

# Long-Term Care Insurance

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Long-term care insurance can be helpful to clients who are healthy enough and affluent enough to afford it. As elder and disability law attorneys, we must all be aware that Medicaid and other public assistance programs may not continue to exist in the future as we know them today. In fact, the Deficit Reduction Act of 2005 has made it more difficult to become eligible for Medicaid. It would be a disservice to our clients to advise them to rely on these programs in the future. Clients who can afford long-term care insurance and who may be insurable should be urged to consider purchasing the insurance. Premiums for long-term care insurance can be controlled to a certain extent by the client. The features that affect the premium cost, which can be selected by the client, are the maximum daily benefit, the elimination period, the benefit length, the inflation rider and the amount of home care covered. There are two factors that the client cannot control that greatly affect the premium. These are the client's age at application and health history. For this reason, clients should purchase long-term care insurance at the earliest possible time. Most experts consider that the best time to purchase long-term care insurance is about age fifty. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided tax deductions and tax relief for "qualified long-term care insurance contracts." The New Jersey regulations concerning long-term care insurance contracts are found at *N.J.A.C.* 11:4-34.1 to 34.13.

According to the Genworth Financial 2005 Cost of Care Survey, only about nine percent of the elderly have private long-term care insurance. There are four reasons why people do not buy long-term care insurance:

- Lack of Awareness. The industry has not done a good job in marketing this product.
- Denial. Seventy-seven percent of people surveyed by the American Council of Life Insurance believed they would be healthy in retirement. Longevity and Retirement Survey Fact Sheet, American Council of Life Insurance. Survey conducted between August 12 and September 10, 1997.
- Cost. It is estimated that only 10 to 20 percent of the elderly can *afford* such insurance. J. M. Wiener, L. H. Illston & R. J. Hanley, *SHARING THE BURDEN: STRATEGIES FOR PUBLIC AND PRIVATE LONG-TERM CARE INSURANCE*, 14 (Brookings Institutions, 1994).
- Insurability. Many people wait until they have a diagnosis before applying for long-term care insurance. At that point, they are no longer insurable. Agents estimate that approximately 25 percent of persons applying are rejected for health reasons.

## **A. LONG-TERM CARE INSURANCE FACTORS**

### **1. Coverage**

Policies need to be carefully analyzed to see if there are exclusions for alcohol and drug abuse related services or mental health related services. New Jersey requires that all policies include coverage for Alzheimer's and other organic brain disorders.

### **2. Premiums**

Premiums for long-term care insurance are high. However, the cost of the premiums is relatively low compared to the cost of payment for a nursing home. Each family must make the premium fit within its family budget. According to the Health Insurance Association of America LTC Market Survey, 1996, long-term care insurance coverage for a \$100 per day nursing home benefit and a \$50 per day home health care benefit with a lifetime five percent compounded inflation rider, 20 day elimination period and four years of coverage averaged \$798 per year for a person aged 50, \$1,881 per year for a person age 65, and \$5,889 for a person age 79. Obviously, the earlier the policy is purchased, the more affordable the premium.

Most long-term care insurance policies are guaranteed renewable. This means that coverage cannot be canceled by an insurance company, nor can premiums be raised on an individual basis, because of increasing age or declining health. Premiums can be raised only on a class basis affecting all policyholders with that insurance company in that class, and then only with the approval of the state insurance department. In practice, premiums are seldom, if ever, raised on this basis.

### **3. Daily Coverage**

Persons buying long-term care insurance usually purchase a policy that reimburses their long-term care costs up to a selected maximum amount per day. For example, in New Jersey many people purchase \$200 to \$225 per day of coverage. The actual average cost of a nursing home in New Jersey in 2007 probably ranges from \$250 to \$300 per day for the basic rate. Ancillary charges such as medications and incontinent care are extra. The difference is made up by the individual's Social Security, pension, or other income.

Some policies are written as a pool of money. An individual might purchase \$365,000 of coverage, or the equivalent of \$200 per day coverage for five years ( $\$200 \times 365 \text{ days} \times 5 \text{ years} = \$365,000$ ).

#### **4. Gatekeepers**

Companies can sell qualified or non-qualified policies. Qualified policies offer certain safe harbor tax benefits. The primary advantage of a tax-qualified policy is that the benefits paid under the policy are clearly not taxable income. The disadvantage of a tax-qualified policy is that the figures for coverage are more difficult to achieve. Many agents sell only tax-qualified policies.

For a long-term care insurance policy to be a qualified contract, it must provide for benefit eligibility to be determined by meeting a chronically-ill individual standard. The term “chronically-ill individual” means an individual who has been certified by a licensed health care practitioner as being unable to perform at least two of the activities of daily living (ADLs) and whose disability is anticipated to last for a period of at least 90 days due to a loss of functional capacity; or, requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. There are two triggers under the new law. The ADL Trigger and the Cognitive Impairment Trigger.

##### **a. ADL Trigger**

The ADL’s include eating, toileting, transferring, bathing, dressing and continence. The long-term care insurance policy must take into account at least five of such activities. The inability of the insured person to perform two of the five or two of the six ADLs without substantial assistance triggers eligibility under the policy. I.R.C. § 7702B(c)(2). The 90-day period is not a waiting period. The 90 days can be prospective and does not affect the elimination period.

##### **b. Cognitive Impairment Trigger**

Severe cognitive impairment means a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests that reliably measure impairment in short- or long-term memory; orientation to people, place or time; and deductive or abstract reasoning. The deterioration or loss must place the individual in jeopardy of harming himself or others, thus requiring substantial supervision by another individual. A person who is physically able but has cognitive impairment such as Alzheimer’s Disease or another form of irreversible loss of mental capacity is treated similarly to an individual who is unable to perform (without substantial assistance) at least two ADLs.

IRS Notice 97-31 defines substantial assistance as “hands-on assistance and stand-by assistance.” “Hands-on assistance” means the physical assistance of another person without which the individual would be unable to perform the ADL. “Stand-by assistance” means the presence of another person within arms’ reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual, if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual’s throat, if the individual chokes while eating). An individual is chronically ill only if a licensed health care practitioner has certified that

the individual is unable to perform (without substantial assistance from another individual), at least two ADLs for a period anticipated to last at least 90 days due to loss of functional capacity. A licensed health care practitioner is a physician, registered professional nurse, licensed social worker, or other individual who meets requirements that may be prescribed by the IRS. I.R.C. § 7702B(c)(4).

## **5. Inflation Provisions**

Between 1985 and 1995 nursing home costs in New Jersey increased approximately 9.7 percent per year. Costs of nursing homes increase constantly. Some homes increase annually, some more often. A daily benefit of \$200 purchased today may be sufficient now, but may be inadequate five years from now when the client enters a nursing home. Therefore, inflation coverage should be considered.

Most policies have inflation riders that offer increases based on the Consumer Price Index (CPI). Insureds are offered the right to purchase additional coverage at their attained age. Premiums increase when high coverage is elected. Other companies offer policies with an inflation rider that increases coverage automatically at five percent per year, either on a simple or a compounded basis. Automatic inflation riders keep premiums level as benefits increase. Nursing home costs increase on a compounded basis, so an inflation rider, that increases on a compounded basis, is best.

## **6. Pre-Existing Conditions**

New Jersey long-term care insurance regulations define a “pre-existing” medical condition as any condition for which the applicant received advice or treatment during the six month period prior to making application. Further, if an applicant is accepted, a company cannot impose a pre-existing medical condition waiting period on the insured person for more than six months from the effective date of coverage. Persons with diagnosed Alzheimer’s or Parkinson’s Diseases will always be denied coverage. However, persons with histories of cancer, heart disease or similar conditions are often able to obtain coverage. The insurance companies generally like to see a period of time during which it is clear that the condition is controlled. In some instances, the coverage is obtained at regular rates. In other instances, the coverage is granted, but the client is rated, which means that the client pays a higher insurance premium or is offered a shorter benefit length or a longer deductible.

## **7. Benefit Length**

The benefit length is the period of time over which the insurance company will pay after the client starts receiving benefits for long-term care. Coverage is available for two years, three years, four years, five years, six years or an unlimited time period. The longer the term of coverage selected, the more expensive the premium. Attorneys often advise clients to obtain five years of coverage. This enables the client to do public assistance planning and, under current law, the lookback period is covered by insurance. Because Medicaid, as we know it today, may not be available in the future, it may be well to advise clients to purchase as long a term of coverage as they are able to afford.

## **8. Guaranteed Renewability**

It is important that a policy be guaranteed renewable. If a client purchases a policy when healthy, and is later diagnosed as having a condition such as Alzheimer's, the client needs to have the assurance that his coverage cannot be canceled or his premium individually raised. Federal law now requires that qualified policies be guaranteed renewable. I.R.C. § 7702B(b)1(C).

## **9. Home Health Care**

Most companies have comprehensive "bundled" policies that include home health care. Some companies have home health care riders that can be added to the basic nursing home/assisted living facility coverage. At least one company has a policy that covers only home health care. Clients do not want to spend time in nursing homes. They would much prefer to stay at home. It is important to obtain home health care coverage so that the family can afford to keep the client at home.

## **10. Waiver of Premium**

Some policies waive the payment of premiums when benefits are being received or have been received for a given period of time, typically 90 days. Premiums normally resume once benefits stop being paid.

## **11. Case Management**

Some long-term care insurance policies offer a benefit option referred to as "case management." Under case management a professional oversees the care and the services the insured would receive. The case manager may be an insurance company employee. This is managed care for long-term care insurance, and it should be carefully analyzed. Other policies allow the client to choose his own case manager.

## **12. Adult Day Care and Respite Care**

Most long-term care policies provide benefits for adult day care services and respite care. Respite benefits allow for immediate coverage while an informal caregiver (spouse, child, etc.) gets a break.

### **13. Quality of the Insurance Company**

The quality of the insurance company is important. After paying premiums for a number of years, the client expects the insurance company to pay the claim when made. Because of the experience of Executive Life, Mutual Benefit Life and other insurance carriers that have experienced financial difficulties, it is wise for the attorney to counsel the client to look at the ratings of the insurance companies. Ratings services include the following:

1. Moody's Investors Service  
99 Church Street  
New York, New York 10007  
Telephone: (212) 553-1658  
Fax: (212) 553-4062
2. Standard and Poor's  
25 Broadway  
New York, New York 10004  
Telephone: 212-208-1527  
Fax: 212-208-8571
3. Duff and Phelps  
55 East Monroe Street  
Suite 3500  
Chicago, Illinois 60603  
Telephone: 312-368-3157
4. A.M. Best  
Ambest Road  
Oldwick, New Jersey 08858  
Telephone: 908-439-2200  
Fax: 908-439-3296
5. Weiss Ratings  
4176 Burns Road  
Palm Beach Gardens, Florida 33410  
Telephone: 561-627-3300 or 1-800-289-9222  
Fax: 561-625-6685

### **B. POLICY FEATURES**

The features of the policy that determine cost are:

### 1. **Daily Benefit**

The daily benefit is the maximum amount of money that the insurance company will pay to the insured for each day of long-term care services.

### 2. **Elimination Period**

The elimination period is like a deductible. It is the number of days that the client is willing to pay privately before the insurance begins. Insurance is available that will pay from the first day of care. Other options are a 20 day elimination period up to a 100-day elimination period or even 365-day elimination period. The longer the elimination period, the lower the premium. A 100-day elimination period usually makes sense. It can reduce the premium substantially at older ages, and Medicare and Medi-Gap Insurance may cover at least part of the 100 days, if the patient meets the Medicare requirements for a skilled nursing facility. If not, the client self-insures.

### 3. **Benefit Length**

The benefit length is the number of years the insurance company will pay the nursing home. The term begins *after* the client enters the nursing home.

### 4. **Inflation Rider**

A five percent compounded inflation rider is the most expensive, but affords the best coverage because the increases in nursing home rates are compounded.

## C. **TAXATION**

### 1. **Income Tax Deduction**

Under the HIPAA, qualified long-term care insurance premiums are deductible from federal income tax as a medical expense up to certain limits. I.R.C. § 213(d)(1)(D).

While payment for medical services provided by relatives does not ordinarily qualify for a medical expense deduction under I.R.C. § 105(b), reimbursements through insurance to a relative for such care do qualify. I.R.C. § 213(d)(11). For example, if Dad, who has Alzheimer's, hires his daughter, a licensed practical nurse, to care for him, payments from father to daughter are not tax deductible. However, if the daughter is paid by the insurance company, the payments are not counted as income to the father.

Under I.R.C. § 213(d)(1)(D), eligible long-term care insurance premiums for a qualified long-term care insurance contract up to the following dollar limits qualify as tax deductible medical expenses in 2007.

<u>Attained Age by Yr. End</u>	<u>Annual Limit on Prem. Ded.</u>
40 or less	\$290.00
More than 40 but under 51	\$550.00
More than 50 but under 61	\$1,110.00
More than 60 but under 71	\$2,950.00
Over 70	\$3,680.00

I.R.C. § 213(d)(1)(D). Rev. Proc. 2006-53(3)(20). Unfortunately, this deduction is largely illusory because it is subject to the overall 7½ percent floor of adjusted gross income on deduction of medical expenses. Most people who are healthy enough to purchase long-term care insurance do not have enough other medical expenses to deduct so that they can hit the 7½ percent threshold. It is likely that the tax deduction will be attained only if one spouse is ill and the other spouse has the insurance.

## **2. Exclusion from Taxation of Benefits under Qualified Contracts**

Amounts received as benefit payments under a qualified long-term care insurance contract are treated as amounts received for personal injury or sickness and as reimbursement for expenses actually incurred for medical care and are, therefore, excluded from income for tax purposes. I.R.C. § 7702B(a)(2). On flat indemnity policies, there is a limitation of \$260 per day in 2007. Rev. Proc. 2006-53(3)(41). Amounts greater than this are tax-free to the extent they cover actual costs. These figures are increased to reflect inflation. It is not clear whether benefit payments made under non-qualified contracts are excludable from gross income.

## **3. Grandfathering**

Contracts issued prior to January 1, 1997 benefit from a safe harbor in applying the ADL Trigger or Cognitive Impairment Trigger to its post-1996 contracts, if the insurance company uses the same standards that it uses to determine whether an individual is unable to perform an ADL for purposes of eligibility for benefit payments under its pre-1997 contracts and/or uses the same standards that it uses to determine whether an individual qualifies for benefits due to cognitive impairment under its pre-1997 contracts. All other requirements of I.R.C. § 7702B(c)(2) must be met. To be grandfathered, the contract must have met the long-term care insurance requirements of the state where the contract was issued.

## **D. CONSUMER PROTECTION**

To be considered a qualified long-term care insurance contract, the policy must contain certain consumer protection requirements of long-term care Model Regulations and the Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (NAIC) as adopted as of January 1993 (as well as disclosure and non-forfeitability requirements). The determination as to whether or not the requirements of the Model Regulation or Model Act have been met is made by the Internal Revenue Service (IRS). The IRS service is not to create a federal standard, but is to look at applicable state standards or those specifically in the Model Regulation or Model Act. The standards in New Jersey are contained at *N.J.A.C. 11:4-34.6(a)1*.

### **1. Guaranteed Renewable**

All long-term care insurance policies are guaranteed renewable. *N.J.A.C. 11:4-34.6(a)7*. No policy can contain a mandatory case management provision. *N.J.A.C. 11:4-34.6(a)6*.

### **2. Prior Institutionalization**

No long-term care insurance policy can require prior institutionalization. (*N.J.A.C. 11:4-34.6(a)4*).

### **3. Restoration of Benefits**

No long-term care insurance policy can require more than a six-month period between confinements for purposes of restoration of benefits (*N.J.A.C. 11:4-34.6(a)5*).

### **4. Pre-Existing Conditions**

With respect to pre-existing conditions, if the company accepts the individual for coverage, it may not exclude coverage for more than six months after the effective date of coverage for a condition for which medical advice was given or treatment recommended within six months before the effective date of coverage. *N.J.A.C. 11:4-34.6(b)*.

### **5. Free Look**

Policyholders have a 30-day "free look." *N.J.A.C. 11:4-34.6(d)*.

**6. Exclusions**

Policies may not exclude coverage based on Alzheimer's or other organic brain disease, but may exclude coverage for other mental or nervous disorders, alcoholism or drug addiction. *N.J.A.C. 11:4-34.6(f)*.

**7. Non-Forfeiture and Home Health Benefits**

Insurance companies have an option to offer non-forfeiture benefits or home health care services in a long-term care policy. *N.J.A.C. 11:4-34.6(j)*.

**8. Required Disclosure Provisions**

**a. Renewability**

With respect to disclosure, all long-term care policies must disclose that they are renewable.

**b. Reduction of Benefits**

No rider that reduces or eliminates benefits or coverage in the policy is effective unless signed by the insured. This feature must also be disclosed in the policy.

**c. Pre-Existing Condition Limitations**

All limitations with respect to pre-existing conditions must be disclosed and labeled as "Pre-existing Condition Limitations."

**d. Disability Definition**

If disability is a criterion for payment of benefits under a policy, the policy must include a definition of disability. *N.J.A.C. 11:4-34.8*.

e. **Outline of Coverage**

i) **Waiver of Premium**

The policy must state whether or not a waiver of premium feature is included. *N.J.A.C. 11:4-34.11(f)9iii.*

ii) **Change of Premium**

Companies do reserve a right to change the premium, but they must disclose the circumstances under which the premiums may change. *N.J.A.C. 11:4-34.11(f)9iv.*

**E. ESTATE LONG-TERM CARE PARTNERSHIP PROGRAM**

The Deficit Reduction Act of 2005 § 6021 provides that the long-term care partnership program may be extended beyond the original states of California, Connecticut, Indiana and New York. New Jersey has not yet acted.