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# Long Term Care:

## FACT & FICTION

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# Long Term Care Resources

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## Long Term Care: Fact & Fiction

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**T**he cost of long term care is the monster in the closet. You cannot seriously evaluate the pros and cons of how to pay for long term care until you understand the potential costs associated with long term care and understand the fact and the fiction of alternatives for financing those costs.

Above all, you require reliable information before you can make any decision. Then you need to evaluate long term care alternatives from a personal perspective. How do they fit within your long term objectives, concerns, responsibilities and resources? Decisions about long term care are very personal and, we believe, of great consequence. If you need help in understanding and interpreting the information you may already have and that which we will share with you through this website, we will be pleased to assist you. But you must be the final judge of what makes the most sense for your circumstances.

### **The Cost of Long Term Care**

Let's open the door. The cost of long term care will vary in part by where you live when you receive care, by the level of care you require and by who provides that care. In Pennsylvania, for example, as of July 2006, the average cost of skilled nursing facility care is \$6,757.67 per month. That figure comes from the Department of Public Welfare and is revised yearly.

Skilled care is the highest degree of medical care, the patient is under the supervision of a physician, the care is provided 24 hours a day and the facility has a transfer arrangement with a hospital. In New York State, the cost for similar care is much higher and in other

states it is lower. But, at \$6,757.67 per month, the expense comes to about \$81,100 a year. We use it here to indicate the average cost of the most expensive level of long term care in one area of the country.

Please understand that your medical insurance, including Medicare and Medigap, doesn't begin to cover the cost for long term skilled nursing facility care and covers very little, if any, home health care. Medicaid does provide long term care benefits, but at a price. The price is that you must qualify for welfare to qualify for Medicaid. How you get there varies a little depending on the state in which you live, but the bottom line is that Medicaid requires you to spend down to the poverty level before you can receive long term care benefits from the government. And that process may also significantly impact the financial well being of your spouse.

### **The 4% Rule**

As a rule of thumb, some financial advisors say that, if you limit withdrawals from your retirement savings to no more than 4% a year, the odds are good that you will not outlive your savings. Consider that rule in terms of a \$81,100 average current annual cost for skilled long term facility care. To be able to withdraw \$81,100 a year at a 4% withdrawal rate without diminishing your savings, you would need \$2,027,500. Few of us have such resources!

Then again, the Centers for Medicare and Medicaid Services report that the average skilled care Medicare claim is about 24 days.

So what's the worry? CMMS also reports that the average long term care claim lasts about 21/2 years or 30 months. If the care delivered during those months is largely at a level less than skilled, it's reasonable to assume that the cost would be lower. Let's assume that your care costs \$4,000 a month. And let's further assume that you only needed that care for 30 months. What would you need in savings at the outset to pay for your care and have nothing left after 30 months assuming you earned 4% annualized on the declining balance? About \$114,000.

Before we go any further, please remember the words used in defining these costs... average and assume. They create the danger. The average cost of care may not represent the actual cost of care in a facility acceptable to you.

Most of us could handle several months of care in a crunch. Could you handle the average of 30 months? What if you guess wrong and the need continues? What if the need doesn't arise for 15 or 20 years but the cost of care has grown from \$4,000 a month to \$8,500 a month?

Unfortunately, our crystal ball broke a long time ago. Averages and estimates are all we have to go on to anticipate long term needs. In fact, the long term care risk may not become a reality in our lives but we think you'll agree that the financial consequences of failing to plan for long term care are substantial if the risk becomes reality in your life.

Now let's look at what we call the fact and fiction of what many regard as alternative resources for long term care.

### **Medicare**

Medicare simply does not pay for long term care. Medicare will pay for skilled nursing fa-

cility care for 20 days if you are transferred into such a facility within 30 days of spending three days in the hospital for related care. From the 21st through the 100th day, Medicare subjects you to a daily copay of \$119.00 in 2006 if you still require skilled nursing facility care. From day 101 on, you are on your own.

Medicare may provide a limited home care benefit, which must be rehabilitative. Once your condition plateaus, even if you have not recovered, the benefit ceases. Some advocates argue that the benefit should continue if it enables you to maintain your health at a level to which you have recovered, but to compel continued Medicare home care benefits in such a situation you may well need to go through an appeals process with no guarantee of success.

You should read Medicare & You published each year by the Centers for Medicare & Medicaid Services. You'll find it at [www.medicare.gov](http://www.medicare.gov). It is a very useful website because it also includes links to other helpful government publications concerning health care benefits.

### **Medigap**

Medigap policies, Plan C or higher, will pay the Medicare skilled nursing facility copay of \$119.00 a day. However, it is most important that you realize that Medigap only pays for deductible and copay gaps in Medicare. If Medicare won't pay, but for deductibles or coinsurance, your Medigap policy won't pay.

If you are enrolled in a Medicare HMO, you don't need a medigap policy. But your Medicare HMO won't provide you with long term care benefits any more than would traditional Medicare coverage.

## **Medicaid**

Medicaid long term care benefits are a God-send for individuals who are otherwise uninsured and without assets to pay for their care. Medicaid is, in fact, the only government program that provides long term facility care. Should Medicaid appear to be an appropriate consideration in your particular circumstances, you should meet with an elder law attorney to discuss the complicated Medicaid rules as they may apply to you. A good resource for identifying attorneys in your area who hold themselves out as offering elder law services is the website of The National Academy of Elder Law Attorneys, Inc. [www.naela.org](http://www.naela.org).

This brief discussion of Medicaid focuses on the means tests which must be met before you may be financially eligible to receive Medicaid long term care benefits. By demonstrating the actual cost of qualifying for Medicaid, we mean to emphasize the importance of incorporating provision for long term care in your financial planning and the financial good sense of not relying on governmental benefits.

Although Medicaid is a federal program, it is administered by the various states. The rules for qualifying for benefits thus vary a little from state to state. To be financially eligible for Medicaid benefits in Pennsylvania, for example, an individual who is single or widowed cannot have more than \$2,400 in assets.

There are several exempt or non-countable assets, including the Medical Assistance applicant's primary residence so long as he or she is alive, but the bottom line is that you must be indigent to qualify for Medicaid long term care.

If you are married, the same rules apply except that you and your spouse can also cur-

rently shelter one half of your jointly owned assets with a minimum protected amount of \$19,908 and a maximum of \$99,540. If your jointly owned assets total, for example, \$250,000, you can shelter \$99,540, not \$125,000.

Your home is exempt so long as the healthy or "community" spouse maintains it as his or her primary residence. Upon the death of the second to die, however, the Department of Public Welfare in Pennsylvania will recover from the proceeds of the sale of the house any Medicaid Assistance benefits paid for nursing facility services for an individual owner who was 55 or older at the time the benefits were paid.

Jointly owned assets in excess of the protected amount must be spent before you can qualify for Medicaid benefits. Furthermore, you must spend your pension benefits, if any, and your Social Security benefits for your care regardless of whether you are single, widowed or married.

If you give away countable assets within five years (sixty months) prior to applying for Medical Assistance, the Department of Public Welfare will declare you ineligible for Medical Assistance benefits for a period of time now, under the Deficit Reduction Act of 2006, running forward from the date you apply for Medicaid, not from the date you made the gifts.

The lookback period is sixty months for gifts to individuals and sixty months for assets transferred to a trust. The fair market value of the gifted assets is divided by the Medicaid divisor, currently \$6,757.67 in Pennsylvania. The resulting number is the number of months for which you are ineligible for benefits. Those months are your period of ineligibility and should not be confused with the thirty six or sixty month lookback period.

You must pay for your care out of pocket during the period of ineligibility. The Catch 22 is that in order to apply for Medicaid, you must be financially as well as medically qualified, which means that you will have spent down your unprotected assets. How will you pay for your care during a period of ineligibility?

## **LONG TERM CARE INSURANCE**

### **LTCI Underwriting**

Before we look at the many different forms long term care insurance can take, please note the word insurance. This is not something you get by just signing up for it. You must show evidence of health acceptable to the insurer. That process is called underwriting. The outcome of it will determine whether or not the insurer will agree to issue a policy covering you.

In some cases of employer-sponsored LTC programs, the health questions may be reduced to just a few “knockout” inquiries designed to eliminate applicants who would immediately qualify for benefits. In some cases there may be no health questions.

However, an individual LTC insurance application typically asks a lot of questions about your health history and requires you to identify your physicians. You should assume that the insurer will write to your physicians concerning your health and that your physicians will fully disclose their records to the insurer.

If your age is 70 or beyond, the insurer will typically require a face-to-face meeting between you and a nurse or social worker, paid for by the insurer, to provide a basic evaluation of your physical and mental capacities. These are not medical exams such as you may have experienced with life insurance, though the insurer will reserve the right to require one at its expense. Medical exams are

rarely used in LTC underwriting.

It is also important to realize that different companies may underwrite the same health condition differently. If you have any significant health history, be particularly careful to speak with an LTC broker, an individual who does business regularly with at least three different LTC insurers. Ask the broker to discuss your health history with the insurer offering the policy benefits most appropriate for you before you submit your application.

Such “pre-qualifications” don’t guarantee the underwriting outcome because they are conducted anonymously (you are not identified by name) and the underwriters always condition their comments on subsequent reviews of your actual medical records. However, such an inquiry will give the broker and you a better idea whether or not underwriting by that company may be favorable to you or whether you should consider another insurer as well. Be careful here, because, if you are declined by one LTC insurer, you’ll find that many other quality insurers will not consider an application from you.

The booklet, *A Shopper’s Guide to Long Term Care Insurance*, published by the National Association of Insurance Commissioners, provides a useful introduction to LTC insurance. Insurance agents are required by regulation to provide you with a copy at the first meeting in which they discuss LTC insurance with you.

We have developed the review which you are now reading to provide greater depth and perspective on the complicated subject of governmental and privately insured long term care benefits but we also encourage you to read the *Shopper’s Guide*.

## **Qualified Long Term Care Insurance Policies**

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) created “qualified” LTC policies. If policies incorporate certain provisions specified in HIPAA and exclude certain other provisions, they are said to be qualified under HIPAA.

HIPAA also “grandfathered” LTC policies issued prior to 1/1/97. They are considered qualified so long as material changes aren’t made to them after 12/31/96. If you have an LTC policy issued prior to 1/1/97, be sure to let your advisor know.

One value in having a qualified LTC policy is that you may receive an income tax benefit for some or all of your premium. More importantly, you are guaranteed that any benefit you receive from the policy, up to the per diem limitation noted earlier, will be exempt from federal income taxes. Benefits in excess of the per diem limitation will also be free of such tax so long as you actually incurred qualified expenses at least equal to the benefit received.

Benefits received from non-qualified LTC policies are not exempted from federal income taxes by HIPAA. However, non-qualified policies are permitted to have a benefit trigger not allowed in qualified policies. That trigger is medical necessity. A “trigger” is a condition that may cause you to be eligible for policy benefits.

Non-qualified policies may also allow you to be eligible for benefits by needing assistance with just one activity of daily living (ADL). Qualified policies require you to need at least stand-by assistance with two of six ADLs (eating, bathing, dressing, toileting, continence or transferring) in order to be eligible for benefits. Qualified policies also require

that a healthcare practitioner certify annually that your condition is likely to last ninety days or longer. Thus non-qualified LTC policies appear to be somewhat more liberal in how you may become eligible for benefits.

We note that both types of policies also provide that you are eligible for benefits if you have severe cognitive impairment, the most common example of which is Alzheimer’s disease.

It is our opinion that the HIPAA guarantee of federal income tax exemption for benefits paid from a qualified LTC policy outweighs the possibility that you could develop a long term health care need which would involve a deficit in only one activity of daily living or that would be sufficiently medically serious as to cause you to require long term care services but not need stand-by assistance with two activities of daily living.

Which type of policy you select is, of course, your decision - just be aware of the pros and cons of each type.

## **Long Term Care Policy Provisions**

Your eligibility for benefits will depend on the terms of your LTC policy. Before you apply for a policy, review a specimen policy that stipulates the provisions for each of the terms that you want included in your coverage. Be sure that you understand the terms before signing on the dotted line.

The following provides an overview of the basic provisions which appear in all policies. But be warned, companies do differ in how even these provisions are applied. We will note some of the variations.

**1. The Elimination Period.** This is the time between the onset of your claim and when

you are actually eligible to accrue policy benefits. It is a built in delay between the time you need care and when your policy will provide payment for all or some of the cost of your care. Prior to your satisfying the elimination period requirement, you will be responsible for the cost of services. You select the elimination period at the time you apply for coverage. Companies may offer a variety of choices such as 30, 50, 60, 90, 100, 180 days or even longer.

For example, if you elect a 30 day elimination period when you buy your policy, the policy will not pay for expenses otherwise eligible for coverage between the onset of the claim (the day you first needed care) and the end of the 30th day.

Companies, however, can differ in how they credit the days required to fulfill the elimination period. Some policies credit one day of care for one day toward satisfying your elimination period. Other policies may credit one week (seven days) toward the elimination period if you require otherwise covered services during just one day of a given week. Still other policies may vary the theme crediting seven days if you require otherwise covered services on three days during a given calendar week.

The more liberal the crediting of days toward the elimination period, the sooner you will receive coverage for health care expenses you incur.

“One time only” is also an important point to keep in mind. Most policies today provide that you need only satisfy the elimination period once in your lifetime. You may have surgery that requires several weeks of rehab. If, for example, you need assistance with bathing and dressing during that rehab period, you may earn days in permanent satisfaction of the elimination period which could be most

important later on if you develop a truly long term health care need. Your policy benefits will be available to you sooner.

The elimination period will have an impact on your premium. A policy with a 30 day elimination period will have a higher premium than one with a 60 or 90 day period. Remember that the insurance company will not pay benefits for expenses you incur during the elimination period. Be sure to compare the premium you save with a longer elimination period against the greater out of pocket expense you will incur should you have a long term care claim.

Don't count on Medicare to help pay expenses during the elimination period. Remember that Medicare only pays for skilled nursing facility care and then only under certain conditions and that Medicare benefits are subject to a \$114.00 a day co-pay after the first 20 days.

However, days covered by Medicare may count toward satisfying the elimination period - another reason to check out specimen policies before you buy.

**2. The Benefit Amount.** LTC insurance policies usually express the basic benefit in terms of a maximum daily benefit amount. Thus you may buy a policy with a \$150 a day maximum benefit. Some companies express the benefit amount in monthly terms (e.g., \$4,500 a month), but the daily benefit is the most common benefit description.

You select a maximum daily benefit when you apply for a policy. We think that today a \$150 daily or a \$4,500 monthly benefit is a reasonable starting point. Remember the \$6,757.67 “Medicaid divisor” to which we referred earlier? It works out to about \$202 a day. We suggest using a \$150 daily or

\$4,500 monthly benefit, recognizing that in most cases some personal funds may be available to contribute to the cost of care and that the more likely need for care will be at a custodial rather than a skilled nursing level with a corresponding reduction in the cost of the care.

You may have seen \$100 a day referred to in media articles on long term care. In our experience, that number, at least in Pennsylvania, is an underestimate even for the cost of quality custodial care. Your needs and resources will be the ultimate arbiter of the basic benefit appropriate for you, but we recommend that your competitive evaluation require at least \$150 a day as a constant for each insurer's quote.

If you prefer to use a lower daily benefit number with the assumption that you will supplement the cost of your care with personal funds, be sure to consider whether or not the available amount of those personal funds will increase as time passes. Otherwise, you may find fifteen or twenty years from now that, even with a 5% automatic annual compound benefit increase built into your insured benefit, the total funds (insured and out of pocket) available for your long term care are seriously deficient.

At the outset of this section, we referred to the basic daily benefit amount. Some companies persist in offering "nursing home only" or "home care only" benefit policies. Unless you have a full proof crystal ball, we recommend that you avoid such limited benefit contracts. Be sure that the policy you purchase provides "comprehensive" benefits, that the policy will cover your care whether it is delivered at home by a licensed home health care provider, in adult day care, in an assisted living facility, or in a skilled nursing facility.

Every company also offers riders, extra bene-

fits for extra costs, which can enhance your coverage. When comparing costs, be careful to first examine the basic, no frills, comprehensive benefit cost of each insurer you want to consider.

**One more basic point.** Be sure to ask how the "daily" benefit is actually paid out in the event of a claim. Some companies limit what they will pay to the stated daily amount. If your daily care costs more, the excess cost over the daily benefit is your responsibility.

The trend, however, appears to be for companies to provide for the stated daily benefit to be accessible at claim time as a weekly or even a monthly multiple. For example, your daily benefit may be \$150 but the company will allow you to access during a seven day period (or a calendar week) \$1,050 (7 x \$150) without limiting the payout to a daily maximum. Thus if you need physical therapy but only three times a week and the therapy costs \$250 each time, the LTC policy will cover you for the full amount each time because the total covered expense didn't exceed \$1,050 during the seven day period.

Incidentally, if your benefit is paid on a reimbursement basis (the structure used by the majority of LTC policies,) the left over \$300 (\$1,050-\$750) is kept in reserve for you and could extend your maximum benefit period.

**3. The Benefit Period.** This is the number of years for which the full daily benefit is payable once you are eligible for benefits.

You select the benefit period when you apply for your policy. Companies typically offer 2, 3, 4, 5, 6 and even 10 year benefit periods called "limited" because the number of years for which benefits are payable is limited. You can also elect an unlimited or life-

time benefit period.

If you have a limited benefit period with a reimbursement based policy and the cost of your covered expenses does not use up the full amount of your daily, weekly or monthly benefit amount, the balance is kept in reserve for you and will extend the maximum duration of your benefit period.

There are a few policies on the market called indemnity policies for which the last statement is not applicable. Indemnity policies pay the full amount of your daily benefit to you if you incur covered expenses even though the expenses don't add up to your maximum daily benefit amount. Most policies, however, are structured on a reimbursement basis and pay, up to your policy's maximum benefit, only to the extent you actually incur covered expenses. Several major insurers do offer the option to select either type of policy structure at the time of application for coverage.

It is worth noting that, in the early days of a claim, an indemnity policy could pay you benefits even though Medicare is covering the cost of your care. However, because of a provision in HIPAA, a reimbursement based policy cannot pay benefits if Medicare is paying for your care. We don't think that the HIPAA limitation on a reimbursement based LTC policy is, in itself, a reason to purchase an indemnity policy structure, but it is a planning consideration of which you should be aware.

Just as your premium cost is affected by the length of elimination period you elect, so also will the premium be impacted by the benefit period you select. The longer the benefit period, the greater will be the cost of the policy.

Because the average long term care claim is about two and one-half years, we encourage you to consider at least a three year benefit period. For greater planning flexibility, we

think that a four year benefit period is a prudent minimum. However, your financial circumstances now and for the foreseeable future will guide you to the appropriate, manageable premium level. It is certainly better to have even a two year benefit period in force than no coverage at all.

There is another consideration which may influence your choice of a benefit period. If you are inclined to carry insured coverage for a period sufficient to pay for your care during a potential five year Medicaid period of ineligibility, you should consider buying a five year benefit period policy.

**4. Shared Benefits.** This is a relatively new concept in LTC benefits and may take the form of a rider on a policy or of a joint policy.

A shared benefit rider may provide that you and your spouse (or, with some companies, your life partner) can "piggyback" on the other's policy benefit if one of you exhausts your own benefit. Using this option would reduce the maximum benefit available to the healthy individual should she or he need long term care at a later date. However, policies which structure the shared benefit in this manner may provide a floor or minimum benefit which will be available to the healthy spouse in the future, although it will not be as great as the benefit they originally purchased. Be sure you understand the impact of using the shared benefit before electing such a policy structure.

An alternative structure creates a third pool of money which either individual or both can access after their individual policy benefits are exhausted until that pool is also used up. This format assures each individual that they will always have their own policy benefits for their own use in the event of a long term care claim.

The advantage of a shared benefit rider is clear where a limited benefit period is purchased. You could effectively double the maximum number of years for which benefits would be payable for one of two individuals depending on how the future unfolds.

A disadvantage is that one insured could exhaust the benefits available to both insureds. To our knowledge, only one major, well-rated LTC insurer offers some protection in such a case. That company will offer a two year benefit period policy to the other insured but at the then current age rate for that individual. The cost could be prohibitive.

As with any additional benefit, the shared benefit rider adds a cost to each policy. You should examine that cost and the potential benefit in terms of your long term budget and the needs which most concern you.

One major insurer takes a different approach by offering a joint policy which insures two individuals under the same plan. Either or both insureds can access the single benefit account. If you consider such a policy, be sure to weigh the premium savings you may achieve against the risk of one individual completely exhausting the policy benefits.

**5. Inflation Riders.** This benefit is intended to provide some protection against the future cost of long term care. It can take several different forms; an automatic annual fixed percentage increase in your benefit or a periodic option for you to purchase an increase in your benefit.

The increase can be simple or compound or it may be based on a periodic option to purchase an additional percentage of your base policy benefit. The cost of the benefit increase may be included in the cost of the rider itself or it may be an additional premium based on your age at the time you exercise an option.

Which rider, if any, is appropriate for you is more than anything else a function of your age at the time you first apply for long term care insurance. In our opinion, if you are younger than age 70 at the time you apply for a policy, you should consider an automatic annual compound benefit increase provision. If you are 70 or more senior, you should consider a simple benefit increase rider.

An inflation rider is likely the single most expensive additional benefit you can include in a long term care policy. It can double the initial cost of the policy. The longer the interval between the policy issue date and a claim on the policy, the more critical in hindsight the decision to purchase the rider becomes. An annual benefit increase of 5% compounded will double the policy benefit in about 15 years. A 5% simple increase will double the benefit in 20 years. Think about what the cost of long term care may be in 15 or 20 years.

Having said the above, you may want to consider purchasing coverage at the outset which significantly exceeds the current cost of care in your area and decline to purchase an inflation rider. All of your premium dollars will then go for current benefit dollars. This planning concept may be appropriate if you have substantial and reasonably liquid assets which could be used in later years to cover the gap which will likely exist between the cost of care and your fixed insured benefit.

Note that, if you use this concept and purchase an indemnity policy, part of the benefit may be subject to federal income tax even though you bought a qualified policy. Such a consequence would happen if the daily benefit paid to you exceeds the maximum tax free daily benefit amount (\$250 daily for 2006) and the actual cost of care

paid by you is less than the cash benefit paid to you.

**6. Premiums.** Two points must be understood at the outset of your LTCI planning: Currently no LTC insurer guarantees that the premiums for a policy will not increase. There can be a significant difference between the premiums charged by one LTC insurer compared to another for very similar benefits.

It does pay to shop. We believe that you should first determine the most appropriate basic benefit structure for your needs before you shop. If you heed our advice to work with a broker who is not the agent of just one or two companies, that individual should be able to provide you with competitive quotes for the benefits important to you and based on your health history from a number of well established and well rated long term care insurers.

While no LTC insurer currently guarantees that the premium will never change, what is guaranteed in every HIPAA qualified LTC contract is that the policy cannot be cancelled by the insurer so long as you pay the premium. Neither can an insurer single you out for a premium increase. The company must apply to each state insurance commissioner for permission to change the rates charged for a class of insureds and show cause why the rate change is needed.

Some LTC insurers offer the option, at a higher cost, of paying the premium for a limited number of years with the guarantee that no premiums will be due thereafter. With such policies premium increases imposed after the limited premium paying period would not affect you.

You should take care to examine the history of the insurer in terms of previous rate increases. In Pennsylvania and a number of other states, companies are now required to

disclose to you whether they have raised the rates in the past on the policy for which you are applying or on any similar policy.

**7. Extras.** As noted earlier, most companies offer a selection of enhancements that you can add to your policy at the time of application. Our purpose in this discussion has been to help you sort out the basics so that you can reasonably decide whether insured LTC coverage is appropriate for you and to provide you with some guidelines on how you can objectively evaluate the underwriting practices, fundamental benefits and costs of various insurers.

Don't get caught up in extras until you reach a sound decision on your needs and on the basic policy structure which fits you best.

**8. Combo policies.** The long term care insurance marketplace offers not only "stand-alone" LTC policies but also policies in which long term care benefits are coupled with universal life, whole life and even variable life policies.

These policies may be appropriate for the individual who has significant liquid assets, who needs additional life insurance, and who needs insured long term care protection. You should understand that they are not primarily marketed as long term care contracts. Rather, basic long term care benefits can be added to them by riders or they are described as incorporating the option to access a limited long term care benefit should the need arise. Typically, however, the use of the long term care benefit directly impacts the life insurance benefit and the investment value of the product.

You should also know that, at least in the current state of their development, the LTC benefits offered by these products are not

as comprehensive as you will find in stand-alone LTC policies.

The question we think you need to ask yourself if you are presented with such a policy is why, if you need life insurance, would you place value on a rider or an option (an LTC benefit) which, by using it in a long term care claim, would potentially reduce your death benefit to a nominal amount?

At least part of the answer to that question is in the willingness of some individuals to hedge the LTC risk if they can accomplish other purposes at the same time such as the conservative growth of a portion of their assets or the provision of some additional death benefit. If you fit that profile, you may want to consider such products but be sure to do so in comparison to stand-alone LTC contracts (as well, for that matter, conventional life insurance products and various conservative investment products) so that you understand the benefits offered by each approach. Then ask yourself whether or not, for you, the combo product offers acceptable solutions to your long term care, life, and investment needs.

**9. Financials.** Financials are fundamental. You should require the broker to provide the financial ratings of each insurer under your consideration. We strongly recommend that you only consider insurers with financial ratings of “A” or higher from at least two of the following five rating firms: A. M. Best Company, Fitch Ratings, Moody’s Investors Service, Standard & Poor’s, or Weiss Ratings.

### **Cost/Benefit Matrix**

We developed a cost/benefit matrix to give you a perspective on how premiums can vary depending on your age at the time you purchase coverage, on the duration of the benefit period you select for your coverage, and on

whether or not you are in really good health (receive the best rate offered by the insurer) or good health (receive the standard rate for the coverage you request.)

The matrix also addresses the “time value of money” issue - what if I didn’t buy the insurance and, instead, saved the premium dollars for, let’s say, 20 years. How long would my savings cover my expenses if I had a claim that started in 20 years? You may be surprised at the answer.

Please see 7/06 Cost/Benefit Matrix Update, located at [futurecareassociates.com](http://futurecareassociates.com), for the most current matrix.

Because a fundamental goal of the matrix is to provide you with a basic planning tool and because those supplemental benefits are not offered by every company and may not be appropriate for meeting your needs, the cost of them is not included in the matrix.

We think that the matrix also provides a useful perspective for individuals who may, because they do have substantial assets, be thinking about self-insuring against long term care. Since the premium outlay wouldn’t be a significant budget issue for such an individual, we submit that the value of the insured benefit is in the fact that it frees those dollars for family or charitable purposes and assures the insured of tax free benefits from a qualified LTC policy.

Finally, while the matrix focuses on what you may receive in dollar benefits for what you pay, don’t forget the human side of the equation. The greatest protection afforded by LTC insurance is for the community spouse, the healthy spouse. Elder law attorneys, CPAs and financial advisors often tell us about how the cost of caring for an uninsured spouse left an otherwise healthy

spouse near poverty after the death of their loved one.

## **Conclusion**

We hope that this discussion provides you with a basic understanding of the realities of long term care benefits, both governmental and those available through private insurance.

None of us looks forward to an additional and ongoing expense as we approach retirement. Few of us enjoy investigating a complicated product that is, itself, still evolving in the marketplace. Most of us recognize the value of having “final documents” in place, our wills, advance directives, powers of attorney and, perhaps, irrevocable trusts, to provide guidance to our loved ones and a measure of certainty to the protection and distribution of our assets. But long term care insurance is the new subject we do our best to ignore, to put off for now or to regard as something we just don’t or won’t need.

However, the consequences of failing to incorporate long term care in our planning, at least as we approach retirement and while, hopefully, we still enjoy reasonably good health, can be financially catastrophic. The good news is that long term care insurance products have developed to a point at which they are, we believe, worthy of serious consideration. We encourage you to discuss your needs, concerns and resources with an elder law attorney, your financial advisor, and an experienced LTC broker so that you can take appropriate measures to reasonably protect yourself and your family as the future unfolds.

Please do feel free to call us toll-free at 1-877-687-4700 or to contact us by e-mail at [info@futurecareassociates.com](mailto:info@futurecareassociates.com).