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Guidelines to Consider in Purchasing Long-Term Care Insurance

We all know that long-term care is expensive. The cost of long-term nursing home care can expose families to economic ruination (if proper planning is not done in advance). Long-term care insurance is the one private insurance product that will help pay for long-term care expenses. A good policy can optimize one's selection of long-term care services and provide the insured and his or her family peace of mind that enough money is available to pay for the cost of care.

A bad policy will not provide the coverage needed or only add to a person's "patient pay" obligation under Medicaid. Unfortunately, long-term care insurance policies can be confusing, as the variety of available options can appear limitless. This article is intended to serve as a brief primer in helping sort out issues to consider when purchasing long-term care insurance.

In choosing a policy, two of the biggest impediments are medical underwriting and cost. The applicant has little control over underwriting. Unless one is lucky enough to have an employer who offers long-term care insurance as part of its employee benefits package, in most cases the insurer will determine if the applicant is medically qualified to purchase insurance. In general, the odds of acceptance will diminish if the applicant has ever used some long-term care services or has some medical problem that the insurer may consider as an indicator of needing long-term care. As a practical matter, this means that as the applicant gets older, the odds of acceptance diminish.

Although long-term care insurance premiums are guaranteed for life and "fixed," meaning that the premiums do not rise as the applicant ages, the premium is more costly the older the applicant is at the time of purchase. Note, however, that some insurers have instituted "across-the-board" premium increases, which is permissible even if the policy promises no increases based on age. The bottom line is that the younger the applicant (e.g., 40s 50s or lower 60s), the less expensive the annual cost of the policy and the better the odds of acceptance. Assuming the insurer accepts the application and the applicant has the resources to pay a premium, the applicant may need counsel in reviewing the policy and selecting the best options. There is no substitute for a careful review of the policy contract, particularly the "definitions" and "benefits" sections, in determining whether a particular policy is appropriate. Our firm can perform such a review.

1. Types of Services Covered

The purchaser can select just a particular service, such as only nursing home care or only at-home care, or a more comprehensive policy covering at-home care, adult day care, assisted living and nursing home care. Generally, a comprehensive policy ensures that no "gaps" in

coverage exist. One should review the definitions to make sure that no coverage “gaps” or other surprises are lurking.

2. Amount of Benefits

Policies can pay benefits, typically on a per-day basis, in varying amounts. Ideally, the benefit would cover all of the out-of-pocket expenses so as not to drain savings, taking into account other income and the expenses of the spouse to maintain his or her living standard.

3. How Payment is Made

The plan can be either a “reimbursement” policy or an “indemnity” policy. A reimbursement policy pays the “reasonable and necessary” claims submitted by a nursing home, home health agency, etc. and is the least expensive option (used by 70 - 80 percent of policyholders). An indemnity policy pays a set cash benefit (such as \$150 per day) and the policyholder keeps the difference if the daily benefit amount exceeds the cost of care. Indemnity is generally 50 percent more expensive.

4. Length of Benefits

Policies can provide for different payout periods. Benefit periods can range from one or two years to life. The purchase of a three-year policy when a nursing home stay is six years may result in a depletion of assets after all. Note that a policy that includes at-home or assisted living care may require a longer coverage period.

5. Inflation Protection

This is a very important consideration. Benefits that do not take into account the cost of inflation may not pay for as much as anticipated. (For instance, a \$200 per day policy may pay the entire cost of nursing home care today, but less than the full cost in the future.) Note that annual health care costs have almost always increased at a higher rate than other services. This fact, combined with the likelihood that a long-term care insurance policy may not be needed for many years after the year of purchase, requires the purchaser to try to consider what costs and expenses may be like in 20 or 30 years. This may mean purchasing more coverage than what is needed today, or purchasing inflation protection. Some policies offer selection of inflation protection at a specified annual rate, such as five percent per year. Other policies offer inflation protection by offering the policy holder the right to add coverage at a later time.

6. What Triggers the Payment of Benefits

Most policies written since 1996 are “qualified,” meaning a portion of the premium payments may be deductible from federal taxes as a medical expense deduction. In brief, a triggering event under a qualified policy is certification by a licensed health care professional that for at least 90 days the beneficiary is unable to perform without substantial assistance at least two of six activities of daily living (eating, toileting, transferring, bathing, dressing and continence), or the beneficiary requires substantial supervision due to severe cognitive impairment. See Internal Revenue Code §7702B for a more detailed explanation of these requirements. The triggering event in a non-qualified policy can be less generous or more generous than a qualified plan.

7. Elimination Period Before Policy Goes into Effect

Benefits may be paid on the first day the insured qualifies for benefits, or after a number of days after the time of triggering event. Some have considered coordinating the elimination period with Medicare (e.g., a 90- or 100-day elimination period), but as we know from our clients' experiences, one cannot rely on Medicare coverage for the maximum available period. The longer the "elimination period," the lower the premium.

8. Procedure to Notify Insurer of Claim.

To ensure full coverage, the insured must know the procedures the insurer requires to be notified of a claim. For example, the policy may require notification within a certain period of time of the triggering event to commence coverage. A late notification may result in coverage commencing later than desired.

9. Joint Policy or Rollover to Spouse

With joint policies, couples may choose between a single policy with two owners sharing a single pool of funds, or two policies with a sharing provision, allowing one spouse to use the other spouse's benefits when his run out. Some policies may permit an eligible spouse to receive benefits if the other spouse did not need long term care.

10. Protection When the Purchaser Forgets to Pay the Premium

Policies may offer options to ensure continued eligibility if the purchaser forgets to pay the premium. Certain benefits may be offered even if the premium is stopped, or family members may be notified to make sure premiums continue to be paid.

11. Protection When the Policy Begins to Pay Claims

An important feature to look for in a long-term care insurance policy is a "waiver of premium" rider. This provision means that the purchaser will not have to continue making premium payments once the policy has begun to pay claims for long-term care.

12. The Insurer

One needs to feel confident that the insurer will be around in thirty years to pay out premiums. It may be worthwhile to investigate the quality of the insurer with a rating service such as Moody's or A.M. Best.

For information or help in considering long-term care insurance and other ways to pay for good care, contact us today at 601-987-3000 or at our toll-free number 1-866-ELDERLAW.