) the duration of any limitation on benefits for pre-existing conditions i) inflation protection, j) nonforfeiture benefits, and k) any return of premium benefits.

## Chapter Review

In which of the following situations is the purchase of long term care insurance clearly unsuitable?

* 1. The client has less than $35,000 in investable assets
	2. Paying the premium for the long term care insurance policy would require the client to forgo purchasing prescription medication
	3. The premium for the proposed long term care insurance policy is 8% of the client’s income
	4. The client is under age 55

What is the usual alternative for funding long term care for an individual with few financial assets?

* 1. Medicare
	2. Long term care insurance
	3. Medicaid
	4. Medigap policies
		+ 1. At what minimum amount of investable assets may self-funding of long term care be considered reasonable?
	5. $75,000
	6. $150,000
	7. $1,500,000
	8. $3,000,000

[See answers to chapter quiz at end of course.](#_Chapter_4)

# Glossary

**Activities of daily living** (ADLs) — The basic activities of caring for oneself: eating, dressing, bathing, using the bathroom ("toileting"), moving back and forth from a bed to a chair ("transferring"), and remaining continent. Insurance companies use the inability to perform a specified number of ADLs to help determine eligibility for long-term care insurance benefits.

**Adult day care facility**— A place that provides a program of activities and services to individuals in need of long-term care.

**Acute care** — Care provided by a physician or other health care professional designed to treat or cure an illness, wound, or condition.

**Alternate plan of care** — Benefits for services not specifically covered under an insurance plan.

**Alzheimer’s disease** — A progressive neurological disease that affects brain functions, including short-term memory loss, inability to reason, and the deterioration of language and the ability to care for oneself.

**Assisted living facility** (ALF) — A licensed residential facility that provides room, board and 24 hour personal care to individuals with long-term care needs.

**Automatic inflation option** — A method of protecting the value of insurance over time under which long term care insurance benefits are increased annually at a set rate irrespective of the actual inflation rate.

**Bed reservations** — A benefit found in certain long term care insurance plans under which the insurer will pay for actual charges incurred to hold a space to enable the insured to return to that facility.

**Benefit period** —The length of time long term care insurance protection will continue if care is received every day at a cost equal to or more than the policy’s daily maximum benefit amount.

**Benefit trigger** — A term used by insurance companies to refer to the requirements an insured must meet in order to become eligible for benefits. Benefit triggers in tax-qualified long term care insurance policies are (a) the inability to perform at least 2 out of 6 activities of daily living for an expected period of at least 90 days and (b) requiring substantial supervision due to a severe cognitive impairment.

**Care coordination services** — Services such as information, advice, and arranging of long-term care by a professional care coordinator.

**Caregiver** — The person who assists an individual to accomplish the basic everyday activities he or she can no longer perform without assistance due to illness, injury, or cognitive impairment.

**Chronic care** — Care provided to help maintain daily function. There is no expectation that the care recipient will improve or recover. Long-term care is chronic care.

**Cognitive impairment** — Deterioration or loss in intellectual capacity that results in impairment in some or all of the following: short and long-term memory, orientation to people, place, and time, deductive or abstract reasoning (including judgment), and ability to perform activities of daily living.

**Community-based services** — Services, such as meals on wheels and adult day care, designed to help people remain independent and in their own homes.

**Continence** — An activity of daily living that refers to the ability of the body to control urination or bowel movements or both.

**Custodial care** — Services aimed at maintaining an individual’s health and/or preventing deterioration in functional status, provided on an extended basis. Long-term care includes custodial care.

**Daily maximum benefit** — The maximum benefit amount a long-term care insurance policy will pay for eligible care in any single day.

**Elimination period** — The time between becoming eligible for benefits and when a long-term care insurance policy begins accruing those benefits. The longer the elimination period is, the lower the premiums are for otherwise comparable coverage.

**Exclusions** — Specific conditions or circumstances for which a long term care insurance policy will not provide benefits.

**Formal home care** — Care which is provided by a home health aide or homemaker arranged or supervised by a home care agency, or provided by a nurse or therapist.

**Free look period** — A protection which allows a policyowner to cancel coverage within 30 days after receipt of a long term care insurance policy and receive a complete refund of any premium paid.

**Future purchase option** — An inflation protection feature that allows a policyowner to periodically purchase additional coverage without proof of good health.

**Grace period** — The period following the due-date of any unpaid premium during which time coverage remains in force.

**Guaranteed renewable** — An insurance policy provision pursuant to which an insurer cannot cancel or fail to renew coverage because of a change in a person’s health or age. When a plan is guaranteed renewable, premiums may be changed on a class basis only.

**Health Insurance Portability and Accountability Act (HIPAA)** — Federal health insurance legislation passed in 1996 which, among other provisions, specifies conditions under which certain long-term care insurance policies qualify for tax advantages.

**Home care** — Services provided at home which may include nursing care; occupational, physical, respiratory or speech therapy; personal care; and homemaker services.

**Home health aides** — Individuals who provide care to older adults or people with disabilities at home. Training or certification may vary for home health aides, but typical services they provide include assistance with activities of daily living, managing medications, and some household tasks.

**Homemaker services** — Household chores performed for someone unable to do them on their own (e.g. shopping, light housekeeping and menu planning).

**Hospice care** – Care for those individuals who have been diagnosed with a terminal illness. Hospice care is palliative, i.e., focused on pain relief and maintaining comfort, rather than curative.

**Inflation protection** — A feature or option of long-term care insurance coverage that increases the value of benefits over time to keep pace with the anticipated increasing costs of care.

**Informal home care** — Care provided by an unlicensed caregiver whose services are not arranged and supervised by a home care agency.

**Lapse** — Termination of insurance coverage due to nonpayment of premiums.

**Lifetime maximum benefit** — The maximum amount of benefits that a long term care insurance policy could pay.

**Long-term care (LTC)** — Personal care and other related services provided on an extended basis to people who need help with activities of daily living or who need supervision due to a severe cognitive impairment. It can be provided at home, in a nursing home, assisted living facility, or an adult day care center.

**Long-term care insurance** — Insurance that helps defray the costs of assistance with the activities of daily living or the costs of supervision due to a severe cognitive impairment.

**Medicaid** — The joint federal-state program that pays for certain health care services for individuals who meet their state’s poverty guidelines.

**Medicare** — A federal health care program for most adults age 65 and older and certain disabled individuals. It pays for long-term care under limited circumstances and for limited periods of time.

**Medicare Supplement Insurance (Medigap)** — Private insurance to help pay hospital and medical costs Medicare does not cover. It pays for long-term car under limited circumstances and for limited periods of time.

**Nonforfeiture benefit** — A feature that ensures some value is provided by a policy in the event coverage is cancelled.

**Nursing home** — A licensed facility that provides 24-hour-a-day room and board, nursing care and personal care services. Nursing homes also provide medical care, therapy, and other health related services.

**Personal care** — Care to help a care recipient meet personal needs such as bathing, dressing and eating.

**Plan of care** — A plan prescribed by a licensed health care practitioner that identifies ways of meeting an individual’s need for long-term care services.

**Pool of money** — An approach to providing long term care insurance policy benefits under which insureds qualify for a specified amount of funds they can use, within limits, to pay for needed long term care.

**Premium** — The money paid to an insurance company for insurance coverage.

**Reduced paid-up benefit —** A nonforfeiture benefit provision that allows an insured to stop premium payment and retain a portion of his or her benefits.

**Respite services** — Services by a substitute provider, from a few hours to a few days, to give time off to the regular caregiver.

**Return of premium benefit** – A provision in a long term care insurance policy that allows for the return of a portion of the insured’s premium in the event of a precipitating event, such as surrender or death.

**Spend down** — A term that refers to an individual’s depletion of income and assets to meet eligibility requirements for Medicaid benefits.

**Tax-qualified** — A long term care insurance policy conforming to federal standards that enable the policyowner to receive certain federal tax advantages.

**Toileting** — An activity of daily living that refers to getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene-related tasks.

**Transferring** — An activity of daily living that refers to the ability to move in or out of a bed, chair or wheelchair.

**Underwritin**g — The process of reviewing an individual’s health status to determine eligibility for coverage under a long-term care insurance policy.

**Waiver of premium** — A provision included in many long-term care insurance policies that allows a policyowner to stop paying premiums while receiving benefits.

# Answers to Chapter Quizzes

## Chapter 1

Question #1 Feedback

1. Your answer is incorrect. Custodial care generally consists of services aimed at maintaining an individual’s health and/or preventing deterioration in functional status, provided on an extended basis. While the term “long-term care” includes custodial care, and custodial care may be delivered in a nursing home, it is not the principal type of long term care required by patients with uncontrolled, unstable or chronic conditions. Please try again.
2. Your answer is correct. Skilled care is long term care that consists principally of nursing care generally required for patients with uncontrolled, unstable or chronic conditions.
3. Your answer is incorrect. Alzheimer’s care, most often delivered in Alzheimer’s facilities, is designed principally to address the special cognitive needs of persons with Alzheimer’s disease. While an individual with Alzheimer’s disease may also have an uncontrolled, unstable or chronic condition, dealing with such a condition would not generally be accomplished through Alzheimer’s care. Please try again.
4. Your answer is incorrect. Respite care is short-term care offered by various facilities that is designed to provide temporary relief to an uncompensated caregiver from caregiving duties. It is not care designed to help a care recipient deal with an uncontrolled, unstable or chronic condition. Please try again.

Question #2 Feedback

1. Your answer is correct. Custodial care is care that primarily involves assisting individuals with the activities of daily living.
2. Your answer is incorrect. Skilled care is a type of nursing care generally required for patients with uncontrolled, unstable or chronic conditions, or for patients recovering from a medical condition that requires hospitalization or from surgery; these patients usually need a relatively high level of monitoring by nursing professionals. Although such care recipients would also receive assistance in performing ADLs, if needed, providing assistance with ADLs is not a primary focus of skilled care. Please try again.
3. Your answer is incorrect. Alzheimer’s care, most often delivered in Alzheimer’s facilities, is designed principally to address the special cognitive needs of persons with Alzheimer’s disease. Even though assistance with a care recipient’s performance of ADLs would be provided in an Alzheimer’s facility, providing such care is not the principal function of Alzheimer’s care. Please try again.
4. Your answer is incorrect. Hospice care is the term used to identify palliative care comprised of a wide range of services designed to provide health and comfort to individuals who are nearing the end of their life. Accordingly, individuals eligible for hospice care are terminally-ill and expected to live for six months or less. Often, these are people who have refused additional treatment or who are ineligible for further curative measures, such as additional surgery, further chemotherapy, etc. Please try again.

Question #3 Feedback

1. Your answer is incorrect. An *alternate care facility* is a facility that may provide needed long term care in a venue that is an alternative to a nursing home. Such facilities do not provide services performed or supervised by nurses. Alternate care facilities include assisted living facilities, Alzheimer’s facilities and custodial care facilities. Please try again.
2. Your answer is incorrect. A community-based care facility provides services designed to enable individuals to live independently in their homes for as long as possible while receiving long term care assistance. Such facilities provide services including home health care, adult day care, homemaker services and hospice care. Typically, these services are not performed by or under the supervision of nurses. Please try again.
3. Your answer is correct. A nursing home is generally defined as a facility that provides long term care services which are performed by, or under the supervision of, a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN).
4. Your answer is incorrect. Adult day care facilities provide community-based services for individuals that are frail or impaired, either physically or cognitively. The services are generally offered during what is usually considered “normal working hours,” i.e. Monday through Friday from 7:00 a.m. to 6:00 p.m., although the times and days of operation may vary from one adult day care facility to the next. Adult day care facilities are not normally under the supervision of nurses. Please try again.

Question #4 Feedback

1. Your answer is incorrect. A nursing home is a licensed facility that provides 24-hour-a-day room and board, nursing care and personal care services as well as medical care, therapy, and other health-related services. Nursing home services are performed by, or under the supervision of, a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Alternate care facilities represent an alternative to nursing homes. Please try again.
2. Your answer is correct. Alternate care facilities are facilities in which long term care may be delivered at a cost that is generally less than the cost of nursing homes. Alternate care facilities include assisted living facilities, Alzheimer’s facilities, and custodial care facilities.
3. Your answer is incorrect. Hospice refers to a wide range of palliative services designed to provide health and comfort to individuals who are nearing the end of their life. It is considered a community-based service rather than an alternate care facility. Please try again.
4. Your answer is incorrect. Independent living units offer a safe, secure, environment where individuals can choose a private lifestyle or enjoy more social benefits within a community. Except for normally providing access to social activities, independent living units generally offer no long term care services.Please try again.

Question #5 Feedback

1. Your answer is correct. The term “long term care” describes a continuum of services, and assisted living facilities can be seen as the portion of that continuum forming a bridge between long term care received in the individual’s home and nursing home care.
2. Your answer is incorrect. A skilled care facility is a nursing home providing nursing care generally required for patients with uncontrolled, unstable or chronic conditions, or for patients recovering from a medical condition that requires hospitalization or from surgery. It could not reasonably be considered a “bridge” between home care and nursing home care. Please try again.
3. Your answer is incorrect. Adult day care facilities are venues providing community-based services for individuals that are frail or impaired, either physically or cognitively. They are generally offered during what is usually considered “normal working hours,” i.e. Monday through Friday from 7:00 a.m. to 6:00 p.m. Such services enable individuals to remain in and receive long term care in their homes. Please try again.
4. Your answer is incorrect. Hospice services do not represent a bridge between receiving long term care in the recipient’s home or in a nursing home. Instead, hospice provides palliative care offering health and comfort to individuals who are nearing the end of their life and expected to live for six months or less. Often, these are people who have refused additional treatment or who are ineligible for further curative measures, such as additional surgery, further chemotherapy, etc. Many care recipients receiving hospice care die while receiving it. Please try again.

[Return to text.](#_Key_Points)

## Chapter 2

Question #1 Feedback

1. Your answer is correct. In 2014, the national average daily rate for a *private room* in a nursing home providing custodial care was $240; that is $87,600 each year.
2. Your answer is incorrect. In 2014, the national average daily rate of $212 was the rate for a semi-private room in a nursing home providing custodial care. Please try again.
3. Your answer is incorrect. A daily rate of $500 may be the minimum rate for basic services in a nursing home providing skilled care. A nursing home providing only custodial care is likely to provide such services at a substantially lower cost. Please try again.
4. Your answer is incorrect. A daily cost of $65 is the national average cost for long term care delivered in an Adult Day Care facility. Such services are community-based services for individuals that are frail or impaired, either physically or cognitively. They are generally offered during what is usually considered “normal working hours,” i.e. Monday through Friday from 7:00 a.m. to 6:00 p.m. Please try again.

Question #2 Feedback

1. Your answer is incorrect. Medicare is a federal health insurance program for persons age 65 or older, individuals of any age with permanent kidney failure, and certain disabled persons. It provides Hospital Insurance protection under Part A and a voluntary Medical Insurance program under Part B. In addition to providing hospital insurance, Medicare Part A also provides limited nursing home coverage. That limited nursing home coverage is for skilled care only. Medicare generally pays only about one-fifth of national annual long term care costs. Please try again.
2. Your answer is correct. The principal overall long term care payment source is Medicaid. Medicaid is a welfare-assistance program involving both the state and federal governments that is designed to provide healthcare benefit access for the indigent. Because of long term care’s substantial costs, Medicaid has become a principal source of funding as care recipients deplete their existing assets paying long term care costs.
3. Your answer is incorrect. Because of the substantial costs associated with long term care, only a limited portion of its cost is paid from the care-recipient’s personal assets. Instead, only about 15% of the national long term care cost is paid out-of-pocket. Please try again.
4. Your answer is incorrect. Long term care insurance sales have generally been disappointing, particularly in light of the high cost of care and the risk of requiring it. As a result, only about 7% of long term care cost is paid by private insurance. Please try again.

Question #3 Feedback

1. Your answer is correct. Virtually all hospice care for care recipients who have Medicare Part A (Hospital Insurance) coverage is covered by Medicare. No deductibles apply, and the beneficiary pays only small coinsurance amounts for outpatient drugs and inpatient respite care.
2. Your answer is incorrect. Medicaid, a welfare-assistance program involving both the state and federal governments, designed to provide healthcare benefit access for the indigent is a principal source of overall long term care funding. However, it pays virtually no hospice costs. Please try again.
3. Your answer is incorrect. Although hospice care recipients not covered under governmental insurance programs may be required to pay for such care, the bulk of the hospice care funding does not come from care recipients. Please try again.
4. Your answer is incorrect. Long term care insurance policies contain a non-duplication of benefits provision under which the policy pays no benefits for a service if the same covered charges by Medicare, Workers’ Compensation or other government programs. Please try again.

Question #4 Feedback

1. Your answer is incorrect. The 3-day requirement with respect to Medicare’s payment of skilled nursing care costs refers to the requirement that a care recipient must have been confined in a hospital for a minimum of 3 consecutive days (not counting the day of discharge) before admission to a participating skilled nursing facility. Please try again.
2. Your answer is incorrect. Medicare will pay skilled care cost for a Medicare beneficiary who meets the requirements for such payment for up to 20 days in full. However, Medicare coverage for skilled care does not end after 20 days. Please try again.
3. Your answer is incorrect. The 30-day requirement with respect to Medicare’s payment of skilled nursing care costs refers to the requirement that admission to the skilled nursing facility must occur within a short time following hospital discharge, typically within 30 days. Please try again.
4. Your answer is correct. Medicare covers nursing facility care when the care required is skilled care, and Medicare Part A will pay for the first 20 days of care in a skilled care facility in its entirety. After 20 days in a skilled care facility, the individual must pay a coinsurance amount from the 21st to the 100th day that tends to increase each calendar year. After the 100th day, Medicare nursing home coverage ends.

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## Chapter 3

Question #1 Feedback

1. Your answer is incorrect. Benefits are paid under a long term care insurance policy whenever the insured person receives covered care, provided the elimination period has been satisfied. Thus, John would have received some benefit. Please try again.
2. Your answer is correct. In a long term care insurance policy under which benefits are paid pursuant to an indemnity provision, an insured who receives covered care would receive the specified daily benefit *regardless of the actual cost for the covered care*. Since John’s policy provides a $200 daily benefit on an indemnity basis, that is the amount the policy would pay even though his actual daily cost was only $175.
3. Your answer is incorrect. If John’s policy paid benefits on a reimbursement basis, your answer choice would be correct. However, the policy pays an indemnity benefit. Reimbursement provisions pay the lesser of the specified benefit or the actual cost for the care. Please try again.
4. Your answer is incorrect. A long term care insurance policy would not pay a daily benefit that is greater than the $200 daily benefit specified in the policy. Please try again.

Question #2 Feedback

1. Your answer is incorrect. The termination notice is deemed to be received by the insured 5 days after it is mailed by the insurer. However, the total grace period extends beyond that 5-day period. Please try again.
2. Your answer is incorrect. Ten days is the duration of the “free-look” period applicable to life insurance and disability insurance policies. Please try again.
3. Your answer is incorrect. At the end of 30 days following the date the still-unpaid premium was due, the insurance company will send a notice of termination for non-payment of long term care insurance premiums to the insured and any person designated by the insured to receive such notice. However, the grace period for non-payment of long term care insurance premiums extends beyond that 30-day period. Please try again.
4. Your answer is correct. In a long term care insurance policy, the grace period that applies to any premium not paid by the due date is usually 65 days. At the end of 30 days following the date the still-unpaid premium was due, the insurance company will send a notice of termination for non-payment of premiums to the insured and any person designated by the insured to receive such notice stating that the coverage will lapse in 30 days after the insured receives the notice. The termination notice is deemed to be received by the insured 5 days after it is mailed by the insurer.

Question #3 Feedback

1. Your answer is incorrect. Policies that are conditionally renewable give the insurer the opportunity to refuse to renew the coverage based on poor claims experience. Although the premium for conditionally renewable coverage would likely be lower than for policies providing otherwise comparable benefits but with stronger renewability guarantees, such policies would not be tax-qualified. Please try again.
2. Your answer is incorrect. A tax-qualified long term care insurance policy may be noncancelable, i.e. having a renewability option that prohibits insurers from canceling the policy or increasing its premiums, but such a guarantee is significantly more expensive and is not required for a policy to be considered tax-qualified. Please try again.
3. Your answer is incorrect. In an optionally renewable insurance policy, an insurer may refuse to renew the policy for any reason. Such a renewability provision would cause a long term care insurance policy to not be tax-qualified. Please try again.
4. Your answer is correct. In order for a long term care insurance policy to be tax-qualified it must be guaranteed renewable. Such policies guarantee that the insurer may not cancel the policy or increase its premiums except on a class basis.

Question #4 Feedback

1. Your answer is incorrect. Taxpayers younger than age 65 may normally deduct tax-qualified long term care insurance premiums to the extent such premiums, when added to other medical expenses exceed 10% of adjusted taxable income. In this case, however, the taxpayer is self-employed and subject to somewhat different rules. Please try again.
2. Your answer is incorrect. If Arthur had not been self-employed, your answer would have been correct since Arthur’s tax-qualified long term care insurance premiums, when added to other medical expenses, only exceed 10% of his AGI by $500. Since Arthur is self-employed, different rules apply. Please try again.
3. Your answer is incorrect. If Arthur had not been self-employed and had been age 65 or older, your answer would have been correct since Arthur’s tax-qualified long term care insurance premiums, when added to other medical expenses, only exceed 7.5% of his AGI by $2,500. Since Arthur is self-employed, different rules apply. Please try again.
4. Your answer is correct. Self-employed persons may deduct tax-qualified long term care insurance premiums not in excess of the dollar limitations without the need for medical care expenses to exceed an AGI threshold. In short, tax-qualified long term care insurance policy premiums are 100% tax-deductible to the extent they don’t exceed the dollar limits.

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## Chapter 4

1. Your answer is incorrect. The NAIC statement on suitability of a long term care insurance policy states that a long term care insurance policy would not be suitable for an applicant whose investable assets were less than $35,000 on the assumption that Medicaid would likely provide long term care funding if needed. However, although the NAIC’s suggested asset test may provide a benchmark to help arrive at an appropriate decision as to suitability, it is important to view it only as a benchmark on which to judge whether long term care insurance is suitable for a specific client. Please try again.
2. Your answer is correct. A long term care insurance policy is not suitable for a client if paying for it can be expected to adversely affect his or her ability to meet monthly bills. The client who would need to reduce expenditures for food, prescription drugs or other essentials in order to afford to pay a long term care insurance policy premium is clearly unsuitable.
3. Your answer is incorrect. According to the NAIC income test, a long term care insurance policy may not be suitable for an applicant if its premium exceeds 8% of the client’s income. However, although the NAIC’s suggested income test may provide a benchmark to help arrive at an appropriate decision as to suitability, it is important to view it only as a benchmark on which to judge whether long term care insurance is suitable for a specific client. Please try again.
4. Your answer is incorrect. Although the risk of needing long term care increases with age, such care may be required at any age. Buying a long term care insurance policy at an age younger than 55 may also result in a much lower premium than if it were purchased when the applicant was older. Thus, the fact the applicant was younger than age 55 would not, of itself, make the purchase of a long term care insurance policy unsuitable. Please try again.

Question #2 Feedback

1. Your answer is incorrect. Medicare is a federal health insurance program for persons age 65 or older, individuals of any age with permanent kidney failure, and certain disabled persons. In addition to providing hospital insurance, Medicare Part A also provides limited nursing home coverage. However, that limited nursing home coverage is for skilled care only and is not based on the Medicare beneficiary’s assets. Please try again.
2. Your answer is incorrect. Long term care insurance is not generally an available option for individuals with few financial assets particularly since the premium cost for such coverage tends to be high. Please try again.
3. Your answer is correct. The usual alternative for clients with few financial assets and no long term care insurance who require long term care is Medicaid. Medicaid, however, is not accepted by all long term care facilities. In some locations nursing homes that accept Medicaid are generally considered among the least desirable.
4. Your answer is incorrect. Medigap policies generally pay only the charges for those services that are covered by Medicare. Since Medicare generally limits long term care coverage to skilled nursing care only, Medigap policies are not alternatives available for funding long term care costs. Please try again.

Question #3 Feedback

1. Your answer is incorrect. The decision to self-insure against the risk of long term care requires fairly substantial assets. Since the average annual cost of a semi-private room in a nursing home exceeds $75,000, such an amount could not reasonable be expected to fund the average nursing home stay that exceeds two years in duration. Please try again.
2. Your answer is incorrect. Based on the average stay of 835 days in a nursing home and its current cost, $150,000 would be exhausted before the need for long term care ended. Please try again.
3. Your answer is correct. The client’s assets need to be considered in determining suitability. In general, for clients with investable assets in excess of $1.5 million, a cogent argument can be made in favor of self-funding any long term care need. That does not mean that a client with more than $1.5 million in investable assets should not purchase long term care insurance. It means only that the assets and the income those assets produce need to be considered.
4. Your answer is incorrect. Although investable assets of $3 million could be expected to self-insure against the need for long term care, many advisers believe a cogent argument could be made for self-insuring at a lower amount. Please try again.

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2. The term “cognitive dysfunction” applies to a wide range of problems associated with intellectual functioning. Cognitive dysfunction typically refers to difficulties with thinking clearly, problems with recall and decreased concentration. [↑](#footnote-ref-2)
3. National Center for Health Statistics, [www.cdc.gov/nchs/fastats/lifeexpec.htm](http://www.cdc.gov/nchs/fastats/lifeexpec.htm). [↑](#footnote-ref-3)
4. Certain small, rural hospitals may be authorized by the Social Security Act to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or skilled nursing care. A swing bed hospital is a hospital or critical access hospital participating in Medicare that has approval from the Centers for Medicare and Medicaid to provide post-hospital skilled nursing care and meets certain requirements. [↑](#footnote-ref-4)
5. Henry J. Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org). Last accessed 10/11/2014. [↑](#footnote-ref-5)
6. See Kaiser Family Foundation nursing home statistics at http://kff.org/other/state-indicator/number-of-nursing-facilities/. [↑](#footnote-ref-6)
7. Jones AL, Dwyer LL, Bercovitz AR, Strahan GW. The National Nursing Home Survey: 2004 overview. National Center for Health Statistics. Vital Health Stat 13(167). 2009. [↑](#footnote-ref-7)
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20. Ibid. [↑](#footnote-ref-20)
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22. For adults, overweight and obesity are determined by using weight and height to calculate the individual’s body mass index (BMI). An adult with a BMI between 25 and 29.9 is considered “overweight.” An adult with a BMI of 30 or more is considered “obese.” [↑](#footnote-ref-22)
23. CDC National Center for Health Statistics, December 8, 2005. [↑](#footnote-ref-23)
24. Article may be found at http://www.mayoclinic.com/health/obesity/DS00314/DSECTION=6. [↑](#footnote-ref-24)
25. U.S. Census Bureau, “Population Profile of the United States,” <http://www.census.gov/population/www/pop-profile/natproj.html>. [↑](#footnote-ref-25)
26. *“Medicaid’s Role in Meeting the Long-Term Care Needs of America’s Seniors,” Kaiser Commission on Medicaid and the Uninsured, January 2013.*[www.kff.org](http://www.kff.org). [↑](#footnote-ref-26)
27. A “short time” in this context generally means within 30 days. [↑](#footnote-ref-27)
28. A representation on an application for coverage is considered “material” if it influences the insurer’s decision with respect to the contract. [↑](#footnote-ref-28)
29. NAIC Long Term Care Insurance Model Act, Section 6 C. [↑](#footnote-ref-29)
30. [www.Inflationdata.com](http://www.Inflationdata.com). Last accessed 10/11/2014. [↑](#footnote-ref-30)
31. When existing insurance products are “grandfathered,” they are deemed to meet the new requirements and therefore qualify for the favored tax treatment. [↑](#footnote-ref-31)
32. A self-employed individual, for purposes of long term care insurance premium tax-deductibility, includes sole proprietors, partners, and owners of S corporations, limited liability partnerships and limited liability companies. [↑](#footnote-ref-32)