

# Chapter 15

## Key Design Elements of a Long-Term Care Insurance Plan

Every long-term care insurance product contains some common plan design features. If you master these, it will then be easier to understand and properly create the right solution for your client.

Each of these key components is reviewed in this chapter; many of them apply to all types of long-term care insurance solutions, from individual to worksite to combination products. The better you understand these vital elements of a long-term care insurance contract, the better guidance you can provide your clients as they plan ahead for potential long-term care expenses.

### **Tax-Qualified Plans**

The overwhelming majority of policies sold today are *Tax-Qualified* (TQ) plans. This is the result of federal legislation contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In this legislation, Congress created a new section of the tax code, Internal Revenue Code section 7702(b), specific to long-term care insurance policies. Up until that time, long-term care insurance was sold without benefit of tax clarification.

This clarification was significant. The benefits paid out under a TQ plan are excluded from income to the extent they reimburse actual LTC expenses—without limit. TQ benefits which pay without regard to expenses incurred are also excluded from income, but only up to a per diem limit which rises each year (\$330 in 2014).

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In addition, both individuals and businesses paying the premium can take advantage of a tax deduction. This means that a premium for long-term care coverage could be deductible without jeopardizing the tax-free status of benefit payments.

Of course, the government gives with one hand and takes with the other. To be considered a TQ plan, a policy must contain this definition of disability, without exception (See Chapter 9):

*Chronically ill* is defined as:

1. the inability to perform, without substantial assistance (including standby assistance) from another individual, at least two of six Activities of Daily Living (ADLs) for a period of at least ninety days due to a loss of functional capacity;

or

2. the need for substantial supervision to protect one from threats to health and safety due to severe cognitive impairment.

Every TQ policy shares this standardized definition of *chronic illness*, rendering side-by-side comparisons of benefit eligibility not just easier, but literally obsolete. Those calling for greater standardization among long-term care insurance plans (similar to Medicare Supplements) may not realize the extent to which it has already taken place.

The 1996 HIPAA legislation grandfathered all long-term care policies issued before January 1, 1997, so they meet the requirements to be considered TQ. All policies issued from January 1, 1997, to the present must contain the definition of *chronically ill* stated above to earn the TQ label.

Policies issued since January 1, 1997, which do not meet the criteria defined by IRC 7702B are considered *Non-Tax-Qualified*, or NTQ. No specific tax language speaks to these plans with regard to either deductibility of premiums or benefits received.

Most financial advisors recommend TQ policies because of their clear tax guidance, tax favorability, widespread adoption, mandated consumer protections, and Partnership pre-requisite (namely, only TQ plans can qualify for Partnership, more on this later).

Having said that, NTQ plans offer the promise of more generous benefit triggers, since they do not have to comply with one-size-fits-all TQ language. We find latitude in what can trigger NTQ claims, including inability to perform “Instrumental Activities of Daily Living” (IADL’s), and even Short-Term Care events (those lasting fewer than ninety days). Unfortunately, easier access to benefits has typically meant higher premiums, and that spelled the end of NTQ policies, which today comprise less than 1 percent of the market.

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The first part of a chronically ill definition refers to ADLs. These *Activities of Daily Living*, noted in the first test of the definition of disability, are:

- Bathing
- Dressing
- Eating
- Transferring (mobility)
- Toileting
- Continence

ADLs originated more than thirty years ago from *The Index of Independence in Daily Activities*.<sup>1</sup> *Daily activities* are defined by a person's ability to perform normal functions.

Each of these activities is specifically defined in a long-term care policy. The loss of two or more ADLs that lasts at least ninety days (considered *long-term* by the Internal Revenue Service) is one way to trigger policy benefits. Any licensed healthcare practitioner, including a social worker, can make the required annual certification. The idea is that this medical problem is not an acute, short-term, or rehabilitative situation, defined here as less than ninety days. LTC is designed for conditions which are chronic and progressive, but also can be indefinitely maintained—as long as rapid improvement or recovery is unlikely.

The loss of these ADLs does not necessarily mean the insured needs hands-on assistance. The definition also includes standby assistance, where the need for *supervision* of the activity is also considered a loss. This is an important distinction, because it could include more claims.

Once these two ADLs are lost and disability is certified, the long-term care policy may also cover homemaker services such as shopping, cleaning, transportation to doctors' appointments, cooking, and responsibility for taking one's medication. These are considered *instrumental* activities of daily living and, although they do not trigger a claim, they can be part of reimbursable expenses once the claim has been certified.

The other way to trigger policy benefits under a TQ plan is to be diagnosed with a cognitive impairment (e.g., an organic brain disorder). Conditions such as dementia, Alzheimer's and Parkinson's disease automatically ensure eligibility for benefits.

Under the second definition, there is no need to meet the two-ADL requirement. These kinds of organic brain disorders initially may mean little or intermittent loss of activity(ies). No matter.

They confer automatic eligibility activation, much as the loss of sight, speech, hearing, or the use of two limbs does under the Presumptive Total Disability clause in an individual disability income contract.

These are the only two triggers for a claim under a TQ long-term care insurance contract. When the need for long-term care arises, meeting the eligibility requirements of the definition to receive policy benefits is not too burdensome.

### **Plan Design**

Your client must make four important coverage selections as detailed below:

#### **Amount of Coverage (Benefit Amount)**

Generally, the amount of coverage selected is expressed as a *daily or monthly benefit amount*. This is because long-term care facilities typically charge a daily rate for room and board. Ideally, you want a daily rate typical of the norm in the area where you plan to seek long-term care assistance.

Of course, all kinds of long-term care services can be provided in a variety of settings, some more expensive than others. To be sure of establishing a starting point that will meet the maximum care needed, it is best to base the selection on the average cost of a Skilled Nursing Facility (SNF) in the client's area. Although this is the least likely place to initiate a long-term care claim, it is likely to ensure that there will be enough in the insurance bank to cover the costs of any other service or setting.

The national median for a semi-private room in a SNF, as noted earlier, is currently \$212 perday.<sup>2</sup> A benefit selection should begin as close to that amount as possible, adjusting it up or down depending on your client's local costs. An Internet search of local area costs can fine-tune this number even further. Better still, a few visits to local facilities can provide the same information and allow you to eliminate any place that you react to negatively.

I recommend that you print a list of these local facilities from the "Nursing Home Compare" program on the Medicare Web site ([medicare.gov](http://medicare.gov)). You can read the reviews and ratings, but be advised that a personal visit can accomplish much more. It enables you to make a second list of places you approve of if something were to happen to you. Then, average the costs of this second list to give your client an accurate daily or monthly benefit amount from which to start. They will ask for this.

It is important to find out where, in all likelihood, the insured would seek long-term care assistance should it become necessary. By asking this question, you will learn, for example, whether someone intends to move to another state to be near family if long-term care assistance

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is needed. This lets you focus on the costs in the area where the insured would likely reside should a long-term care event arise.

Some insurers also offer clients the option to buy a higher—or lower—daily benefit amount for home health care. Because of the wide fluctuation in home care costs (which depend on the services needed) combined with the consumer’s likely desire to stay at home, it could be tempting—depending on the premium cost—to choose a higher daily benefit amount than would be paid for a skilled facility stay.

However, if you have tracked the local SNF rate closely enough and use that as your application amount, there is a better use of that premium dollar for your client than buying more home care benefits than will likely be needed: the option to waive the elimination period if the client’s ultimate need is for home care (more on this shortly).

With limited success, carriers have tinkered with policy designs by attempting to mimic the co-insurance model consumers are used to from their health insurance. By getting policyholders to put “skin in the game” (e.g., 80/20 co-insurance), LTC insurers hoped to get in front of the increasing over-utilization they’d been seeing. In spite of the fact that such designs also benefit from affordability, not one iteration has yet seen widespread adoption.

### **When Benefits Begin (Elimination Period)**

When a long-term care situation commences, the number of days one must self-insure before long-term care insurance starts paying for long-term care assistance is called an *Elimination Period* (EP). Because you are paying expenses out-of-pocket before your insurance kicks in, many liken the elimination period to a “deductible” in other forms of insurance. The longer you wait for insurance coverage to begin, the lower the premium payment you will pay. With many insurers, coverage can begin as early as the first day. Other EP options include 20 days, 30 days, 60 days, 90 days, 100 days, 180 days, and 365 days.

Reacting to pressure from clients to reduce premiums, many producers have fallen into the trap of selling longer elimination periods, particularly ninety to a hundred days (which now account for greater than 90 percent of all sales<sup>3</sup>). This strategy suffers from several fallacies:

1. Producers mistakenly believe Medicare (and associated MedSupps) will cover the first 100 days of care. While this is possible, Medicare’s stringent pre-requisites<sup>4</sup> all but require that the prudent advisor disregard Medicare participation for all intents and purposes.
2. The paltry premium savings gained by taking a longer elimination period (i.e., a larger deductible) are almost never offset by the eventual outlay of that very deductible. This is a case of being “penny wise and pound foolish.” For example, by agreeing to

bear the first ninety days of care yourself, you might save \$250 per year. This sounds compelling until you realize you're forfeiting over \$10,000 out-of-pocket at claim time (for example). In this case, the break-even point of your savings is forty years. Was it worth it?

3. Which brings us to the most important problem with long elimination periods: the length of time between sale and claim. At the time of sale, both applicant and producer are concerned primarily with keeping the price down. Fifteen, twenty or thirty years later, the policyholder—or more likely his or her children—are most concerned with quick and unobstructed access to their cash. Do you see the disconnect? Claimants rarely remember buying long elimination periods, or why. They are a frequent cause of policyholder complaints and a black mark on our industry. In one study of so-called “denied claims” (which came about as an inquiry into supposed bad practices) it was discovered that the majority of claims weren't being denied—merely postponed because the policyholders had not met their elimination periods.

One option that has been popular in recent years is the waiver of elimination period for home care benefits. This means that the long-term care insurance policy has two deductibles. Facility care carries the EP you choose—likely ninety days. But if your client needs home care, benefits would begin on “day one”. Frequently made a part of the waiver of elimination period for home care is a tandem benefit in which days of home care services received are applied against the facility elimination period.

EPs are most commonly satisfied by two methods: service days and calendar days.

Under service days, the insured must be receiving long-term care services (sometimes defined as X number of hours per day) to satisfy the elimination period for a given day. Thus, an individual who receives care just three days per week would not meet the ninety-service day requirement until thirty weeks, or 210 days (!). Conversely, calendar days begin on the first day of “chronic illness”: ninety calendar days later they are satisfied whether one day of service was received, or ninety. Knowing the difference, which would you recommend?

This becomes more important when you understand that almost all long-term care insurance policies require the insured to satisfy the EP only *once* over the lifetime of a policy. If the insured recovers and has already satisfied the EP, benefits are available from the first day of any subsequent claim.

Don't undervalue this option for your clients.

### **Duration of Benefits (Benefit Period)**

The *Benefit Period* (BP) is another coverage choice. The longer a policy pays benefits, the greater the premium cost. Typical options include two years, three years, four years, five years,

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**Table 15.1. Percentage of Claims Lasting X-or-More Months<sup>5</sup>**

<i><b>Duration of Claim in Months</b></i>	<i><b>Percentage of Claims</b></i>
<b>36 months or greater</b>	13.1%
<b>48 months or greater</b>	7.6%
<b>60 months or greater</b>	4.5%

six years, eight years, and ten years. Not so long ago, lifetime (a/k/a “unlimited”) benefit periods were available, but these are increasingly hard to find, and may be all but extinct by the time you are reading this. Although there’s no peace of mind like a benefit which never runs out, such “long tail” benefit periods posed an actuarial nightmare for carriers. Even though a small fraction of total claims, unlimited benefit periods ultimately fell into the category of “too risky at *any* price”.

After policy issue, the BP is often converted into a maximum dollar amount (which can be increased by an inflation feature). For example, a \$200 per day policy purchased with a five-year BP represents total coverage of \$365,000 (\$200 x 1,825 days). This calculation is obviously unnecessary for a lifetime BP.

Long-term care insurers that issue coverage on a monthly basis may calculate total coverage amount differently. A \$200 per day election is a \$6,000 per month benefit. When multiplied by sixty months (five years), this yields a total coverage value of \$360,000—slightly less than carriers who use the daily measurement.

Length of BP is a much-debated issue. Some medical problems like Alzheimer’s disease can last several years, making the longest BP affordable a desirable choice. Ever-improving medical technology has slowed mortality and increased life spans. Consequently, it has also increased disability rates because conditions that would have been deadly in the past now severely disable people.

The ultimate question is, though, for how long?

A recent long-term care claims study by Milliman, Inc., concluded that the likelihood of a long-term care insurance claim that lasts longer than three or four years is relatively low. Table 15.1 shows the percentage of claims lasting longer than a given duration:

The study also found that only 8 percent of those with a three-year benefit period actually exhausted their insurance policy benefits.

With less than 5 percent of claims lasting longer than five years, a lifetime BP purchase could be an unnecessary allocation of precious premium dollars.

<b>Table 15.2. The Potential to Save<sup>6</sup></b>	
<b>5 years</b> vs Unlimited	<b>30% to 39%</b> Savings
<b>3 years</b> vs Unlimited	<b>42% to 54%</b> Savings
<b>2 years</b> vs Unlimited	<b>51% to 64%</b> Savings

The definition of *chronically ill* in TQ policies is a serious disability definition. When one reaches the point of accessing policy benefits based on this qualification, prospects for significant longevity are dim. This supports the belief that five or six years are more than adequate protection for the overwhelming majority of people.

Because cost is an issue for most consumers, reducing the BP can save a substantial amount of premium dollars. It's far better to have some coverage than none at all. Many financial advisors have walked away from a sale because the consumer claimed the price was too high rather than alter some plan design elements (such as BP) to better fit the client's budget.

Most long-term care insurance proposals come with an alternative premium page that lists the various EP and BP combinations and their corresponding costs. See for yourself how much money can be saved by a shorter BP, realizing that it may be more than adequate for the majority of long-term care situations.

It is a fine line to walk. A consumer's budget likely will dictate the length of the BP. For the cash-conscious, a five-year benefit period can still provide an adequate safety net. Even a ten-year benefit saves money over the lifetime choice and provides a feeling of security about the adequacy of coverage. See Table 15.2.

It should be noted that spouses (or domestic partners) can share the benefits of each other's policies (often called "shared care") if they elect this option when applying for coverage. Once one spouse or partner runs through their personal benefits, the other policy's benefits become available if the other insured has not already depleted them. (This will be addressed again in a discussion of spousal options in Chapter 17.)

The bottom line is, the choice of BP can result in substantial premium savings without sacrificing much peace of mind. Remember also that only about 5 percent of claimants under the Long-Term Care Partnership Program with BPs of five years or less have exhausted their benefits and needed Medicaid.

Shorter may be better here.

## Inflation

Planning for inflation is one of the most important elements of a long-term care insurance contract. This plan design feature is so important to regulators that the inflation option is



a required component of a Long-Term Care Partnership Program policy for purchasers aged seventy-five and under.

It is a given that the cost of furnishing long-term care services will continue to increase in the future. Buying a flat daily benefit amount without considering the rising cost of medical care will leave your client underinsured for these expenses a few years from now.

This is especially important if your client is under age sixty when purchasing this policy. Although there is no guarantee regarding when a disability that necessitates long-term care services may arise, it is likely to be a few years between the purchase of a long-term care insurance policy and the use of policy benefits. (We note that the average claim tends to run between seventy-nine to eighty-two years of age, depending on the source.) Thus, it is important to address rising medical costs when designing a client's long-term care insurance plan.

There are several inflation options to consider that will increase the daily benefit—and pool of money—selected over the life of the policy to help offset inflation.

1. *Guaranteed purchase option:* Also called *future purchase option*, this rider allows one to buy additional benefit amounts at specified future dates without evidence of insurability. In effect, this feature locks up insurability, something quite valuable in a disability-based policy.

So, when does one pay for the increased benefits? Subject to great variability from policy to policy, one might generically find offers made every three years up to a certain age (e.g., age seventy-five or eighty-five), so long as no claims were made in the two years prior. Some carriers charge for this rider, while others build it in as the “default” if no other inflation options are chosen. Typically, one pays only for the additional (increased) benefits at the time they are purchased, at one's original health rate class, but at “attained” age rates. Some carriers require that the insured exercise the option periodically, for example, electing the purchase option at least once every two or three times offered, or the option lapses.

If clients choose this option with the idea of exercising it every time it comes up, they are better off buying an inflation option whose price is already built into the premium. The guaranteed purchase option makes sense when buying a higher daily benefit amount than needed, and it will be exercised only when current costs catch up with the larger purchase amount (see Item 3 below). In the worksite market, most employers offer both the guaranteed purchase option and a true inflation option and let employees decide.

Regulators do not like the guaranteed purchase option much. It cannot be used to meet the inflation requirements of a long-term care partnership policy. It can be somewhat deceiving as an inflation hedge if the insured consistently spurns the

increases when they are offered. However, this may be the only way for some people to address inflationary long-term care costs, because there is no up-front premium for this benefit choice.

2. *Inflation-specific riders:* A specific inflation benefit rider may be added to increase the daily benefit each year. Because the rider cost is factored into the premium paid every year, there is no additional premium increase just because benefits are adjusted upward annually. The amount by which the daily benefit—and benefit pool—are increased each year vary from insurer to insurer, but are most commonly 3 or 5 percent.

Although 5 percent compound used to dominate the landscape—in no small part because it was and still is required to be offered to all consumers at the point-of-sale on a TQ application—there's been an explosion of alternatives within just the past few years. This innovation has been fueled by unprecedented low interest rates and by consumer demand for more affordable options. Today we find inflation options at every half percentage point between 1 to 5 percent, multiple options tied to the Consumer Price Index (CPI), options which cap at a certain age, others which cap at two-times or three-times growth, others whose growth is synchronized with the Partnership Program rules, and still others which grow in Step-Rated fashion (i.e., benefits *and* premiums rise in tandem).

Traditionally, the insured's biggest decision was between "Simple" or "Compound": the former bases every increase on the Original benefit, while the latter bases each increase on Last Year's benefit. In the short run, there is little difference in the effect of simple and compound inflation on the daily benefit amount. Over more than ten years, however, there is a substantial difference in the benefit amount. Older clients in their seventies may consider the simple increase option because it is more affordable and there is probably less time between the date of purchase and the possible usage of benefits. Otherwise, a compound option is generally a better deal (despite the premium difference) because the benefit increases substantially more over the life of the policy.

How does this compare with inflation? The 2014 Genworth Cost-of-Care Survey measured an average 4.19 percent compound annual growth rate in private skilled nursing facility costs over the past 5 years (4.29 percent for assisted living). Meanwhile, the inflation rate for licensed home health aide services over the same time frame has grown at just 1.32 percent, while homemaker services have risen even less—1.20 percent.<sup>7</sup>

At these rates, 5 percent holds up well, but predicting health care inflation is as problematic as picking the Belmont Stakes winner. Any fixed rate can be problematic: set it too low and it won't keep pace with the cost of care; set it too high and the policy is

unaffordable. As we've noted, at least one carrier has flirted with a "floating" rate tied to an economic indicator—the CPI-U. Why not the CPI-Medical? Because that index is driven by aggressive investment in cutting-edge research, life-saving care, and medical malpractice. Instead, the CPI-U is largely comprised of labor and housing, which tracks well with the costs incurred running HHC Agencies and Assisted Living.

Premium affordability often becomes the deciding factor in these elections, but one should be careful to compare the potential difference in benefits with the differential in premium cost. Once again, financial advisors should remember that some coverage is better than none at all.

Table 15.3 illustrates these yearly increases based on the inflation option selected for a \$200 per day policy benefit. The most common question is the difference in benefit level between the 5 percent simple and 3 percent compound increases, because their pricing is similar. Unless a compounded inflation rider for long-term care partnership purposes is needed, the 5 percent simple increase starts higher and maintains that margin over the 3 percent compound rider for the full thirty years of increases, as shown in Table 15.2.

3. *Higher daily benefit amount:* As an alternative to purchasing an inflation option, some advisors recommend purchasing a higher daily benefit amount than is currently needed. At some ages, it may make more sense to buy a much higher daily benefit amount than your client currently needs based on local costs than to pay the extra premium for an inflation option.

For example, instead of buying \$200 per day to cover today's costs, you select \$300 per day. That could be a sufficient inflation hedge, primarily for people in their sixties and seventies, especially when coupled with a guaranteed purchase option should the costs of care catch up with the amount initially purchased.

This is not a long-term tactic, but more of a short-term gambit. As you can see from Table 15.4, over a period of years, the compound inflation feature may be a better buy.

Although it is difficult to know whether even a 5 percent compound inflation option will be sufficient for future long-term care costs, addressing this problem in your clients' plan design is a crucial part of purchasing long-term care insurance as a means of managing future unreimbursed long-term care medical expenses.

### **Dropping Inflation Protection**

Another important aspect of the inflation option is what might happen if your client chooses this rider but later decides it's unaffordable. Inflation is generally the most expensive benefit to add to a long-term care insurance contract, so later in life when money may be tight and assets

**Table 15.3. Annual Increases to \$200 Daily Benefit by Type of Inflation Option**

<i>No Inflation</i>	<i>5% Simple</i>	<i>3% Compound</i>	<i>4% Compound</i>	<i>5% Compound</i>
\$200	\$200	\$200	\$200	\$200
\$200	\$210	\$206	\$208	\$210
\$200	\$220	\$212	\$216	\$221
\$200	\$230	\$219	\$225	\$232
\$200	\$240	\$225	\$234	\$243
\$200	\$250	\$232	\$243	\$255
\$200	\$260	\$239	\$253	\$268
\$200	\$270	\$246	\$263	\$281
\$200	\$280	\$253	\$274	\$295
\$200	\$290	\$261	\$285	\$310
\$200	\$300	\$269	\$296	\$326
\$200	\$310	\$277	\$308	\$342
\$200	\$320	\$285	\$320	\$359
\$200	\$330	\$294	\$333	\$377
\$200	\$340	\$303	\$346	\$396
\$200	\$350	\$312	\$360	\$416
\$200	\$360	\$321	\$375	\$437
\$200	\$370	\$331	\$390	\$458
\$200	\$380	\$340	\$405	\$481
\$200	\$390	\$351	\$421	\$505
\$200	\$400	\$361	\$438	\$531
\$200	\$410	\$372	\$456	\$557
\$200	\$420	\$383	\$474	\$585
\$200	\$430	\$395	\$493	\$614
\$200	\$440	\$407	\$513	\$645
\$200	\$450	\$419	\$533	\$677
\$200	\$460	\$431	\$554	\$711
\$200	\$470	\$444	\$577	\$747
\$200	\$480	\$458	\$600	\$784
\$200	\$490	\$471	\$624	\$823

dwindling, as retirement stretches farther than the finances to support it, clients may re-examine expenses with an eye to trimming them.

The inflation option is an easy target. One can retain basic long-term care insurance coverage and simply forgo future increases to daily or monthly benefits.

<i>Age</i>	<i>5% Compound Inflation</i>	<i>Higher Benefit Amount</i>
<b>60</b>	\$150 per day	\$300 per day
<b>74</b>	\$297 per day	\$300 per day
<b>80</b>	\$397 per day	\$300 per day
<b>85</b>	\$506 per day	\$300 per day

Carriers used to deal with requests to drop the inflation option by reducing the premium and freezing the benefit level accumulated to date. Actuarially speaking, this may have been a bit generous on the part of the insurer. Whereas all those years of extra premium had been paid for the option, the insurer is now simply charging the cost of the original benefit level for the duration of the policy life and hoping that the money already paid in for the inflation option was sufficient to cover the additional risk. No muss, no fuss.

Some insurers may still handle such requests this way; but today, bean counters handle this situation inconsistently. Instead of dropping the premium and freezing the benefit, they might:

1. Drop the premium and return the benefit to the level chosen at the time of application. In this case, the insured can be said to have gained the benefit of the “growth” during the entire time the policy owner paid the rider premium, but forfeited all of it as soon as the rider was dropped. No matter how it’s expressed, most consumers find this wholly unsatisfying.
2. Freeze the benefit level and calculate a new premium that accommodates the current increased daily or monthly coverage amount. This would likely result in a premium similar to what is currently being paid, except under the new calculation, the benefit would no longer increase. In this case, the insured is better off paying the original premium because at least the benefit would still adjust upward annually.
3. Total the additional premium paid in by the insured for the inflation option at the time of the request to drop the rider. The carrier then makes a second calculation, figuring how much additional benefit can be added to the original amount as a result. This newly calculated daily benefit becomes the new coverage level and remains in place for the life of the policy. The rider premium is dropped.

This third exercise seems to make the most sense and be the most equitable to both insured and insurer. The rider premium is eliminated, making the policy affordable to the insured, who retains the monetary value of what was already paid for the inflation option. The insurer does not assume additional risk that has not been paid for.

*For example:* an initial \$200 per day plan with a 5 percent compound inflation option (which doubled the total premium cost) is dropped twelve years after purchase. It could yield a permanent extra benefit of \$85 per day (for a new total of \$285 per day) for the life of the policy. Although the rider had nearly doubled the original amount to \$396 per day, this solution represents a compromise where both parties benefit from the request to drop the inflation option.

Financial advisors should check with their long-term care insurers to see how they handle this particular situation. It is part of your due diligence with regard to the inflation option. Regulators are insistent that you discuss inflation protection with your prospects, but you should be aware of the consequences of dropping these riders as well. Just as important, dropping or reducing inflation protection can disqualify your policyholder from Partnership status—this is called “stepping down”, and whether or not it’s permissible varies from state to state. This is just one of the reasons state-specific Partnership training should not be treated casually.

### **Cash versus Expense Reimbursement**

In the weeks, months, and even years that followed the passage of HIPAA in 1996, there were many passionate arguments about the value of TQ vs. NTQ plans for consumers. Although many of these discussions have faded away because the industry overwhelmingly embraced TQ plans, this passion has now been transferred (in part) to evaluating the methods of claim payment.

Most long-term care insurance plans have traditionally been paid on an expense reimbursement basis, meaning that the insured or, more likely, the provider of the long-term care services submits a bill to an insurance company and is reimbursed according to the limits of the long-term care plan. For example, if your long-term care policy pays up to \$200 per day in benefits and the facility of choice costs only \$180 per day, the policy will pay \$180 per day. You don’t lose the \$20 per day difference; it simply stays in the policy to pay out on another day. In essence, it extends the pool of money that was originally chosen at the time of application.

In the last few years, a “cash” payment system has grown in popularity, with some products paying entirely in cash, others promoting cash “alternatives” (at a discounted rate from one’s maximum benefit), and still others hybridizing the cash and reimbursement at the same time. To be clear, “cash” is a different model than “indemnity” which had its day in the 1990’s and seems to have run its course.

In an indemnity-style plan, as long as you receive a service on a given day, your policy would pay you the daily benefit you purchased (regardless of charges). In other words, if you bought a \$200 per day indemnity policy and your expense was \$180 per day, your policy would pay you \$200. Cash is different—but easily confused. In a cash (or “disability”) model, you do not even need to incur services. Instead, you need only prove that you are “chronically ill”. Often, the cash is paid prospectively, meaning at the beginning of the month; whereas

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reimbursement plans must pay at the end of the month (or later), since the bills must be received first.

Cash has a simplicity and flexibility that makes it attractive to agents and consumers alike, and increasing numbers of plans include some variation nowadays. These contracts are much easier to explain and the idea that your client will receive cash if she is chronically ill and can choose whatever care she desires is appealing—especially informal care from family, friends or neighbors. Among the drawbacks of cash are concerns over accountability (will the money be used appropriately, will the patient receive the right care?), mismanagement, fraud and abuse (will there be someone trustworthy to manage the patient’s finances, especially if single or cognitively impaired?).

This plan design decision also may come down to affordability, which favors the expense reimbursement plan. As emphasized frequently throughout this book, some coverage is better than none at all.

There is also a tax issue that could arise with cash plans. It won’t happen with an expense reimbursement plan because policy benefits do not exceed the expense incurred. But with a cash policy, it is possible that the policy benefit paid could be higher than actual long-term care charges, which brings the per diem limit into the equation (\$330 per day in 2014).

If a policy benefit is both higher than the per diem limit and costs incurred, there may be a taxable situation with a TQ plan. For example, if your client has a \$400 per day policy and incurs \$350 per day of expenses (in 2014), the policy will pay the client \$400, and there will be a tax on the payout differential of \$50 because the policy paid in excess of the per diem limit, and in excess of actual charges. If the expenses were \$400 per day instead of \$350, then there would be no tax because the policy did not pay out more than the costs incurred.

Still, look for cash options to continue to increase as insurers continue to fine-tune their products. One “best of both worlds” policy solution today combines the expense reimbursement method with a partial monthly cash payment. With such a product, the insured (if meeting the *chronically ill* definition) can opt for a portion of the monthly benefit available to be paid in cash, and the balance left for any specific expenses that need to be reimbursed. Carriers have flirted with this concept for the last decade with modest success.

These are the plan design choices you will explore with your client during a discussion of insurance as a long-term care planning solution. Table 15.5 lists 2012 sales results for some of these plan design alternatives, although the reader will keep one bit of advice in mind while reviewing the survey results. Although these were the choices made by our peers in consultation with their clients, they are by no means an expert consensus. We should always take what “the crowd” says with a grain of salt. If we had taken a survey in Galileo’s age, 99 percent of the insurance industry would’ve been selling Flat Earth insurance to protect against the risk of sailing off the rim of the sea. Treat each of your client’s circumstances as unique.

<b>Table 15.5. Individual Long-Term Care Insurance Sales by Plan Design Selection<sup>8</sup></b>	
<b>2012 Sales by Elimination Period</b>	
<b>Less than 30 days</b>	2.7%
<b>31 to 89 days</b>	1.5%
<b>90 to 100 days</b>	92.3%
<b>Over 100 days</b>	3.5%
<b>2012 Sales by Benefit Period</b>	
<b>Less than 3 years</b>	10.5%
<b>3 Years</b>	31.2%
<b>4 Years</b>	27.0%
<b>5 Years</b>	17.4%
<b>6 to 10 Years</b>	9.6%
<b>Lifetime Coverage</b>	4.3%
<b>2012 Sales by Inflation Mode</b>	
<b>5 percent compound for life</b>	42.0%
<b>5 percent simple for life</b>	9.0%
<b>3 percent compound for life</b>	30.0%
<b>CPI-based formula</b>	6.0%
<b>GPO</b>	4.5%
<b>No inflation option</b>	4.5%
<b>Other inflation choice</b>	4.0%

### Endnotes

1. Katz S., Down, TD, Cash, HR, et al. (1970) progress in the development of the index of ADL. *The Gerontologist* 10:20-30.
2. Genworth, Cost of Care Survey, Summary of 2014 Findings.
3. American Association for Long-Term Care Insurance, 2014 LTCi Sourcebook, [www.aaltci.org](http://www.aaltci.org)
4. "You should not rely on Medicare to pay for your long term care needs," A Shopper's Guide to Long Term Care Insurance, January 1, 2014, National Association of Insurance Commissioners.
5. American Association for Long-Term Care Insurance, 2010 LTCi Sourcebook, [www.aaltci.org](http://www.aaltci.org). Percentage of Claims Lasting X or More Months by Benefit Period. "Weighted average includes both open and closed claims. Open claims are a dynamic number and are likely still understated compared to what the final number will be."
6. American Association for Long-Term Care Insurance, 2010 Sourcebook, [www.aaltci.org](http://www.aaltci.org). 2010 LTC Price Study.
7. Summary of Findings, Genworth 2014 Cost of Care Survey, March 25, 2014.
8. American Association for Long-Term Care Insurance, 2014 LTCi Sourcebook, [www.aaltci.org](http://www.aaltci.org). Sales & Claims Data—Individual LTC Insurance.