
Long-term care services may be necessary at any age. An older adult might gradually find that day-to-day living is becoming increasingly difficult without help, or they may develop Alzheimer's Disease. Someone younger may have a heart attack, a stroke, a disabling accident or develop a serious chronic illness such as Parkinson's Disease. Long-term care services are generally custodial and personal in nature but, in some cases, may be rehabilitative.

Because neither medical insurance nor Medicare is primarily designed to pay for long-term care services, long-term care insurance can help provide a way for you to pay for this care. Long-term care insurance can help you retain assets set aside for retirement and can help you remain independent by providing the money to allow you to decide where and how your care will be provided.

This guide is a general introduction to long-term care insurance. It defines terminology generally used in the long-term care insurance industry, presents some basic issues, and provides answers to some frequently asked questions. We hope you will find it helpful.

Table of Contents

General Information

What is long-term care?	1
Where can I receive long-term care services?	1
What are Activities of Daily Living (ADLs)?	2

The Cost of Long-Term Care Services

What is the cost of long-term care services?	3
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Paying for Long-Term Care Services

How are long-term care services paid?	4
Self-Insure	4
Medicaid.....	5
Medicare.....	6
Long-Term Care Insurance.....	7

Is Long-Term Care Insurance Appropriate for You or a Family Member?

Who could benefit from purchasing long-term care insurance?	9
What is the right age to purchase long-term care insurance?	10
Is there anyone who should not purchase long-term care insurance?	10

What About The Cost Of A Long-Term Care Insurance Policy?

What is the cost of a long-term care insurance policy based on?	10
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How To Select A Policy

What decisions do I need to make?	11
How can I protect myself against the rising cost of care?	14
How much coverage is right for me?.....	16

What About Different Types Of Policies and Coverage?

What is the difference between “reimbursement,” “indemnity,” and “disability” type policies?	17
What is a “Tax Qualified” policy?	18
What are “Partnership Programs”?	18

How Long Will I Need Coverage?

How long can I expect to need coverage?	19
---	----

What About Benefits?

How do I become eligible to receive benefits?	20
Who determines when I am eligible for benefits?	20
What happens to my benefits if I stop paying my premium?	21
What is a “return of premium on death” benefit?	22

What Else Should I Know?

Can I change my mind if I buy a policy?	22
Can my premiums be raised?	23
How can I evaluate a long-term care insurance company?	23
How can I obtain detailed information on long-term care insurance?	24



Introduction to Long-Term Care Insurance

Insurance is technical—there’s just no way around it. And the technicalities are important – you need to understand them to know what to look for in a policy. In some cases, different insurance companies use different terms to describe similar features. We’ll be sure to define these terms that describe features and benefits of typical long-term care insurance policies. Please use this booklet as a guideline only. By the time you’re done, you should have a good, general understanding of long-term care insurance.

Like other insurance coverage, long-term care insurance policies contain certain exclusions, limitations, reductions of benefits and terms for keeping them in force. For complete details, contact an insurance company offering long-term care insurance.

General Information

Q. What is long-term care?

A. Long-term care (LTC) refers to a variety of services designed to help people perform the functions of day-to-day living to help them remain independent. Some long-term care is aimed at providing help with day-to-day activities for people with a chronic illness, or cognitive impairment, such as dementia. Other long-term care services may be rehabilitative, helping someone regain function after a serious injury.

Disability rates are falling as a result of preventive care and medical advances; but the longer people live, the greater the chances are that chronic conditions may develop, resulting in an increased need for assistance with everyday activities.¹

Q. Where can I receive long-term care services?

A. Many people think that long-term care refers only to services provided in a nursing home. It's much more than that.

Long-term care services can be provided by:

- Nurses
- Certified Nursing Assistants
- Physical, occupational and respiratory therapists
- Home Health Aides and homemaker services

It can be provided in many different settings such as:

- Your own home
- An assisted living facility²
- A nursing home
- An adult day center
- A hospice facility or hospice services provided at home

Long-term care services may also be received in a continuing care retirement community. This type of facility usually provides housing, services and various levels of long-term care services when needed, in one location. The types of housing,^a services and care services offered change with the needs of the resident and allow the older adult resident to “age in place.”

Life expectancy after age 65 is now 17.9 years, an increase of 5.1 years since 1940.³

Q. What are Activities of Daily Living (ADLs)?

A. The insurance industry has specific definitions that they use involving certain activities and functions. These are referred to as Activities of Daily Living (ADLs), which are listed below.

- Dressing
- Bathing
- Transferring (moving in or out of a bed or chair)
- Toileting
- Eating
- Continence

^aTerminology used to indicate care facilities may vary from state to state.

The Cost Of Long-Term Care Services

Q. What is the cost of long-term care services?

A. The cost depends on what kind of care you need and where you are living when you need the care. Based on the MetLife Market Survey of Nursing Home & Home Care Costs⁴ and the MetLife Market Survey of Assisted Living Costs⁵, the costs for 2003 are as follows.

Nursing Home Costs for Semiprivate Room

Semiprivate high = \$608.00 Semiprivate low = \$75.00

National average daily rate = \$158.26

National average yearly rate = \$57,765

Home Health Care

Costs for Home Health Care Aides

Hourly high = \$42.50 Hourly low = \$10.00

National average hourly rate = \$18.12

Average yearly rate (assumes five hours a day, five days per week) = \$23,556

Assisted Living — Base Rate

Monthly – \$2,372

National average yearly rate = \$28,464

If you require in-home assistance from a Home Health Aide (HHA), you may start out with an hourly visit but if you become frailer in the future, you may also begin to need help with activities such as bathing. This may increase the time the HHA would need to spend with you per day and may increase the cost of service. Also, if your needs change and you require the services of a skilled nurse instead of a HHA, the cost of care would generally be higher.

Because care situations vary greatly among individuals, the costs and location of care received may also vary. Generally, the yearly average cost of a HHA is less than that of a yearly average cost of a nursing home, but, for instance, if you need around the clock care, the costs may be more expensive. Again, much depends on your care situation.

Paying For Long-Term Care Services

Q. How are long-term care services paid?

A. There are basically four ways of paying for LTC services.

- 1. Self-Insure**
- 2. Medicaid**
- 3. Medicare**
- 4. Long-Term Care Insurance**

- 1. Self-insuring** means setting aside or having enough money to pay privately for future LTC services, if they

become necessary. This plan may require a dedicated, aggressive and immediate savings plan. It's impossible to know if or when these services will be needed, and that makes the target savings amount difficult to determine.

For example, if a family member is involved in an accident that leaves the family member even partially paralyzed or if a family member develops Parkinson's Disease, some type of long-term care services would most likely be necessary to help the family member function on a daily basis.

- 2. Medicaid**, a joint federal-state government program for low income individuals, will provide coverage for long-term care expenses if your income and assets are very low or after you have exhausted almost all of your own assets. It is an entitlement program based on strict income and asset guidelines. You may be required to spend your own money for care, living expenses and other "allowable" expenses before becoming eligible for Medicaid. This is referred to as the "spend-down" period.

Even though every state has different eligibility criteria for this government program, assets and income are subject to review in order to determine your eligibility. Many people try to transfer all their assets immediately after it has been determined that they require long-term care assistance; however, this time period will not always meet the "look-back" period criteria.⁶

The look-back period is a 36-month period of time prior to a Medicaid application date. This means that certain assets that have been transferred for less than fair market value or simply “gifted” to others in this time period are still considered to be the care recipient’s money, funds that the care recipient must use to pay for long-term care services. The look-back period for assets transferred to a trust is 60 months.

When it comes to Medicaid eligibility, be sure to research your state’s requirements.

- 3. Medicare** is the federal medical insurance program for people age 65 or older, and disabled persons of any age receiving Social Security benefits for not less than 24 months. It was designed to pay some of the costs of certain health care services in order to provide recipients access to a basic level of health care. The majority of care provided in the U.S. today in connection with chronic long-term illnesses or conditions is personal or custodial care and may be rehabilitative in some cases. Medicare will generally not pay for personal or custodial care. However, Medicare will cover some long-term care expenses for a short period of time per Medicare benefit period if:
 - After a minimum three-day stay in a hospital, not including the day of release, you require a high level of care, as prescribed by a doctor, such as skilled nursing care or rehabilitation services. Medicare pays for the first 20 days of your stay in a skilled, Medicare approved nursing facility.

- On the days 21st through 99 of your stay, you pay a daily co-pay amount determined yearly by the Centers for Medicare and Medicaid Services (CMS). Medigap policies may cover the daily co-pay amount.
- After 100 days, Medicare will pay nothing for these services.

Medicare Supplements (also known as “Medigap”)^b

The intent of Medigap policies is to provide coverage for Medicare copayments and deductibles. The various types of policies, generally classified by the letters A-J in most states, are not primarily designed to cover long-term care expenses⁷ except for those described in number three.

Admission to a nursing home is not enough to qualify for Medicare payment. The level and type of care determines whether short-term Medicare coverage for long-term care will be provided. Medicare does pay for short-term home health care, providing certain guidelines are met.

4. Long-Term Care Insurance

This is insurance designed to help pay for the cost of long-term care services if you need them. It is not the same as medical insurance, which generally provides coverage for

^bNot connected with or endorsed by the U.S. Government or the Federal Medicare program.

doctor visits and hospital stays. Depending on the type of policy and coverage selected, long-term care insurance can provide coverage for long-term care in many settings: your own home, nursing homes, adult day care, and assisted living facilities.

Long term care insurance can be issued on a group or an individual basis. If it is issued on a group basis, the group sponsor is the policyholder and is issued the policy. The insured will receive a certificate as evidence of coverage. If it is issued on an individual basis, the insured is the policyholder and is issued the policy.

Often times, employees enrolling in a group plan can be guaranteed coverage without providing any medical history, on the condition that employees enroll during the initial enrollment period and are actively at work (not absent due to disability, leave or illness) on their effective date of coverage. Issuers of individual long-term care insurance policies require that you be underwritten before they approve a long-term care insurance policy.

Is Long-Term Care Insurance Appropriate For You or a Family Member?

Q. Who could benefit from purchasing long-term care insurance?

A. The need for long-term care can happen at any time, not just as you age. If you are single, it is less likely that unpaid care by family members will be readily available. Long-term care insurance can help you obtain and pay for the services that you require.

If you are married or live in a multi-member household and you and your partner age together, your day-to-day functions may decline at the same rate. If your adult children live in another location or if your care needs are greater than a family can provide, you may require paid assistance. Also, if certain chronic conditions run in your family – the kind that require some type of daily assistance – long-term care insurance might be important for you to consider.

If you don't have a specific policy designated as long-term care insurance (called "Nursing Home and Home Care Insurance" in some states) you usually are not covered for long-term care expenses.

Q. What is the right age to purchase long-term care insurance?

A. In general, long-term care insurance can provide coverage for anyone 18 years of age and older. The younger you are when you buy long-term care insurance, the greater the chance that your health will be good and you'll be insurable. Generally, the younger you are, the lower your annual premiums will cost per year.

Q. Is there anyone who should not purchase long-term care insurance?

A. It is important to be able to afford the premiums, not only now, but in the future. If you are on a fixed income or if you have limited savings, the premiums may be too difficult to pay over the long run. In this situation, you may want to look closely at your needs and resources and perhaps talk with a family member or financial advisor to decide if this is the right purchase for you.

What About The Cost Of A Long-Term Care Insurance Policy?

Q. What is the cost of a long-term care insurance policy based on?

A. The cost of a policy is based on such factors as:

- Your age at the time the policy was purchased

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- The type of the policy purchased (a “basic” policy may cost less than one compared to one from the same company that offers more features)
 - The amount of the daily/monthly benefit you have purchased
 - The number of “extras” such as riders or options you may choose to purchase within a particular benefit level
 - The amount of time the daily/monthly benefit will be paid
 - The elimination period or “waiting period,” which are the days you must pay for your care out-of-pocket

Every insurer offers different long-term care insurance policies, but don't shop by price alone. The lowest cost policy might not be the best choice for you or your family.

How To Select A Policy

Q. What decisions do I need to make?

A. If you decide to purchase a policy, it's important to ask the following questions to help decide which options will be the most appropriate choice for your situation.

1. Should I choose a Comprehensive or Facilities-Only plan?

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2. **What Daily Benefit Amount should I select?**
 3. **What Benefit Period should I choose?**
 4. **How long should the Elimination Period be?**
 5. **How can I protect myself against the rising cost of care?**

1. Comprehensive Plan

Comprehensive plans help pay for care received in the home as well as care received in facilities. A comprehensive plan covers long-term care services in a nursing home, assisted living or residential care facility, hospice care in a facility, and respite services in a facility. It also covers home care, adult day care, hospice care and respite care services at home. The ability to receive benefits for home care may allow the care recipient to live independently in their home instead of living in a long-term care facility.

Facilities-Only Plan^c

This plan covers long-term care services provided in a nursing home, assisted living facility or a hospice facility.^d Facilities-only plans do not cover home care but are typically less expensive than comprehensive plans.

2. Daily Benefit Amount (DBA)

Policies offer a benefit in the form of a “Daily Benefit Amount.” The DBA may be either the maximum or the actual amount the insurance policy will pay per day for covered services.

^cFacilities only policies may not be offered or sold in Vermont.

^dLong-term care facilities may be known by different names in various states.

Some policies offer benefits that are paid on a weekly or monthly basis. It's important to know what the rules are for any policy that you might consider purchasing.

3. Benefit Period

This is defined as the amount of time you wish to receive a DBA. This period can range from two to 10 years or an unlimited amount of time.

Here is a simple formula to help determine the total lifetime benefit of the DBA you choose.

$\text{DBA} \times \text{Benefit Period (in days)} = \text{Total Lifetime Benefit.}$

For example, a \$100 DBA x 1,095 days
(3 years x 365 days) equals \$109,500.

For the most part, the DBA is paid for as long as you qualify for benefits and need services, until you have used your total lifetime benefit.

4. Elimination Period

To keep the cost of your premiums lower, most policies become payable only after a period of time called an “elimination period” or a “waiting period,” which is similar to a deductible. These terms generally mean the same thing. This is the period of time during which you must be eligible for benefits (and in certain types of policies you must also be receiving covered services) before your insurance benefits become payable. During this time you will generally continue to pay premiums.

Policies with a short or no elimination period are usually more expensive than policies with an extended elimination period. Some companies require that you meet the prescribed elimination period only once in your lifetime. Others require you to meet the prescribed elimination period each time you need long-term care services. Policies may provide different methods for calculating elimination period requirements when you receive home health care.

There are a number of options available to help keep pace with the future cost of care. Before you purchase a policy, be sure you understand the benefits and options offered with the policy that you are considering

5. How Can I Protect Myself Against the Rising Cost of Care?

There are four options that may help you protect yourself against the increased costs of care in the future.

A. Automatic Compound Inflation Option

Automatic inflation protection helps keep pace with the future cost of care. This annual increase is based on your compounded DBA. It's important to note that not all policies offer the option of automatic inflation increases. Choosing an Automatic Compound Inflation Option will result in a higher DBA than the Automatic Simple Inflation option.

B. Automatic Simple Inflation Option

The annual increase, for the life of the coverage, is based on the DBA originally purchased.

Selecting either of these options at the time of purchase will result in initially higher premiums, but they will also provide an “automatic” yearly increase in benefits without an increase in premium — typically five percent each year.

Daily Benefit Amount Increases at Simple and Compound Rates (5%)			
Year	Simple	Compound	Difference
0	\$100	\$100	\$0
10	\$150	\$163	\$13
15	\$175	\$208	\$33
20	\$200	\$265	\$65
25	\$225	\$339	\$114
30	\$250	\$432	\$182

Source: *Planning for Long-Term Care*, United Seniors Health Council, McGraw-Hill, 2000
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C. Periodic Inflation Protection

The premium that you pay when the insurance is purchased pays for the daily benefit amount you initially choose.

Opportunities are offered periodically to increase coverage usually without having to provide evidence of good health.

In some policies, these offers are only given to people who have not declined a certain number of increase offers. Your premium will increase based on your age at the time each inflation offer is accepted, but it will only increase for the current additional benefit you purchase.

D. Future Purchase Option (FPO)

This option also offers protection against increases in long-term care costs. It increases your DBA and the remaining amount of your Maximum Lifetime Benefit every few years at an extra cost, as long as you are not eligible for benefits and you don't decline the increase.

In some policies, once you have declined a certain number of increases that have been offered to you, you will not receive other increase offers unless you specifically request an increase in your DBA and pass the insurance company's underwriting requirements.

Q. How much coverage is right for me?

A. The cost of care varies throughout the country so when selecting a Daily Benefit Amount it's important for you to buy sufficient coverage that will pay for care where you expect to receive it. Costs for home care, nursing homes and assisted living facilities vary widely, depending on the region. The Area Agency on Aging may be able to provide current cost figures for you. See page 3 for national average costs.

You should also consider whether or not you wish to purchase an inflation or benefit increase option, and what amount, if any, you are able or willing to self-insure.

What About Different Types Of Policies and Coverage?

Q. What is the difference between “Reimbursement,” “Indemnity,” and “Disability” type policies?

A. A reimbursement policy, also known as an “expense-incurred policy,” is the most common type of policy currently purchased. To prove benefit eligibility you are required to meet the ADL or severe cognitive impairment benefit triggers as indicated in your policy. You will receive benefits only when eligible services are received; benefits are paid directly to you or to the provider. This type of coverage pays for the expense incurred or up to your policy’s monetary limit, whichever is less.

Unlike a reimbursement (expense-incurred) policy, benefits paid by an indemnity policy are a set dollar amount. Benefit eligibility is generally the same as for a reimbursement policy. When eligibility is established and you are receiving covered long-term care services, the insurance company will pay the pre-determined daily benefit amount indicated in your policy on days you receive a covered service.

A disability type policy will pay a flat dollar amount on any day that you are determined to be eligible to receive benefits. Under this plan, provider bills are not needed, and the insurer will often pay out monthly the fixed amount you selected, regardless of whether services have been received to who provides them.

Q. What is a “Tax Qualified” policy?

A. Policies that are tax qualified meet certain standards as set forth in the Health Insurance Portability and Accountability Act, commonly referred to as “HIPAA,” which Congress passed in 1996. HIPAA ensures that benefits paid from policies that meet its standards are not considered taxable income and that qualified premiums may be deductible as medical expenses if certain thresholds are met. Almost half of all states offer tax incentives for long-term care insurance premiums.

Q. What are “Partnership Programs?”

A. There are four states that currently have Partnership Programs: California, Connecticut, Indiana, and New York. The Partnership Programs are joint efforts by state governments and the private long-term care insurance industry to create an option to help individuals plan to meet their future long-term care needs without depleting all of their assets to pay for care.

Features of the Partnership Program generally vary by state but function in a similar way. If someone purchases state approved Partnership long-term care insurance, and the benefits under that insurance coverage are exhausted, the individual may apply for Medicaid (called “Medi-Cal” in California) coverage. The person may retain all or a portion of the assets he or she would otherwise have to “spend down” if Partnership long-term care insurance had not been purchased. The individual will then, however, generally have to contribute any income to the cost of any long-term care services provided under Medicaid. Consult the Partnership Program in your state for further information about how these partnership programs operate.

How Long Will I Need Coverage?

Q. How long can I expect to need coverage?

A. The average stay in a nursing home is estimated to be 2.4 years.⁸ Some people stay much longer or require an extended period of home care before they require admittance to a nursing home. There are a number of factors that should be considered in selecting a benefit period – your age at purchase, your current health, your family’s health history, the increase in life expectancy and even your marital status.

By the year 2030, the over 65 population will more than double to 70 million.⁹

What About Benefits?

Q. How do I become eligible to receive benefits?

A. Typically, you become eligible when you are unable to perform two out of the six Activities of Daily Living (ADLs). This number may vary from insurer to insurer. Also, the period of time when you are unable to perform the ADLs should be anticipated to last for at least 90 days. You will also need to have satisfied the elimination period. Policies start to pay once you are eligible and have met the elimination period. You may also become eligible when you have a severe cognitive impairment (for example, you develop Alzheimer's Disease).

Q. Who determines when I am eligible for benefits?

A. Under a Tax-Qualified long-term care insurance policy, a licensed health care practitioner must certify that you are chronically ill and that a Plan of Care, including the qualified long-term care services you need, is in place for you. Being chronically ill means that you are unable to perform the requisite number of Activities of Daily Living, according to your policy, for a period that is expected to last for at least 90 days or you have a severe cognitive impairment.

Q. What happens to my benefits if I stop paying my premium?

A. If you stop premium payments, with most long-term care insurance policies, your policy terminates. Most policies offer an option called “nonforfeiture” which preserves a part of your benefits even if you should stop paying premiums. Typically this option offers you a benefit equal to the premiums you’ve paid. And also typically, you need to keep the policy in force at least three years before you’re entitled to this “nonforfeiture” benefit, usually available at an additional cost.

Policies also include “Contingent Benefit Upon Lapse” as a consumer protection. This means that if your current premium increases over a certain level outlined by the National Association of Insurance Commissioners, and you decide you cannot afford the new premium, you can choose one of two benefits. One benefit provides a reduction of your current policy’s benefits so that your premium will not increase. The other benefit allows you to reduce your policy’s benefits by shortening the original benefit period, thereby converting the policy to a “paid up” status. Of course, you may elect to keep your policy’s benefits the same and pay the higher premium.

A good rule of thumb is this--if you purchase a long-term care insurance policy, plan on paying the premium until you need benefits. Most policies do not expect you to pay premiums once you begin to collect benefits, but the way in which this works may differ from policy to policy, so be sure to know what your policy provides.

Q. What is a “return of premium on death” benefit?

A. The “return or refund of premium on death” benefit will return or refund all or part of the premiums you paid, and in most cases, any “refund” is paid to your estate. This benefit varies from policy to policy. Some policies require payment for a specific number of years before this benefit can be received. Others may only refund premiums up to a specific age.

What Else Should I Know?

Q. Can I change my mind if I buy a policy?

A. Generally, you will have 30 days from delivery date to review the policy and return it and get your money back if you find that it does not meet your needs. This period of time is called the “free look period.”

Q. Can my premiums be raised?

A. Most long-term care insurance plans are guaranteed renewable. This means that premiums cannot be raised solely in response to the number of claims an individual has filed, nor can they be raised solely because of age or change in health.

Companies whose policies are Guaranteed Renewable may increase premiums on policies on a class-wide basis, usually only with state approval.

Q. How can I evaluate a long-term care insurance company?

A. Look for a company that achieves consistently high ratings from the leading insurance company rating agencies, such as Standard and Poor's (www.standardandpoors.com), Moody's (www.moody.com), or A.M. Best (www.ambest.com). These ratings represent the overall financial stability of the insurance company.

It is important to base your purchase on the company's reputation and benefit offerings. Premiums that are less expensive but don't offer the coverage that is best for you won't always save you money in the long run. Monthly premiums that start out much lower than others may not always stay low.

Q. How can I obtain detailed information on long-term care insurance?

A. You can obtain more detailed information on long-term care insurance in several ways – through an association, your employer, an insurance agent, or via the Internet. You may also contact your state's Department of Insurance or local Area Agency on Aging. As with any major purchase, being an informed consumer is the best way to make a decision.

Endnotes

¹ *Long-Term Care: Medicaid's Role and Challenges* (publication #2172), The Henry J. Kaiser Foundation, November 1999.

² In California, Assisted Living Facilities are called Residential Care Facilities.

³ *Older Americans 2000: Key Indicators of Well Being*, Federal Interagency Forum of Aging-Related Statistics, Washington, D.C., Updated June 2004.

⁴ *The MetLife Market Survey of Nursing Home & Home Care Costs*, MetLife Mature Market Institute, August 2003.

⁵ *The MetLife Market Survey of Assisted Living Costs*, MetLife Mature Market Institute, October 2003.

⁶ *Transfers of Assets*, Center for Medicare & Medicaid Services, www.cms.hhs.gov/medicaid/eligibility/assets.asp.

⁷ Driscoll, M., *Medicare and Medicare Supplements 1*, *The Complete Idiot's Guide to Long-Term Care Planning*, (2003). Alpha Books: Indianapolis, IN 46290. ISBN: 0028643801

⁸ Merlis, M., *Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy?*, Prepared for The Kaiser Family Foundation, March 2003.

⁹ *The Older Population*, A Profile of Older Americans: 2001, Administration on Aging.