The Individual Long-Term Care Insurance Product

Regardless of the hype surrounding combination products, the fact remains that so-called stand-alone individual long-term care insurance is still the dominant product in its market. Even as both products continue to evolve, this dominance is expected to continue: asset-based solutions tend to attract a niche client (an affluant one with significant nonqualified capital) and are unlikely to gain mass market appeal. By contrast, traditional LTC insurance can be designed for any price point, and its manufacturers have studied consumer attitudes at length in order to design products specifically tailored to America’s vast middle market.

Almost certainly guaranteeing this forecast is the lack of Partnership eligibility of combo products: you will recall that Partnership’s primary targets are those in the middle. Consumers who desire the estate protection promised by their state’s Partnership program will wish to avoid asset-based products.

Thanks to an ever-growing body of experience, today’s pricing is more confident than ever, and not only includes built-in cushioning for Moderately Adverse Experience (MAE), but must be certified each year by the company’s chief actuary. Stand-alone long-term care insurance is also easy to navigate at claim time: today’s top insurers pay out nearly eleven million dollars per day in benefits.

In an earlier chapter, you had a chance to view the main design elements of every long-term care insurance plan, what one carrier has cleverly dubbed “The Core 4℠”[[1]](#endnote-1): 1) how much do you want to receive per day or month (*benefit amount*); 2) how long do you want the benefit to last (*benefit period*); 3) how soon do you want benefits to begin (*elimination period*); and 4) how fast do you want the benefits to grow (*inflation protection*)?

Now we’ll explore the other features of a standalone long-term care insurance contract, which also apply (mostly) to combo and worksite long-term care plans. It is important to be familiar with all of the benefits, limitations and exclusions of these policies, as well as the purpose of optional riders that can be added to enhance the basic contract.

# Covered Services

The vast majority of policies sold today are *comprehensive*[[2]](#endnote-2), by which we mean coverage for care received in a nursing facility, assisted living, or in one’s home. No matter where care is received, the benefit is paid from the same pool of money. (By contrast, the policies of yesteryear were more popularly *nursing home only* or *home care only* and one might add one or the other via rider or pay each from a separate pool of money.)

Perhaps unique to qualified LTC insurance, care is *purpose*  driven. According to IRC Section 7702(B)(b)(1)(a):

“… the only insurance protection provided under such contract is coverage of qualified long-term care services.”

The law goes on to define qualified long-term care services in IRC Section 7702(B)(c)(1):

“The term ‘qualified long-term care services’ means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services”[[3]](#endnote-3)

We have discussed the triggers (two of six ADL’s and Cognitive Impairment), but neglected to mention that severity is largely inconsequential. Had it survived, the CLASS Act would have paid increasingly larger benefits to those individuals who were more disabled (e.g., could not perform three of six ADL’s or four of six ADL’s). This is the same practice used in some foreign countries—but not with private long-term care insurance. (Severity of disability is only measured indirectly: we expect sicker claimants to use more services than healthier claimants, but indemnity or cash policies wouldn’t even take note[[4]](#endnote-4).)

The following are an assortment of settings where extended care may be provided; in each location the level of skill may vary from low to high, as you’ll read. We should preface this discussion with mention of just two NAIC Model Act revisions (1987 though 1989) since these are relevant to the conversation which ensues. First, policies cannot stipulate one type of care as a prerequisite for another (e.g., requiring a nursing home stay as a prerequisite for home care coverage). Second, they cannot require a higher level of care as a prerequisite for coverage of a lower level of care (e.g., requiring skilled care as a prerequisite for custodial care coverage).

## Intensive Care

This is the most serious medical situation, in which a patient is monitored at all times. A person may be placed in intensive care following surgery and then monitored for any negative signs, usually on a twenty-four hour basis. A hospital is the most common facility for this type of care.

## Acute Care

Individuals who are no longer on the critical list and do not need twenty-four hour care may still need to be monitored periodically in a hospital-type setting. In a twenty-four hour period, medical personnel may spend up to eight hours with a patient.

The preceding services are typically short-term and covered by health insurance or Medicare, but not by long-term care insurance. On the other hand, should a nursing facility claimant take a sudden turn for the worse and need to visit the hospital for an acute condition and recovery, the policy’s bed reservation benefit would continue to pay the nursing home’s daily rate until the claimant returned so the room would not be forfeited. As we know, any kind of transition (even down the hall) can be unnecessarily traumatic.

## Skilled Care

Skilled care is intended for people who have uncontrolled, unstable, or chronic conditions that require intensive care or for people who are recovering from a condition that initially required hospitalization. This type of care can be administered in the home, an assisted living facility, nursing home, or hospital and, like the name suggests, is provided by professionals with advanced education such as RN’s, LPN’s, LVN’s, Physical Therapists, Occupational Therapists, or Speech Language Pathologists and others.

## Intermediate Care

This type of care is similar to skilled care, except it is provided on a periodic basis. It is designed for people with chronic conditions who cannot live independently, and it stresses rehabilitation that enables individuals to either return home or regain and retain as many ADLs as possible. Changing a bandage every eight hours, for example, is considered intermittent treatment. Skilled medical personnel deliver or monitor this type of care.

## Custodial Care

This care involves assisting individuals with ADLs, which include, but are not limited to, bathing, dressing, eating, toileting, and walking. This is the most common type of care received, and can be provided by anyone from a Certified Nursing Assistant (CNA), to an informal caregiver such as a neighbor or family member. Between 70 and 80 percent of paid long-term care in the United States is provided by direct care workers, for example home health aides, CNA’s and personal care aides, a workforce of four million.[[5]](#endnote-5)

## Subacute Care

It is helpful to think of *sub* acute care as *post* acute: post-surgery or rehabilitative care that often takes place for a short period of time in a skilled nursing facility. Although Medicare may reimburse for this type of care, surveys are often uncomfortable labeling it long-term care for obvious reasons. It may include extensive physiological monitoring, intravenous therapy, postoperative care, intensive rehabilitation, or other medically complex interventions.

On the other hand, the objective of most long-term care is not the restoration of a person to preaccident or preillness health, but the prevention of further deterioration. This maintenance care has not traditionally been covered by Medicare, nor by comprehensive major medical insurance to any degree.

This lack of coverage left the door open for the emergence of long-term care insurance.

## Alternate Plan of Care

The settings in which long-term care services are delivered are also defined within a long-term care insurance policy. These provisions define where the insured may receive this care. Long-term care insurance policies have long hedged their bets regarding such services—in a good way.

Because the long-term care provider industry, like the insurance product that covers it, is still evolving, long-term care policies typically include a clause called an *Alternate Plan of Care*. This is a catch-all feature intended to broadly cover services that are not specifically named in a contract, including those that have not yet been invented in this technology-driven age, such as robotics and telemedicine. Since these contracts are designed to remain current for ten, twenty or thirty years into the future, APC is a vital way of ensuring flexibility and modernity.

Having said that, care must be taken when explaining this feature. The Alternate Plan of Care requires the mutual consent of the insured, the insured’s doctor and the insurance company. Depending on the particular contract, a nursing home confinement must otherwise be required (in other words, the Alternate Plan of Care is contemplated to keep the insured out of the nursing facility). For instance, an insurance company might see the value of paying $30,000 for home modifications (wheelchair ramps, widening doorways, grab bars) to keep an insured at home versus a much more pricey nursing home confinement. The advocacy of an agent in these circumstances cannot be overstated.

Alternate Plan of Care came under fire in the last decade as a result of being either oversold by agents, or misunderstood by consumers. Insureds who purchased cheaper Nursing Home Only policies attempted to qualify for Home Care benefits under their APC features. The argument was sensible: wouldn’t it be less expensive to keep us at home than force us to enter the nursing facility? True, said the insurance companies, but you should have bought comprehensive coverage, which was priced for this risk![[6]](#endnote-6)

Alternate Plan of Care’s true success story (and an unsung chapter in the annals of LTC) was its handling of assisted living. When many of the early popular policies were written, Assisted Living Facilities (ALFs) were undefined and unregulated and as such, were not included in the older plans, either explicitly or by definition. There was no requirement to pay for care received in Assisted Living, and premiums did not contemplate care received there. But, true to the spirit of the Alternate Plan of Care as a growing, living document, carriers responded to this explosive growth in the 1990’s by paying these claims.

No one could’ve predicted the rise of ALFs, but the insurance industry was faced with a choice: deny the claims and/or force policyholders out of these desirable settings into less desirable nursing homes to seek reimbursement, or pay the claims (even though they weren’t obligated under their contracts) and potentially have to raise rates down the line since ALFs weren’t originally priced. We know how it turned out.

## Facility Care

Today, the following settings are specifically named in a long-term care insurance contract:

* *Nursing facility care:* Most consumers still associate long-term care insurance with nursing home coverage, which is a shame since the majority of long-term care is now received at home. In fact, the very presence of LTC insurance may be what allows policyholders to stay *out of* a nursing facility (which is why we sometimes call it anti-nursing-home insurance). Generally, skilled facilities cover people in short-term recovery from a hospital stay or those who need around-the-clock skilled care (and who may be near the end of life). Still, it is an important part of long-term care insurance coverage because it can be the most expensive, and the need for third-party financial assistance is probably greater. Family caregivers often reach the point where they can no longer handle the insured patient, and the movement to a facility triggers the act of claiming long-term care insurance policy benefits.

The cost of this care locally is an important number, as mentioned earlier in the book. Because it is the most expensive method of delivering long-term care services (short of 24/7 home care), if these costs are used to determine benefit level at the beginning of the insurance process, this amount will likely be more than sufficient to handle other, less expensive covered services.

* *ALF care*: Long-term care policies of the 1980s and early 1990s didn’t even reference this long-term care venue. A commonly cited definition of *assisted living* is “a congregate residential setting that provides or coordinates personal services, twenty-four hour supervision and assistance (scheduled and unscheduled), activities, and health related services.”[[7]](#endnote-7) In some states these facilities are licensed, and in some they are not. We see a variety of names, from Adult Congregate Care to Residential Care Facilities (in CA). The most important point is to follow the policy definition, which will usually dispense with names and instead list a set of criteria. In other words, “If it walks like a duck and quacks like a duck, it’s a duck.”[[8]](#endnote-8)

More and more people in need of care are turning to such places for assistance for two primary reasons: price and comfort. ALFs are about half the cost of a skilled nursing facility, and until one requires more intensive skilled care, these more “homey” abodes are attractive to people who need assistance with ADLs.

According to the first-ever national estimate of people living in assisted living,[[9]](#endnote-9) we can make the following description of residents: “mostly female, non-Hispanic white, and aged eighty-five and over, and had a median length of stay of about twenty-two months. For about 20 percent of residents—or 137,700 persons—Medicaid paid for at least some long-term care services provided by the RCF. Almost 40 percent of all residential care residents received assistance with three or more ADL limitations, and over 40 percent had Alzheimer’s disease or other dementias.”

At Residential Care Facilities (RCF), 38 percent of residents received assistance with three or more Activities of Daily Living (ADLs), 36 percent received assistance with one or two ADLs, and 26 percent did not receive assistance with any ADL. Table 1 shows the specific breakdown by type:

|  |  |
| --- | --- |
| Table 1 Percentage of Assisted Living Residents Needing Help by ADLs | |
| Activities of Daily Living | Percentage of Residents ***Needing Help*** |
| Bathing | 72% |
| Dressing | 52% |
| Toileting | 36% |
| Transferring | 25% |
| Eating | 22% |

## Home Care

Something of a Holy Grail, care at home has become the overwhelming favorite of people who receive long-term care services. And why not? Few people prefer a facility to their home, and medical technology has made it possible to bring most equipment and support into the house. According to a 2013 “National Study of Long Term Care Providers” published by the National Center for Health Statistics, there were an estimated 12,200 home health agencies in the US at last count.[[10]](#endnote-10) They serve a population of around 4.7 million (“On any given day in 2012, there were 273,200 participants enrolled in adult day services centers, 1,383,700 residents in nursing homes, and 713,300 residents living in residential care communities. In 2011, about 4,742,500 patients received services from home health agencies, and 1,244,500 patients received services from hospices. Overall, these five long-term care services provider sectors served about 8,357,100 people annually.”)

When recommending long-term care coverage, it’s important to take into account our client’s prospective living arrangements. Of course everyone wants to stay at home, but will there be a supportive network of family, friends and neighbors to help make this possible? People living alone are more likely to face institutionalization, simply because they are unable to easily bring in a caregiver for assistance. A spouse, partner or sibling makes the home a likely destination. The transition to home care is much easier when there is someone present to help with the basics. (Hence one of the reasons for 10 to 20 percent partner discounts: the partner can both delay institutionalization, and decrease the amount of paid care required.)

Physicians often recommend home care because it provides an important foundation for the emotional well-being of the person in need of care. According to the The Sandwich Generation Web site, long-term care in the home is commonly associated with the following positive factors:

* Control of one’s lifestyle, including designated times for daily activities and social life
* Being within one’s own environment
* Emotional and physical security
* Independence
* Privacy and maintenance of one’s own space
* Memories, magnified by personal history
* Being the source of financial security
* Extension of one’s self-expression

Grammarians will notice that care in the home is sometimes divided into two further categories: home *health* care and simply home care. Where this is the case, home health care is meant to refer to care of the *person*, while home care is meant to refer to care of the *home* (or other hands off services). In other words, HHC would take into account all of the skilled nursing care, physical and speech therapy, lab services, and intermediate care previously discussed, while home care might mean assistance with Instrumental ADL’s (shopping, bill paying, driving to appointments), laundry, housekeeping, cleaning dishes, or shoveling the walk.

HHC services may come from a multitude of sources: professional agencies which are part of large national chains, independent, or affiliated with a nursing home or hospital. Most policies accept individuals operating independently (if they are licensed and acting within that scope). Still others accept and will reimburse informal caregivers, which refers to unlicensed, untrained and/or uncertified caregivers such as family, neighbors or friends.

This last point is worth discussion, since it’s very important to consumers. Most care in the US is provided by family. Of all the benefits to review when designing and selling long-term care insurance, few are more important than home health care. Why? Home is where your clients want to stay. A policy without strong HHC benefits doesn’t do them much good. (And home is where they *are* staying: according to one company’s internal statistics, over 70 percent of claims originate in the home, and 77 percent of claims never transition from their original site.) Further, your clients would love to receive care from people they know and trust over strangers. Now, this is obviously not always possible, but sometimes it will be.

Depending on the contract, some insurers will reimburse informal caregivers with limitation. These may include preapproval, or use of Care Coordination, or limitation on certain kinds of care services (e.g., help with ADL’s and IADL’s), or only after undergoing training. It’s worth noting that most policies do provide a small benefit for Caregiver Training. Policies which provide a Cash Benefit (or Cash Alternative) obviously permit informal caregivers—remember that when cash is paid, the company is writing a check with no strings attached. The policyholder receives the money and is not told how to spend it.

Insurers commonly use a monthly benefit calculation to more broadly reimburse for HHC services nowadays. For example, insurers convert a $200 per day plan to a benefit of $6,000 per month for home care purposes. If, in the first covered claim week, the insured incurred home care expenses of $550 on one day and $700 on another and did not sustain any charges on the other five days, these amounts would simply be subtracted from the $6,000 monthly total and paid in full. By contrast, if one had an older policy that restricted benefits to a daily cap of $200, the policy would come up short on both days.

Study the home care clause in the policy carefully, because it is likely that this portion of the policy will be used first and foremost. Understandably, clients may have the most questions about this part of a policy.

## Adult Day Care

Just as we dropped off our dependent children at day care centers, we are now doing the same when caring for a dependent adult. Boomer caregivers today are also workers, and adult day care is a welcome placement option when one is toiling at a job.

Some charge by the hour, some by the half-day, and some by the full day; rates may be subsidized by the government (based on income) or by the community (without regard to income). The national median average cost is $65 per day.[[11]](#endnote-11)

A dependent adult in a day care center is supervised, fed, administered medication, and—in some cases—receives skilled care. Adult day care is not designed to replace the nursing home environment, where a significant amount of skilled care is required. But it is a perfect place for an adult who cannot stay home alone unsupervised throughout the day.

It is helpful that some adult day care centers provide activities including speakers, music, and even field trips. Many dependent adults may have diminished physical capabilities, but they are still mentally sharp, and this type of stimulation is both healthy and helpful. Good health is often a byproduct of performing regular activities.

Normally, adult day care is used to relieve the caregiver of duties for the day while ensuring that the care recipient will receive the proper care in a safe, friendly environment. These centers usually operate during normal business hours five days a week, and some centers also offer services on evenings and weekends.

In general, there are three main types of adult day care centers: those that focus primarily on social interaction, those that provide medical care, and those dedicated to Alzheimer’s care. Many of these facilities are affiliated with other organizations, including home care agencies, skilled nursing facilities, medical centers, or other senior service providers.

Generally, care recipients can benefit from adult day care because:

* it allows them to remain in their community while caregivers work;
* it gives them a break from the caregiver;
* it provides needed social interaction; and
* it provides greater structure for daily activities.

Adult day care facilities can provide a variety of services and activities, including:

* assistance with eating, taking medicines, toileting, and/or walking;
* counseling;
* educational programs or mental stimulation;
* exercise programs;
* health monitoring (e.g., blood pressure, food, or liquid intake) ;
* podiatry care;
* preparation of meals and snacks;
* social activities;
* therapy (occupational, physical, speech, etc.); and transportation services.

## Respite Care

This is a service whereby temporary professional care is employed to give the primary informal caregiver time off. With so many adults today providing care for a dependent parent or relative, the need for a break (i.e., respite) can be as often as once a week to run errands or perhaps to take a vacation. Long-term care insurance policies generally reimburse a specified number of days annually for caregivers in need of this break in the caregiving routine.

## Hospice Care

Also a standard part of long-term care contracts and often considered part of the comprehensive scope of services covered is hospice care (palliative treatment for the terminally ill). Hospice can be provided in the home or at a specific facility.

## Additional Individual Long-Term Care Policy Features

Although you may not review each of the following items with your clients during each presentation, a thorough understanding is nevertheless valuable. Any one of these concepts could be important to the next person you assist with long-term care planning.

## Guaranteed Renewability

Long-term care policies must be guaranteed renewable. This means that, once a policy is issued, the insurance company can not single any policyholder out for a rate increase because the policyholder filed a claim, grew older, or got sick. (Insurers occasionally improve their contracts and often send amendments to this effect to policyholders. Improving coverage is fine; but insurers cannot change policy language for the worse—an important consumer protection.) As long as the premiums are paid on time, the insurance company must renew the policy. This is powerful. It explains why the insurance companies go to such great lengths to underwrite up-front. (In fact, as lapse rates have fallen, underwriting has grown more stringent.)

Likewise, once policyholders obtain their coverage, they rarely drop it—as we’ve seen, lapse rates are incredibly low (less than 1 percent per year). In fact, even after a rate increase, most consumers do not lapse. According to one company, after a round of rate increases 81 percent of policyholders paid the increased amount, another 18 percent reduced their benefits and kept their premiums steady, while just 1 percent chose lapse or nonforfeiture.[[12]](#endnote-12)

Of course, the possibility of a rate increase worries many clients, both the insured and those seeking information about coverage. In disability insurance, insurers can sell noncancellable policies in which policy provisions cannot be changed nor rates increased. This rate guarantee lasts until age sixty-five.

This is not likely to happen with long-term care insurance (although there was a product which was sold noncan at one time). It did not happen initially with disability insurance. Insurers built up pricing confidence over time and subsequently were able to offer this renewal provision.

At best, long-term care insurance policies might build-in (or sell via rider) a rate guarantee for a specified period of time such as three or five years (occasionally as long as ten years). Some state insurance departments would not approve these guarantees because they assumed that the insurer would automatically raise premium rates at the end of the guarantee period (a myth). It’s worth noting that agents found a work-around of their own: simply by selling limited-pay premium modes (such as ten pay polices or pay to age sixty-five) they assured their clients a certain measure of safety from rate increases. Once you have paid that last installment, the company can not come back to you to ask for more money, so any rate increase they filed would not pertain to you. (The ultimate limited-pay? Single-pay, which is what most combo product designs entail: Hence one of the ways combo products ensure protection against rate increases.)

Since guaranteed renewable policies cannot single anyone out, how do they raise rates? They must apply to each State Insurance Department by policy form on a class basis. (Carriers are given some discretion over the term class, but it’s what allows those with lifetime benefit periods to receive higher rate increases from those with three year benefit periods, or those with 5 percent compound to be hit harder than those with GPO.)

Unless you’ve been living under a rock, you know the industry has requested its fair share of rate increases on older blocks of business. With only a few exceptions, the pricing mistakes that were made had nothing to do with excessive claims. Many of the rate increases sought have had more to do with other errors, such as underestimating policy persistency (lapse rates) and overestimating investment returns (thanks to the Fed’s policy of artificially suppressing interest rates near zero for the last few years).

Rate increases come in all shapes and sizes, from modest single-digits to eye-popping amounts approaching triple-digits. There are a handful of states which rubber stamp any request for a rate increase, a few which knee-jerk deny all petitions, and the vast majority where it’s a matter of negotiation. Sometimes the carrier does not receive the full amount requested; other times the state may stagger over several years the initial amount requested (e.g., a 60 percent increase may be scheduled as 20 percent per year over three consecutive years). Where consumers originally had very little choice (“pay it or don’t pay it”), they are now given a variety of *prix fixe* benefit reduction options by their insurers when faced with a rate increase. This way, the impacted policyholder is allowed to absorb the rate increase by paying the same premium as before, but with benefits reduced accordingly.

Regulators have grown increasingly reluctant to approve rate increases, and carriers have taken heed. This creates a hostile business environment, one where insurers are suspected of applying for higher-than-necessary increases in an attempt to “grab all they can” before it gets even harder in the future. On the other hand, well-meaning regulators who disapprove increases for the benefit of their constituency may—through the law of unintended consequences—only be making things worse.[[13]](#endnote-13)

Rate increases are not just a problem for consumers—premiums are generally designed to remain predictably level because seniors are assumed to retire on fixed incomes—they are also a public relations scourge. To help alleviate this problem, the NAIC developed rate stability regulations for states to adopt. Among the concepts drafted by its Long Term Care Insurance Task Force were:[[14]](#endnote-14)

* A rate increase charged to an inforce policyholder must not exceed the current new business rate charged to new insureds for like benefits.
* The loss ratio on rate-increased premium must be a minimum of 85 percent (versus 60 percent on regular new business).
* Policies must include Contingent Nonforfeiture Benefits.

Although only a handful of states have formally adopted these regulations (a cumbersome process generally involving State Legislatures), it is customary for insurance carriers to voluntarily include them in their policy forms and/or business practices. Thus, nearly all insurance companies include or honor the above, whether states require them to or not (including other elements of the Model Act, such as Timely Payment of Claims and Third Party Review).

## Contingent Nonforfeiture

As stated, Contingent Nonforfeiture (CNF) ensued from the NAIC Model Act as a lever to limit the cumulative amount of rate increases imposed by insurers. It was adopted by the great majority of states, and insurers have made it a standard part of policies today.

As part of this provision, each long-term care insurance policy comes with a standardized, age-driven table based on the age of the insured at issue. In this table, each age is associated with a percentage at which CNF is triggered. For example, a long-term care insurance policy issued to a sixty-three year-old would have CNF triggered at 58 percent (the *cumulative* amount of rate increases allowed in relation to the initial premium, for the life of the policy). If the insurer exceeds that 58 percent at any time, the policyholder must be offered a paid-up policy as an alternative to paying the increase. (The paid-up policy is typically comprised of a pool of money determined by the net amount of premiums paid, less any claims paid.)

The name makes it sound more complicated than it is. The policyholder does not forfeit the premiums paid, but only if a certain contingency occurs: cumulative rate increases over a benchmark amount. Of course, as an agent, it is rarely good counsel to recommend a policyholder give up the tremenedous leverage of the underlying protection if there’s any way she can continue paying the premium, even if it means reducing benefits.

## Waiver of Premium

A standard part of any disability-based policy, waiver of premium generally is initiated when the insured begins to receive long-term care benefits under the policy, or after a designated period of time. It is part of every long-term care insurance policy because it makes sense not to require the financial burden associated with paying premiums when there are more important bills to pay during this time of crisis. Premium payments are expected to resume after (and if) the policyholder recovers and is no longer receiving long-term care services.

The waiver of premium can be converted into a joint waiver of premium if both spouses are insured and this option is elected. More on this subject can be found under Spousal Benefits later in this chapter.

## Care Coordination / Case Management

Quick—your parent has fallen and needs immediate help. What do you do? Open the yellow pages? Those who think LTC insurance is all about protecting assets are missing the point. Millionaires have plenty of assets, but even they make poor decisions under crisis. What LTC insurance provides is access to a phone number that the general public doesn’t have: access to concierge care. Instead of flipping through the yellow pages and fending for yourself, the insurance company will assign you a Care Coordinator (sometimes in-house, sometimes from a 3rd-party vendor) to conduct an assessment of your care needs, help design a plan of care, and help locate providers in your area. Some Care Coordinators include access to provider quality ratings and reports, and provider discounts (stretching your claim dollar further); still others unlock additional policy benefits if you use their voluntary services. The use of Care Coordination is almost always voluntary and almost never comes out of your policy benefits—the insurance company likes to see you use this service to make sure your care is appropriate—not too much and not too little.

For some companies the Care Advisor is the point person for contact and communication during a claim, which makes the job of the financial advisor easier at this time. This individual has abundant information on various providers of long-term care services, which is convenient for the family who will be making care decisions on behalf of the insured. Explanations of the contractual benefits and how best to maximize them is only part of what this coordinator can do.

## International Coverage

Generally, a long-term care insurance policy is payable if care is received within the fifty states, the District of Columbia, the U.S. territories, and sometimes in Canada. Most policies also have an international coverage clause that spells out benefit particulars if the insured is receiving long-term care services in another country. There may be a daily benefit limit, a benefit period limit, or a change in the elimination period. There could be a cap on the total amount of benefits paid while receiving care in another country, or certain benefits which are explicitly not paid outside the US. Because increasing numbers of Baby Boomers either travel abroad or are considering retiring overseas, questions about international benefits have increased. Remember: these are transitional benefits, geared toward policyholders who suffer an accident or illness while travelling and cannot immediatley return home. Still, some are more robust than others, so it’s worth reviewing the long-term care insurance policies you are selling to see how long-term care insurance benefits are handled in this circumstance.

## First-Day Coverage

Although the ninety day elimination period is far and away the most popular selection sold today, many agents pair this with a rider called Zero Day Elimination for Home Care. (Some products include this as a built-in feature.) This way, although the insured must wait ninety days before benefits are paid for facility care, first-day coverage is received for care at home.

What’s more, each day care is received generally counts against (i.e., offsets) the days needed to satisfy the ninety day facility elimination period. Whenever this rider is available we recommend it. The fact is, at the time of sale many applicants are eager to keep the cost down, so they “nip and tuck” at the edges of their policies. One of the most obvious ways to lower the price is by taking a long elimination period: ninety days.

Unfortunately, what many agents—who haven’t experienced the back-end—don’t realize is what happens at claim time. With thousands and thousands of policyholders on the books for decades, we have. When the family calls, no one remembers the parent’s decision to cut corners—they want their money—now! Do you think the policyholder or family is eager to wait three months? Of course not.

Zero Day Elimination for Home Care is a good compromise, especially since most claims are opened in one’s residence (and rarely transition to another setting).

## Bed Reservation

This contract provision can be very useful. If the insured is in a facility, on claim, and requires hospitalization (or departure from the facility for any reason other than discharge), this feature pays to hold her room until her return. Over the course of a multi-year stay, situations like this are likely to occur. Just like you, once you’ve grown attached to your living quarters, apartment or room, moving is upsetting. We had a client who used this feature to take a two week vacation to visit her daughter, which she was desperate to do.

## Home Modification and Equipment

Separate from the Alternate Plan of Care, many long-term care insurance policies today will contain a flat amount of extra coverage reserved for a variety of products and services to keep the policyholder at home. Items that can be reimbursed include any necessary alterations to the home such as grab bars for showers, wider doorways and wheelchair ramps, and the lowering of electric switches. This feature might also include money for the purchase and set up of needed therapeutic devices (such as a hospital bed) or rental of a monthly medical alert system.

## Exclusions & Limitations

The NAIC Model Act contains a list of standard permissible exclusions from which product designers and actuaries choose when developing new products. As you review policies, you will find the same list re-occur again and again. Some carriers may include as few as three or four, while others may include the entire allowable list:

* Pre-existing conditions.
* Mental or nervous disorders; note, Alzheimer’s Disease is explicitly covered.
* Alcoholism and drug addiction.
* Illness, treatment or medical condition arising out of:
* war or act of war (whether declared or undeclared);
* participation in a felony, riot or insurrection;
* service in the armed forces or auxiliary thereto;
* suicide (sane or insane); attempted suicide, or intentionally self-inflicted injury.
* Treatment in a government facility; services for which benefits are payable under Medicare or other governmental program (except Medicaid); any state or federal worker’s compensation program; employer’s liability or occupational disease law; or any motor vehicle no-fault law.
* Services provided by a member of the insured’s immediate family; and services for which no charge is normally made in the absence of insurance.
* Expenses for services or items available or paid under another long-term care insurance or health insurance policy.
* In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.[[15]](#endnote-15)
* Coverage provided outside the United States. [Read your policy carefully on this one—there’s a lot of variation out there.]

# Optional Riders

Individual long-term care insurance comes with multiple optional benefits that can be added based on the needs and interests of the consumer. This enables you to tailor a plan specifically for your client—but comes at the expense of complexity.

The agent’s job consists of clarifying and recommending appropriate benefits. Take a few minutes to read through the actual policy material each insurer makes available. The optional riders are usually only one or two pages each. They will give you a detailed picture of the purpose of the rider and usually answer any questions you might have.

Some insurers provide rate clarification, for example, advising that the cost of a specific rider is a specific load, such as 5 or 10 percent more per year. This can help you answer clients quickly in an interview situation should such questions arise.

The following is a brief review of the more common optional riders available in the long-term care insurance market today (*inflation protection* was covered earlier in the book):

## Spousal Benefits

Married couples (including domestic partners and those in a civil union) applying together can generally add optional riders that are not relevant to single individuals. Three primary options are available.

The *joint waiver of premium rider* activates the waiver-of-premium provision for *both* policies when one partner becomes eligible for policy benefits. This rider is inexpensive and should be included in any proposal for cases involving either a spouse or domestic partner.

The *survivor waiver of premium rider*(also simply called survivorship)creates a paid-up policy after both policies have been in force for a specified number of years (almost always ten) and one of the partners dies. In such cases, the survivor’s policy would be paid-up in full if it meets the years-in-force requirement. If not, the survivor will continue to pay premiums until the years-in-force time period has been reached, and the policy will then be designated as paid in full. The classic selling scenario for this rider has always been age-mismatched clients (think of an older man with a younger wife): should he predecease her, her policy would be paid-up in ten years. (Unfortunately, a few carriers have suspended sales of this rider just in the last few years.)

Finally, there is the most popular of all, the *shared care rider* (consistently purchased by about 40 percent of couples who both buy a limited benefit period). Although it comes in a variety of designs, the concept is simple: couples can share each other’s benefits. One partner is allowed to use the other’s policy benefits if the first policy is exhausted. This is an efficient planning tool for couples who are trying to stay within a premium budget. Rather than opt for the more costly lifetime benefit period (which has all but disappeared anyhow), the couples elect, for example, a five-year benefit period each. This gives either partner the chance for a ten year benefit. Should one partner die, the survivor inherits the spouse’s remaining benefits, and can drop the rider (for a little bit of premium savings just when it’s needed).

Other shared care designs make use of a third pool (to ensure that neither partner is ever left wanting); others require that each spouse retain a minimum amount of coverage for their own use; still others guarantee to replenish a tapped pool. Because many couples think it likely that only one of them will need the policy (or need a truly catastrophic amount of coverage), this option should be of interest to them.

All three elections are effective planning possibilities and should always be reviewed when interviewing partners.

## Restoration of Benefits

The smaller the benefit period elected, the more consideration should be given to the *restoration of benefits rider*. If the policy owner files a claim and uses less than the full amount of benefits under the policy, then recovers and goes treatment-free for six months, the policy benefits are fully restored to the beginning amount at the time of claim.

This is not a high-cost rider, because the instance of use is not supposed to be frequent; a long-term care claimant is rarely in a position to recover (e.g., Parkinsons? Alzheimer’s?). However, I have seen it used twice: once after recovery from an auto accident and once after rehabilitation following a broken hip. Each time, the claim lasted a little more than a year, and then there was a full, treatment-free recovery. Benefits were restored after six months. That’s the idea behind this rider: an accident or surgery might occur early in your sixties… then twenty years elapse before something truly catastrophic hits in your eighties or nineties.

Because many benefit periods purchased today are short—two, three, or four years—this feature can provide peace of mind that the policy can be used more than once.

## Shortened Benefit Period Nonforfeiture

We’ve discussed the mandatory *contingent nonforfeiture benefit.* You will recall that this feature allows the insured to elect a paid-up policy option should premium rate increases cumulatively surpass a stated percentage based on age at policy issue. There is also something called the *Shortened Benefit Period* (SBP) nonforfeiture rider: although it is optional on the part of the policyholder, HIPAA mandates that it be offered as part of every sale: thus, every product includes it. It’s extremely unpopular and I think in my entire career I’ve only ever seen it purchased once.

For an additional premium, it allows the policyholder to lapse her policy after it’s been inforce for three straight years and receive a paid-up policy whose benefit pool consists of the greater of all her premiums paid, or thirty times the daily benefit in effect when she lapsed. Yes, it does provide a value in the event of lapsation, but with affordabilty one of the primary objections, everyone is looking for ways to drive the price down at the point of sale: this is a conspicuous cost. As part of the suitability process, agents try to determine whether clients can afford to pay premiums for life—even if rates were to rise.

## Return of Premium

For clients interested in receiving guaranteed value, a better choice is probably *“return of premium”*. In its most common form, when a policyholder dies all premiums paid (less any which were waived) are returned to his estate. Some carriers include as a built-in benefit (or sell by rider) a version that applies *return of premium* only if the insured dies by age 65, or 67.

Most riders also deduct the amount of any claims paid from the eligible premium that’s returned; a few do not. The additional premium for this option can be significant and one must weigh whether it’s a better use of money to pay for this feature or invest those dollars in another financial vehicle. Some older ROP riders periodically returned premium to policyholders on a set schedule (say, every ten years) without requiring death or surrender—what a deal! It was also possible to vest the amount of premium returned on an increasing schedule over a set period of years—it may still be possible to find such riders on inforce policies.

We also sometimes see ROP used in worksite: the employer (as policyowner) may include Return of Premium so that its premiums are returned once the insured (employee) dies. Please consult a tax professional for the ramifications of this strategy. The taxation of Return of Premium can be complicated, depending on who originally took a deduction on the premiums, and to what extent.

By requiring death to collect, an ROP rider does not differ too much from combo products which make a similar promise: one way or another you *will* get all your money back—either via claim or paid to your beneficiaries. ROP can also serve as a hedge against rate increases: it doesn’t matter as bad if rates go up 10 percent or 90 percent since your own money will eventually return to you.

If death seems like too high a hurdle to collect, consider that we are once again constrained by a decades-old law (HIPAA), which requires that QLTCI not provide for any cash surrender value, and that any refunds of premium (or policyholder dividends) may only be applied as a reduction in future premiums or to increase future benefits. Thus, you cannot surrender your policy under an ROP.[[16]](#endnote-16) But let’s consider the alternative—when push comes to shove, how many combo policyholders are really going to surrender theirs?

The older covered individuals are, the closer they are to needing care. Even given the choice to *“*Live,Quit or Die”, who in their right mind would choose to *“*Quit*”* in their upper 70’s or early 80’s? Statistically, it turns out they don’t. We know that LTC insurance enjoys a high persistency rate, meaning few consumers drop this coverage. But others insist on seeing quantifiable value for the dollars spent. If the contingent or shortened benefit periodoptions don’t cut it for them, an ROP rider may meet their needs.

# Premiums

Clients can pay their long-term care insurance premiums in several ways. Many people elect to pay once a year (the annual payment mode) because it is easier and often the most incentive-based payment option (i.e., the mode with the lowest load, typically none). One can also elect to pay monthly (through a bank draft), quarterly, or semiannually; there is generally an administrative charge for this billing convenience. Insurers may also accept credit card payments for people who prefer to charge everything to add to the frequent-purchaser programs these cards offer. After all, the purchase of long-term care insurance ought to be worth a plane ticket or two.

Of interest to younger people is the availability of paid-up premium options. Insurers often offer a chance to accelerate premium payments to finish them while an individual is in a prime earning capacity. The most common option is a ten-payment plan, but insurers offer other choices, such as twenty-year or paid-up-by-age-sixty-five plans (one carrier even builds-in a paid-up-to-ninety-five in its products). In today’s era of unpredictable rate actions, ask any agent who owns a policy and they will tell you, “The smartest decision I ever made was buying a ten-pay on myself.” Unfortunately, with the low interest rate environment we’re in, most carriers have suspended sales of these limited-pay options. Still, it’s expected they’ll resume once interest rates return.

If one can afford them, these options answer the question, “How does one pay for long-term care insurance after retirement when living on accumulated income?” The ten-pay (or any similar) option also reduces the risk of harm from rate increases in the future. Once a policy reaches paid-up status, future rate increases no longer apply, because the insured is no longer actively making any more premium payments.

Moreover, if the paid-up policy has an automatic inflation feature, benefit amounts still increase each year, even though premium payments have ceased. This has great appeal for long-term care insurance buyers.

It is also of interest to business owners, who can deduct the full amount of a premium payment for key employees. This enables them to offer an enticing proposal to retain key employees: “Stay with me for ten years and in return I’ll give you a paid-up long-term care insurance policy.”

It is also important to be aware of policy discounts that the individual product offers.

First, there can be a discount because your client is in good health. Let’s accept that carriers each have their own standard rate—except unlike sea level, no two are defined the same, and none are described using the same vocabulary. (It’s as if each insurance company were trying to measure altitude but were five meters apart in all measurements, and each spoke a different foreign language.)

Preferred risks could save 5 to 20 percent off Standard rates. Conversely, less healthy people might slide from Standard to Select rates—the equivalent of a table rating in life insurance. This could cost them anywhere from 25 percent to 200 percent more, and restrict their ability to obtain certain benefits.

Second, couples applying together and both accepting policies will typically receive a two partner discount ranging from 15 to 30 percent. When an applicant is married (but only one spouse is applying), a discount ranging from 10 to 20 percent might be offered. Couples used to receive much higher discounts, but newer research has revealed that the benefit conferred by living together somewhat wears off over time.

Likewise, many companies have shaved their good health discounts (some from 15 percent down to 10 percent or even 5 percent). Why? Because carriers started to realize that all these “healthy as a horse” applicants with no health problems were *living too long*. That lack of mortality was backfiring: the healthiest clients today were living to the ripe old age of chronic illness. Their preferred health discount needed to be reined in. (Remember, from an LTC underwriting standpoint, it’s better to keel over and die quickly.)

We also find discounts that are unique to some carriers and not to others. For instance, one company may extend a loyalty discount (typically 5 percent) if you hold a life or annuity policy with them and also choose their LTC insurance product. Another may make the same offer for carrying your MedSup and LTC insurance through the same company. Others make association discounts available (typically 5 percent) if you are a member of an organization which endorses the product. If you are a member of a worksite which has set-up an employer-sponsored plan (or even in some cases, simply one of five members of a common employer) it may be possible to obtain a 5 percent discount.

The bottom line: what began as a $1,000 premium can start to shrink significantly once a 20 percent couples discount is applied, then a 10 percent preferred health allowance, then a 5 percent association discount, the 9 percent savings for paying by the year, then the tax savings is shown for deducting one’s premiums (both federal and state). All of these discounts can help bring down the premium cost and make a long-term care insurance policy fit better within a client’s budget.

# The Process

Advisors love to complain about underwriting. But without it, there would be no security in owning these insurance policies. Some of the earlier insurers in this market ignored this important aspect of risk management and they no longer have a job in this industry. Worse, consumers who purchased these early policies (sold by agents who thought the easy path was best) have seen their rates increased many times—to the point of being unaffordable.

Then, they are forced to drop coverage and forfeit all they have paid in to date. Is that better than answering some medical questions and having insurers check clients’ medical records? Insurers who exercise solid insurance principles will be paying claims decades from now. We should be glad that they exercise caution regarding who is added to the risk pool.

Declination rates follow age, and that should give every financial advisor the incentive to talk to younger people who are willing to plan for this risk today—while they still qualify. It’s not solely about the premium, but lower rates are part of the reason to address this issue long before the need arises.

Table 2 shows rounded numbers for the percentage of applicants declined long-term care insurance coverage in 2012.

|  |  |
| --- | --- |
| Table 2 Percentage of Applicants Declined Coverage in 2012 [[17]](#endnote-17) | |
| Age 50 and younger | 12% |
| Ages 50–59 | 17% |
| Ages 60–69 | 25% |
| Ages 70–79 | 44% |
| Age 80 and older | 70% |

Memo to Boomers: If you wait to address this issue with insurance until you think you are close to needing help, it’s too late.

Long-term care insurers increasingly exhort you to field underwrite: to prescreen applicants before they reach the home office. Among the tools they make available are exhaustive underwriting guides, disease-specific worksheets, prescreen tools, build charts, underwriting hotlines, fax numbers and dedicated email addresses. In spite of this, placement rates (the number of issued policies that survive the thirty-day free look period) are at an all-time low, while overall declination rates are at an all-time high.

Where industry declination rates used to hum along consistently between 15 and 20 percent for years, they’ve begun to inch up. Some individual carriers are now trying to manage rates between 20 and 30 percent. This could be a combination of inexperienced agents, adverse selection (what one trainer calls “self-nominators”), and carriers becoming increasingly stringent. In a transparent effort to partner with distribution and prevent certain risks from reaching the Home Office, insurers have shared some of the most common reasons for declination with us:

* Diabetes Mellitus (Type II)
* Obesity
* Hypertension
* Depression
* Memory Loss, Forgetfulness, Confusion
* Alcoholism, Drug Abuse

Table 3 is a collection of Build Charts, illustrating the wide variety which exists between carriers. These maximums assume no comorbids such as diabetes (or in the case of underweight females, osteoporosis). It’s followed by Table 4, an example of knockout questions which all carriers use as a first-line screening tool. If any questions are answered affirmatively, the client is excluded from further consideration.[[18]](#endnote-18)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Table 3 Maximum Weight for Consideration by Carrier. | | | | | | | | | |
|  | **Carrier A** | **Carrier  B** | | | **Carrier C** | **Carrier D** | **Carrier E** | | **Carrier  F** | |
| Height | M/F | | M | F | M/F | M/F | | M/F | M/F | | |
| 4' 6" | x | | 157 | 149 | x | x | | x | x | | |
| 4' 7" | x | | 163 | 155 | 185 | x | | x | x | | |
| 4' 8" | x | | 169 | 160 | 192 | 178 | | 190 | 214 | | |
| 4' 9" | x | | 175 | 166 | 199 | 184 | | 198 | 218 | | |
| 4' 10" | x | | 182 | 172 | 205 | 190 | | 205 | 222 | | |
| 4' 11" | 222 | | 188 | 178 | 212 | 197 | | 212 | 227 | | |
| 5' 0" | 230 | | 194 | 184 | 220 | 203 | | 220 | 232 | | |
| 5' 1" | 238 | | 201 | 190 | 227 | 210 | | 227 | 237 | | |
| 5' 2" | 246 | | 208 | 197 | 235 | 217 | | 235 | 243 | | |
| 5' 3" | 254 | | 214 | 203 | 242 | 224 | | 242 | 250 | | |
| 5' 4" | 262 | | 221 | 210 | 250 | 231 | | 250 | 256 | | |
| 5' 5" | 270 | | 228 | 216 | 258 | 239 | | 258 | 263 | | |
| 5' 6" | 279 | | 235 | 223 | 266 | 246 | | 266 | 270 | | |
| 5' 7" | 287 | | 243 | 230 | 274 | 254 | | 274 | 277 | | |
| 5' 8" | 296 | | 250 | 237 | 282 | 261 | | 282 | 284 | | |
| 5' 9" | 305 | | 257 | 244 | 291 | 269 | | 291 | 291 | | |
| 5' 10" | 313 | | 265 | 251 | 299 | 227 | | 299 | 300 | | |
| 5' 11" | 322 | | 272 | 258 | 308 | 285 | | 308 | 310 | | |
| 6' 0" | 332 | | 280 | 265 | 316 | 293 | | 316 | 322 | | |
| 6' 1" | 341 | | 288 | 273 | 325 | 301 | | 320 | 330 | | |
| 6' 2" | 350 | | 296 | 280 | 334 | 310 | | 326 | 338 | | |
| 6' 3" | 360 | | 304 | 288 | 343 | 318 | | 330 | 345 | | |
| 6' 4" | 370 | | 312 | 296 | 353 | 327 | | 344 | 351 | | |
| 6' 5" | x | | 321 | 304 | 363 | 337 | | 350 | 360 | | |
| 6' 6" | x | | 329 | 312 | 372 | 345 | | 360 | 371 | | |
| 6' 7" | x | | x | x | 382 | 354 | | x | x | | |
| Near max, quote: | Accept | | Standard | Standard | Class 2 | Standard | | Class 1 | Class Rated | | |

**Table 4** Sample Elimination Questions on a Long-Term Care Insurance Application.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | AIDS or HIV | | | Alzheimer’s Disease, Dementia, Cognitive Impairment or Memory Loss | | | Amputation due to disease | | | Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig’s Disease) | | | Bowel Incontinence | | | BMI less than 18 or greater than 40 | | | Congestive Heart Failure | | | Diabetes Type I or Type 2 treated with insulin | | | Huntington’s Disease | | | Liver Cirrhosis | | | Multiple Myeloma | | | Multiple Sclerosis | | | Muscular Dystrophy | | | Organ Transplant, excluding cornea or kidney | | | Paraplegia or Quadriplegia | | | Parkinson’s Disease | | | Polycystic Kidney Disease | | | Spinal Cord Injury | | | Stroke/CVA | | | Multiple Transient Ischemic Attacks (TIAs) | | | Retinal Artery Occlusion | | | Schizophrenia | | | Scleroderma | | | Systemic Lupus Erythematosus | | | Diabetes with any one of the following conditions: | | | Blindness | | | Carotid Artery Disease | | | Coronary Artery Disease | | | Kidney Disease | | | Peripheral Vascular Disease (PVD) | | | Transient Ischemic Attack (TIA) | | | Requiring assistance or supervision regarding Activities of Daily Living (ADLs): eating, dressing, toileting, transferring in and out of bed or a chair, bathing, managing bowel or bladder control. | | | Using any medical equipment, such as: wheelchair, walker, hospital bed, cane (any type), crutches, oxygen, stair lift, dialysis, motorized scooter, home intravenous medications, respirator, feeding tube, shunt or a port-a-catheter. | | | Residing in a nursing home, assisted living facility, rehabilitation facility or other custodial facility, or advised to, or planning to enter such facility. | | | Receiving home health care services or attending adult day care. | | | Collecting Social Security Disability Income. | | |

I think you will agree that these are all fairly serious issues that signal the need for imminent long-term care. This is why timing is so important. If your client is contemplating LTC insurance, there is no time like the present to go through the application process. It will ultimately save that person a substantial amount of money and resources should a long-term care event occur.

Insurers are also looking at streamlining the method of processing long-term care insurance application forms. Any advisors who have tried to solve the long-term care needs of clients have probably had a meltdown when the forty-page application was emailed to them. In actuality, perusal of these lengthy packets reveals that just five or six pages are application requiring completion—the rest are worksheets, outlines of coverage, HIPAA-required disclosures, or duplicates to be left behind.

Nearly all insurers have introduced some form of electronic application at this point, although not all agents have gotten on the tech bandwagon. This is a shame, since eApps shorten cycle times by seven to ten days (by eliminating unanswered questions, missing forms, and illegible answers). They also ensure that clients receive—and sign for—each copy of a required form to which they are entitled.

Underwriters for long-term care may use a number of basic tools: 1) the application itself; 2) a telephonic interview conducted by a nurse; 3) the prescription drug database; 4) Medical Information Bureau (MIB); 5) a face-to-face examination which may include the collection of blood and urine; and 6) physician records.

All told, the underwriting process can take anywhere from four to eight weeks, but sometimes longer. By far the greatest delay is waiting for medical records from the client’s doctor (particularly if this office requires its own special authorization to release records). Given the cost to underwrite every case (generally a few hundred dollars), carriers look for every reason to approve a policy. No case is ever declined without two sets of eyes reviewing it. Appeals are not discouraged by any means, but the counter-information must be new and specifically address each reason for the declination. It’s not enough for the doctor to write a letter disagreeing with the underwriter’s decision; rather, he should either say, “I’ve conducted new tests,” or, “I’d like to share the latest status.”

Tell your clients that thorough underwriting is a good thing: not only does it keep premiums down, but they wouldn’t want to be with a company that just accepted everyone, would they? That’s like being with an auto company that lumped all the good drivers with the drunk drivers. Keep your eye on the prize: capable risk management will ensure the company survives to process claims in the future.

Speaking of claims, as noted earlier in the book, long-term care insurance claims are some of the easiest that I have been involved in, partly because of the nature of the disability. Policyholders agree, with 97 percent who’ve received LTC benefits rating insurance companies highly in paying claims.[[19]](#endnote-19) If one meets the definition, it is unlikely the insurer will contest it. It also stems from the activity of the claim consultant assigned to the case, who works diligently to ensure that the insured receives the care stipulated in the contract.

See Table 5 for some long-term care-related claims statistics.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Table 5 Where Newly Opened Claims Begin (2012)[[20]](#endnote-20) | | | | | | |
|  | **Men** | | **Women** | | | **Total** |
| Home Care | 17.5% | | 33.5% | | | 51.0% |
| Assisted Living | 5.5% | | 13.0% | | | 18.5% |
| Nursing Home | 10.0% | | 20.5% | | | 30.5% |
| New Claims Opened by Attained Age (2012) | | | | | | |
|  | | **Men** | | **Women** | **Total** | |
| Age 50 and younger | | 0.1% | | 0.2% | 0.3% | |
| Ages 50–59 | | 0.9% | | 1.0% | 1.9% | |
| Ages 60–69 | | 3.8% | | 4.9% | 8.7% | |
| Ages 70–79 | | 9.2% | | 16.2% | 25.4% | |
| Age 80 and older | | 22.0% | | 41.7% | 63.7% | |

The claim numbers in Table 5 reveal that our average claimant is over age eighty and files a claim that begins at home. The claimant was able to file because a long-term care insurance policy was purchased early enough to be approved. Although years may pass before a policy is used, the return on investment comes quickly—both monetarily and emotionally—for the insured and family.

If you have a client who has used this type of policy, her family is often your best source of referrals. Family members of clients who have experienced what it means to have a long-term care insurance policy in place when the worst occurs have long provided heartfelt testimony about the value of this insurance to the skeptical and unbelieving.

The individual product is the most common type of long-term care insurance sold. It has been eclipsed by the jazzier combo life or annuity products. But it remains the fulcrum upon which the long-term care insurance industry rests.

1. “The Core 4SM is based on the core selections most clients consider when purchasing a long-term care insurance policy.” [↑](#endnote-ref-1)
2. Home Care-Only policies accounted for 2 percent of sales, while Facility-Only just 1.1 percent of sales in 2013. Source: “2014 Long Term Care Insurance Survey,” by Claud Thau, FSA, MAAA; Dawn Helwig, FSA, MAAA; Allen Schmitz, FSA, MAAA. BrokerWorld, July 2014. [↑](#endnote-ref-2)
3. Which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. [↑](#endnote-ref-3)
4. Speaking of periodic payments, 7702(B)(b)(2) carves out an exemption called “Special Rules: Per Diem, etc. payments permitted” which is why—in spite of the purpose-driven rules pertaining to QLTCI—both indemnity and cash alternative designs have been allowed to innovate. [↑](#endnote-ref-4)
5. “Who Provides Long-Term Care in the US? (Updated),” The SCAN Foundation, Fact Sheet, October 2013. [↑](#endnote-ref-5)
6. Due to frequent misunderstandings, in 2014 Iowa Insurance Commissioner Nick Gerhart asked insurers to communicate better with policyholders how the APC benefit works, including a reminder that it does not cover any benefit the insured could have elected when she bought her coverage. Source: “Iowa Calls for LTCI Alternate Plan Safeguards,” by Allison Bell, LifeHealthPro, June 4, 2014. [↑](#endnote-ref-6)
7. David G. Stevenson and David C. Grabowski, “Sizing Up the Market for Assisted Living,” Health Affairs (January 2010): 35. [↑](#endnote-ref-7)
8. “Currently, there are more than 70 different names or designations for facilities licensed as some form of an assisted care facility. Generally, fewer than 40 percent of these care facilities use the term “assisted living facility” as a part of their formal name or licensure designation.” 2014 Genworth Cost of Care Survey. [↑](#endnote-ref-8)
9. Residents Living in Residential Care Facilities: United States, 2010. NCHS Data Brief No. 91, April 2012. Christine Caffrey, Ph.D.; Manisha Sengupta, Ph.D.; Eunice Park-Lee, Ph.D.; Abigail Moss; Emily Rosenoff, M.P.A.; and Lauren Harris-Kojetin, Ph.D. [↑](#endnote-ref-9)
10. Harris-Kojetin L, Sengupta M, Park-Lee E, Valverde R. Long-term care services in the United States: 2013 overview. Hyattsville, MD: National Center for Health Statistics. 2013. [↑](#endnote-ref-10)
11. 2014 Genworth Cost of Care Survey. [↑](#endnote-ref-11)
12. “Genworth Conducting ‘Deep Review’ of LTCI Business,” by Allison Bell, LifeHealthPro, July 31, 2013. [↑](#endnote-ref-12)
13. “...for every 5 years that a price increase is not obtained, the amount of increase that is needed doubles assuming the risks stay exactly the same.” Source: Prepared remarks for Genworth Chief Executive Officer Thomas J. McInerney for delivery before the Intercompany Long Term Care Conference on March 18, 2014. [↑](#endnote-ref-13)
14. Since its adoption in 1986, the Long Term Care Insurance Model Act has undergone no less than twenty major iterations, and numerous red-line drafts and proposals in between major updates. It’s practically a “living document”, since the Task Force never stops working on it, while the States perennially lag behind in implementation. In March 2014 a major update began circulating. [↑](#endnote-ref-14)
15. Confused? This just means QLTCI is not allowed to duplicate any charges which Medicare pays. By law (HIPAA again), all qualified LTC insurance must “coordinate with Medicare”, and only pay above and beyond anything Medicare pays. We’ve taught you not to count on receiving a dime from Medicare, which is why this “Coordination” clause is largely moot. [↑](#endnote-ref-15)
16. IRC Section 7702(b)(1)(d). [↑](#endnote-ref-16)
17. American Association for Long-Term care Insurance, 2014 LTCi Sourcebook. Individual policies. [↑](#endnote-ref-17)
18. Genworth LTCI Application, 2014. [↑](#endnote-ref-18)
19. Prepared remarks for Genworth Chief Executive Officer Thomas J. McInerney for delivery before the Intercompany Long Term Care Conference on March 18, 2014. [↑](#endnote-ref-19)
20. American Association for Long-Term care Insurance, 2014 LTCi Sourcebook. [↑](#endnote-ref-20)