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Long-Term Care Insurance: Is It Right For You?

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There is an approaching crisis in our country over how to provide for long-term care (LTC). Families have traditionally cared for their own elderly relatives, but this “do it yourself” approach is less likely to work for those in the baby boom generation. Daughters who are traditionally the caregivers are now working outside the home in increasing numbers and having children later, leaving them with little or no time to care for elderly parents. Moreover, the pool of family caregivers is dwindling. In 1990, there were 11 potential caregivers for each person needing care but it is estimated that by 2050 that ratio will be 4 to 1. The hidden cost to the caregivers themselves must also be taken into account. Studies show that 61 percent of “intense” family caregivers, defined as those devoting 21 or more hours per week to the required tasks, have suffered from depression and elderly caregivers (those who provide care to a spouse) have a higher mortality rate than those who are not caregivers. For all these reasons, reliance on family is not a realistic solution to our long-term needs.



Government does not provide for the long-term care needs of the middle class. The safety net provided by Medicaid is only for those with limited assets. Even for those who qualify for Medicaid, it will pay only for skilled nursing home care, but not home care or assisted living. Medicare provides only for the acute health needs of the

elderly. It does not provide long-term custodial care. If a patient requires rehabilitation or physical therapy after surgery, such as a hip replacement, Medicare (after a three-day hospital stay) pays in full for 20 days of skilled nursing care plus 80 days after a co-payment. Once the patient is no longer making improvement, Medicare will stop paying. The average number of days paid by Medicare for long-term care is only 23 which is far short of the full 100 days of coverage. Most people would prefer home care, but Medicare provides services at home only for acute illness or injury on a limited and intermittent basis for short-term needs. The government programs will not help the majority of us to pay for our long-term care needs.

Some question whether the need for long-term care is overstated. This is not the case – the need is very real.

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Consider that 60 percent of those persons reaching age 65 will require long-term care services. Younger people are also in need of LTC services – 40 percent of those currently receiving LTC services are under 65. The high cost of LTC services is also a reality. The average cost of a year in a nursing home is \$57,000 – in urban areas it is \$75,000 to \$80,000. The cost of an assisted living facility is almost half the cost of skilled care. Home care is also expensive. In Illinois, a full-time caregiver can range between \$35,000 and \$63,000 a year. All LTC costs are increasing at a greater rate than inflation.

There is a real risk that each of us will need long-term care someday. The issue is how to manage that risk. We purchase insurance to manage risks every day: fire, liability, health, life, disability, automobile and business interruption insurance. Should you consider long-term care insurance? This article will discuss the policy design features of long-term care policies and whether one might be right for you.

What is Long-Term Care?

First, we need to be clear what is meant by the term “long-term care.” It includes the full range of services that may be needed to assist someone with the daily activities of life. It does not include retirement facilities that provide an

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apartment with activities and meals for those who can live independently. Long-term care includes the following types of services:

- skilled nursing facilities: the highest and most intense level of care provided by medical staff; resident requires 24-hour supervision and care; some floors may provide “custodial” care to assist with normal daily activities that can be provided by people without medical training
- assisted living facilities: intermediate care provides reminders of medication and assistance with dressing; most provide meals and a home-like facility, but not constant supervision
- home care: this can range from a full-time caregiver to physical therapy or a home nurse a few days a week
- homemaker services: cooking, shopping, cleaning the home and doing laundry
- adult day care: a group setting for a person living at home or with family
- respite care: a short period in a nursing facility or assisted living facility to give a caregiver a “break”
- hospice care: services for terminally ill in the home or other facility

Long-Term Care Policy Types

There are two general types of LTC policies. The most common is a reimbursement policy that pays benefits to you based on the amount of your actual expenses. An indemnity policy or *per diem* policy pays the stated benefit to you after

qualifying for benefits without regard to expenses paid by you.

An important feature of a LTC policy is whether or not it is a “tax-qualified” policy. The Health Insurance Portability and Accountability Act of 1996 enacted consumer protections to safeguard the integrity of LTC policies and to qualify certain policies for favorable tax treatment. The Act changed the landscape of the LTC industry and has influenced the structure of LTC policies. If a policy meets the requirements of the Act, it will be considered a tax-qualified policy. A tax-qualified policy provides essential consumer protection provisions, such as the following:

- the policy must be guaranteed renewable and cannot be cancelled due to a change in health
- it may not exclude coverage for a claim relating to a pre-existing condition unless loss or confinement begins within six months of the effective date of the policy
- eligibility for benefits cannot be conditioned on prior hospitalization
- the policy cannot exclude coverage based on a particular medical condition or illness, such as dementia, however, the policy may exclude coverage for other types of mental illness or injuries caused by war

Due to the inclusion of minimum consumer protection standards in a tax-qualified policy, you should consider purchasing only a tax-qualified policy. The insurance company is required to advise you whether or not the policy is tax-qualified.

In addition, the benefits paid by a tax-qualified policy are not included in your income and you may deduct a portion of the premium for a tax-qualified policy as medical expenses, subject to the general rule that only medical expenses that exceed 7.5 percent of your adjusted gross

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income are deductible, and subject to certain age limitations. In 2005, you may deduct a part of the premium based on your age, as follows:

- age 40 or less, \$270
- age 41 through 50, \$510
- age 51 through 60, \$1,020
- age 61 through 70, \$2,720
- age 71 or older, \$3,400

Policy Triggers and Features

Each long-term care policy specifies the circumstances under which you will qualify for benefits, the amount to be paid and the services that are covered. Each of these elements must be carefully reviewed to ensure that the policy meets your needs. Given the variety of features offered by different insurance companies, careful comparisons need to be made before purchasing a policy.

Benefit Triggers:

- **Activities of Daily Living (ADL):** This defines when you become eligible for benefits. Benefits under a tax-qualified policy will be triggered when you cannot perform without substantial assistance two out of six daily activities: eating, toileting, transferring (moving from bed to a chair), bathing, dressing and continence.
- **Substantial assistance:** A policy may define the meaning of “substantial assistance.” The policy may provide that you need “hands-on” assistance and not just supervision or “stand-by” assistance to trigger the benefits. For example, you need only “stand-by” assistance if you need someone to bring you a meal, but can feed yourself. You should look for a policy that requires only “stand-by” assistance, so benefits will be available sooner.
- **Cognitive impairment:** This is a significant deterioration in the loss of mental capacity, *i.e.*, dementia or Alzheimer’s. A tax-qualified policy will be triggered when you require substantial supervision due to severe cognitive impairment.
- **Certification:** A licensed health care professional (doctor or social worker) must certify that the condition will continue for at least 90 days. This is not a waiting period but must be re-certified annually.

Elimination Period: This term describes a waiting period before benefits begin after you qualify to start receiving care. The number of days is selected by you. Confirm that the

elimination period uses calendar days and not just days when services are used. The elimination period may be different for home care and care in a facility. Under some policies, the elimination period begins when home care is started. Typical periods are 30, 60, 90 or 180 days. The length of the elimination period is one factor in determining the cost of the policy.

Benefit Amount: This determines the amount the policy will pay once it is “triggered.” Usually this is expressed as a *per diem* amount (*i.e.*, \$150 a day) even in reimbursement policies. Some companies are now offering a monthly

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benefit (*i.e.*, \$4,500 per month). This can be more useful since the actual cost each day may vary in a home setting – sometimes higher than \$150 and sometimes lower. On a monthly basis this will average out. You should select the benefit amount by determining the current monthly cost of nursing homes in your area and then subtracting the part of your monthly income that you wish to spend on your care. In other words, you could self-insure part of your long-term care needs by purchasing a benefit amount lower than the current costs. However, this may not be advisable if your spouse needs all of your income for support.

Term: This defines the time period the policy covers. Typical terms are lifetime, three, five or six years. Since the average nursing home stay is 2.6 years, the term should be at least three years, but five years is typical. Some policies use the term as a multiplier of the monthly benefit to produce a single lifetime account balance. For example, a policy with a three-year term (36 months times \$4,500 per month) has \$162,000 total benefit amount that can be used until spent, but not faster than \$4,500 a month. This could result in the policy lasting longer than the stated term if the actual monthly expenses are less than \$4,500 per month.

Covered Services: These are the LTC services covered by the policy. A good policy will cover all of the LTC services from homemaking services to hospice care. Some policies offer lower benefits for home care and assisted living. Since most people wish to stay in their home, you should consider

purchasing a policy with full coverage for home care, including homemaking and assisted living.

Inflation Protection: The insured can select an option to increase the benefit amount by a specified rate on either compound interest or simple interest method. Since the cost of nursing care is increasing faster than the general rate of inflation, this is a necessary cost in any policy. The cost of an inflation rider increases the benefit amount the insured receives in the future, but the premium is a level amount.

Additional Options:

- Third-party notice: protects you by giving someone else notice if the premiums are not paid
- Waiver of premium: once you begin to receive benefits the payment of the premium is no longer required
- Room reservation benefit: the policy will continue to pay for the nursing home room while you are in the hospital
- Nonforfeiture of benefits: policy will convert to a paid-up policy if you cancel the policy after paying for a specified number of years
- Restoration of benefits: restores the benefits if you recover for a six-month period
- Shared policy for couples: a couple (married or unmarried) who lives together may share one policy and benefits

Is Long-Term Care Insurance the Right Choice for You?

There are many factors that you should consider when deciding to purchase long-term care insurance. You should think about how your family would provide for your care without insurance. The health and longevity of your family should also be considered. Is it likely that a spouse or child will be able to provide your care? LTC insurance allows you to select where you receive assistance – at home, assisted living or nursing home – without being a burden on your family. It also can provide an opportunity for a spouse or other caregiver to receive help with some of the day-to-day work when there is insurance to pay for the expenses. The existence of insurance often results in the insured requesting help when problems arise instead of delaying to a crisis.

Insurance provides another source for the payment of long-term care expenses, so that your assets are preserved and protected. If you wish to save your assets to protect your spouse or to provide an inheritance for your children, insurance may be appropriate. However, you must have disposable income to pay the annual premiums, both now and after retirement, including any increase in the premium. Once the policy is purchased you must pay the annual premiums until you qualify for benefits, so the premium must

come from your income or assets that are not needed for your basic support.

While an existing policy cannot be cancelled due to health problems, the insurance company can deny coverage based on health factors, such as diabetes, memory loss or weight.

You should consider purchasing long-term care anytime after age 50. The cost of the premiums will be lower and coverage will begin immediately in case of an early medical problem. For example, the approximate annual cost of a policy with a monthly benefit of \$4,500, a term of five years and a 90-day elimination period for a 55-year-old is \$1,674 and for a 65-year-old is \$2,970. Also, at an earlier age there is less likelihood of developing a medical problem that will prevent coverage. While an existing policy cannot be cancelled due to health problems, the insurance company can deny coverage based on health factors, such as diabetes, memory loss or weight. These problems are more likely to become an issue with age.

Cost is always a factor when considering an LTC policy. Cost is primarily determined by the benefit amount, term, elimination period and age. Additional options will increase the cost. A comparison should be made between different companies. You may select a longer elimination period, a lower benefit amount or a shorter term to reduce costs. However, you should be realistic about what benefits are most important for your situation and be willing to pay for them.

You must select a policy that will meet your needs from a reputable company. Due diligence would include a review of the company's rating, number of years in the LTC business, number of LTC policies issued and a review of the specific terms in the actual LTC policy. Premiums cannot be increased on existing policies due to health or age, but can be increased for an entire class of policy holders. Therefore, it is important that you check with your state insurance commission to find out the insurance company's history of increasing premiums on existing policies. While this is not a guarantee that the premium on your policy won't be increased, it does indicate the company's past ability to adequately price its products.

It is clear that each of us must decide how to pay for long-term care. You need to consider whether insurance should be part of your plan to provide for this care. It is most appropri-

ate if you wish to protect your current assets, have sufficient disposable income to pay the premiums until you qualify for benefits, and desire not to become dependent on your family. If you decide to purchase a long-term care policy, its features should be examined to see if it meets your unique needs and should be compared to other policies. By

addressing these concerns now, you can feel confident that you have provided the level of protection needed by you and your family. ■

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