

**LONG TERM CARE INSURANCE IN PENNSYLVANIA**

**WHAT'S WHAT TODAY and  
WHAT MAY BE TOMORROW**

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This article discusses the essential elements of insuring against the financial risk of long term care, the Pennsylvania Long Term Care Partnership Program, and the Pension Protection Act of 2006 as it relates to insured long term care. It was originally written for a continuing legal education presentation at the request of the Pennsylvania Bar Institute.

## **The Essential Elements of Insuring Against the Risk of Long Term Care**

### *Insurability*

Before you get into the nuts and bolts of comparing benefits and costs and figuring out what coverage, if any, makes sense for you, you need to get a handle on whether or not you're insurable for long term care purposes.

Long term care insurability can be *very different* from life insurance insurability.

- You should list the prescription medications you've taken over the last year . . . the dosage *and* why they're prescribed for you.
- Jot down when *and* why you've seen any doctors during at least the last five years.
- Have you had any hospitalizations or diagnoses of medical conditions during the last *ten* years? *When, how long, and why.*

Your insurance advisor should review this information anonymously *but specifically* with at least three financially well-rated and major LTCI companies, preferably insurers whose policies are Partnership Program approved in the state in which you reside. For the balance of this article, we'll assume it is Pennsylvania, but the advice is generally relevant wherever you call home.

*Remember*—if you do apply for coverage, the company will most likely request medical records on you— so knowing *up front* how your medical history will likely be treated by a company helps you to

- plan your policy structure and cost realistically, *and*
- minimize the risk of having a denial of coverage on your insurance record.

### Comprehensive Coverage

Act 40 of 2007 prohibits LTC insurers doing business in Pennsylvania from offering “Facility Care Only” or “Home Health Care Only” policies. Benefits must be *comprehensive*—available for home and community care as well as for assisted living and skilled nursing facility care.

*But* insurers may still offer an *option* to structure a policy with a *reduced benefit* for home health care; e.g., 75% or 50% of the facility care benefit.

- *Such a reduced home care benefit often appears in employer sponsored group LTC plans.*
- *Because many long term care needs at least initially can be met by home health care, you should avoid a reduced benefit for home care policy provision.*

### Benefit Triggers

HIPAA, the Health Insurance Portability and Accountability Act, standardized the triggers for benefit eligibility in most long term care policies sold today. Policies in compliance with the HIPAA standards are called Qualified long term care policies.

The *benefit eligibility triggers* are that you must either require

- stand-by assistance with two of six ADL’s—activities of daily living—eating, bathing, dressing, toileting, continence, or transferring,
- *or* be diagnosed with severe cognitive impairment,
- and the condition must be certified as likely to last 90 days or longer.

Policies issued prior to 1/1/1996 were *grandfathered* by HIPAA as qualified policies so long as substantial changes are not made to the policy after 12/31/1995. Such a policy may have “medical necessity” as an alternate trigger, a trigger not otherwise allowed in HIPAA qualified contracts. If you have such a policy *and* it is appropriate for your needs, you should consider keeping it, not only because replacing it would be subject to health underwriting and would be much more expensive at your current age, but also because of the more liberal

“medical necessity” trigger it may contain and the fact that HIPAA grandfathered it as a Qualified policy.

**The concepts we’ll discuss now are important in helping you to plan the coverage most suitable for you.**

*Pool of Money—a Limited or Unlimited Benefit Payout Period*

Think of a long term care policy as a pool of money. Benefits are paid from that pool for a limited period of time or for your lifetime. How large the pool will be and how long it will minimally last on claim is determined when you apply for coverage.

Most insurers offer the choice of a lifetime benefit (an unlimited pool) or of a pool that will last for a period of years ranging from 2 to 10. *For example:*

- If you bought a 5 year benefit period, and a daily benefit of \$150 your pool will be  $\$150 \times 365 \times 5$  or \$273,750.
- If, on claim, you accessed the pool at the rate of \$150 a day continuously for 5 years, the pool would be empty at the end of 5 years and the policy’s benefits would cease.
- If your care cost less than \$150 a day, the pool would last longer than 5 years,
- unless the policy has a *cash* benefit structure which pays out the full daily benefit without regard to the cost of care. *In that case*, the pool would be drained of benefits at the end of 5 years.

*Benefit Access Formula*

The pool is defined not only by the duration for which a benefit may be payable, but also by the benefit access formula—the periodic limitation on the maximum amount of the benefit payable. If your policy says that the benefit is payable on a *daily* basis, say at the rate of \$150, then that is the maximum amount of long term care cost that will be covered each day by your policy. If your actual cost for services otherwise eligible for coverage exceeds \$150 on a given day, the excess cost must be paid out of your pocket.

When you apply for a policy, you should consider opting for a *monthly* access provision. A \$4,500 monthly benefit would allow you to draw on the monthly amount to cover a cost that might exceed \$150 on a given day. You're still limited to \$4,500 a month, but the flexibility of access to that amount could save you out of pocket expense. A monthly benefit provision will carry a higher premium than a daily benefit, but you should be aware of the possible option.

Another aspect of your benefit access formula will be whether your policy has a reimbursement, indemnity, cash or combination structure for benefit payment.

- A *reimbursement* based contract (which is the most common policy structure) reimburses you up to your policy limits (e.g., \$150 a day, \$4,500 a month) for the cost of services covered under the policy which you received (after satisfying the policy's elimination period) and for which you paid.
- An *indemnity* contract typically pays you your full daily benefit so long as you have satisfied the policy's elimination period and received at least one hour of service covered under the contract for that day.
- A *cash* based policy pays you your full periodic benefit so long as you have satisfied a HIPAA benefit eligibility trigger and the policy's elimination period.
- A *combination* policy may give you the option of electing a reduced benefit in cash instead of being reimbursed up to the full limit of the policy for covered services received.

A fully cash based policy provides the greatest flexibility in the event of a claim because you are *not* required to provide evidence that you have received services covered under the contract. You must, however, still satisfy the HIPAA benefit eligibility requirements discussed earlier. A cash based policy will also be substantially more expensive than a reimbursement or indemnity contract since it does not have a "covered services" provision. Your most flexible and reasonably cost efficient option may be a combination policy that allows you to move between a reimbursement and a reduced cash benefit payout as your needs on claim dictate.

### *The Statistical Risk*

Individuals are not statistics, *but* statistics are composed of individuals.

A Boston College Center for Retirement Research article reported that, among individuals turning 65 in 2005,

- 31% will need no long-term care at all in their lives
- 29% will need care for 2 years or less
- 20% will need care for 2 to 5 years, and
- 20% will need care for 5 years or more.

Howard Gleckman, *The Role of Private Insurance in Financing Long-Term Care*, September 2007, Number 7-13, sourcing Kemper, Komisar, and Alecxih (2005).

The point is *not* to suggest that a given individual will fall within a particular risk range—but *to provide a perspective* on the experience of a large population reaching a common retirement age. Mr. Gleckman goes on to say that “[a]bout two-thirds of those over 65 will need some long-term care in their lives, and they will require assistance for an average of 3 years.”

The “long” in long term care is a variable number. You need to consider your personal and family health histories as well as your foreseeable financial circumstances to arrive at a decision about the duration of a benefit period with which you are reasonably comfortable.

### *Shared Care*

Shared care is the *key* to keeping long term care premiums for a couple as lean as possible while still providing a truly long term benefit for one of them. Shared care is a provision in a *limited benefit period policy* whereby one insured can, should he or she exhaust their own policy’s benefits, access, usually with the permission of their spouse or partner, the benefits of the other’s policy.

The couple must apply for coverage at the same time and have identical basic policy benefits. They can, however, have different health underwriting risk classes.

Shared care may be provided

- by a rider attached to individual policies linking them for shared care purposes,
- or through a single policy insuring both insureds, each with access to a single pool of money,
- or, in the case of at least one insurer, each having access to a third pool.

Shared care can be a very economical and tactically useful tool in view of the dramatic extension by the Deficit Reduction Act of the Medicaid look-back period to five years from the date of application for medical assistance.

The bottom line here is that, if you are married or have a life partner and are considering a limited pool of money (a benefit period other than lifetime or unlimited), then a provision for shared care should be included in your comparison of policies *and* in your final product choice.

#### *The Deductible (or the Elimination Period)*

This is the interval from the onset of a claim until the insurer is on the hook for payment of benefits. It is typically 30, 60, or 90 days. The longer the elimination period, the lower will be your premium. However, while a number of insurers offer a further choice of 180 or 360 days, the reduction in premium pales in comparison to the out-of-pocket expense you will incur while satisfying such a longer period.

You should consider adding a provision that *waives the elimination period for home health care*. At least one carrier includes such a waiver as an integral part of its policies.

- Most claims start with home care.
- Having coverage available at the outset can remove one concern at an otherwise very difficult time.

The elimination period only needs to be satisfied once in a lifetime, but you should consider how that deductible period is met—by “service days” or by “calendar days”.

A service day requirement may delay the point at which the insurer is obligated to pay benefits beyond the nominal period (e.g., 90 days) because only days on which at least an hour of health care service covered under the policy is received count toward meeting the deductible. That should not be a problem if you are in an assisted living or skilled nursing facility, but if you are at home and care is needed on an intermittent basis, 90 days could become a longer period than simply 90 calendar days.

Days for which policy benefits would not be payable (e.g., during a hospital stay) typically do *not* count toward satisfying the elimination period.

If you don't elect to carry a waiver of the elimination period for home health care, or if the benefit is not available from a particular insurer or is not likely to be issued because of your health history, be sure to consider a policy with a *calendar day* deductible.

### Inflation Provisions

LTC insurers offer, *at an additional cost*, a variety of provisions for guaranteeing

- either an annual automatic increase in both the pool of money *and* the rate at which that pool can be accessed,
- or the option for the insured to purchase a given amount of additional coverage in the future.

The *automatic increase* approach substantially increases the cost of a policy at the outset. The future purchase option approach only adds to the policy premium as incremental amounts of coverage are purchased. However, because you purchase those amounts at your attained age and at the rate then in effect for that age, the exercise of every option typically results in a significantly higher cost over time than does the annual automatic benefit increase provision.

In recent years, a number of major LTC insurers have introduced variations on the traditional 5% compound and 5% simple automatic annual inflation riders. But most of those variations are *not* approved for sale in Pennsylvania.

One company does offer an annual automatic benefit increase based on the Consumer Price Index for All *Urban* Consumers (CPI-U). That approach does

result in a premium that is 20 to 40% less expensive than policies with a fixed 5% compound annual automatic benefit increase. The company argues that most long term care services are custodial, not acute, and that custodial services are not driven by hospital, physician, and prescription drug charges.

Inflation provisions offered by LTC insurers today don't guarantee that a policy's benefits will keep up with the growth in health care costs. But, without at least some inflation protection, you're virtually guaranteed that your policy benefits will be inadequate to shoulder the cost of your care.

There is, of course, an alternative planning perspective which regards LTC insurance as the front line, a defensive tool which gives you time to marshal other assets in the event that you are afflicted with a catastrophic health condition. The concept here is to purchase a very substantial long term care benefit with a three to five year benefit period and *no* inflation rider.

In the event of a claim early on, you'll be financially well protected and, in fact, your benefits may continue longer than your nominal maximum benefit period should the cost of your care not require the full use of your daily or monthly benefit. Should a claim occur in later years, and you have otherwise managed your finances wisely, the combination of your LTC coverage and other income may allow you to meet the cost of your care without a financial crisis.

My crystal ball broke a long time ago. What you need to know is that there are alternative approaches to structuring long term care coverage. Consider *your* circumstances and build a policy that makes sense *for you*.

### Premiums

*A word on cost:* Premiums are *not* guaranteed in Pennsylvania. An insurer can, with the permission of the state insurance department, raise rates on a class of in-force policies. An insurer cannot, however, single out an insured for a rate increase.

*Premium Increases on In-force Policies:* Most of the major, well-rate carriers have recently and for the first time obtained approval to increase premiums from 5% to 30% on *existing* policy owners. Other insurers have requested much higher rate increases.

I think that it is important to anticipate that the cost of your coverage will increase over time. Every HIPAA qualified policy has “Contingent Non-Forfeiture Provisions” which provide options to you in the event that your policy ends due to non-payment by you of your premium after a substantial premium increase. You should know, however, that, should your needs or financial circumstances change, you can also typically reduce your benefit amount, or your benefit period, or drop an extra benefit you may have as a rider on your policy, or any combination of such changes, with a corresponding reduction in your then current premium.

### Policy Structures and Premiums

“It’s too expensive.” I get tired of hearing that refrain from folks who haven’t said, and sometimes don’t know, what “it” is. LTCI is, like many insurance products, a cafeteria of benefits that are selected by an individual according to his or her foreseeable needs, risk tolerance, and budget.

It may, indeed, not be possible for a given individual to assemble a set of LTCI benefits into an acceptable and affordable structure. But, before dismissing the possibility as too expensive, you should determine whether you are *insurable*, identify *needs of most concern* to you, and consider *competitive* benefit alternatives and costs available from quality insurers *within the parameters* of your likely underwriting class, basic needs, and financial resources.

Variations in the benefit amount and duration (the pool of money and how long it will last), the deductible, alternative inflation provisions (or none), and shared care will affect cost. So will the addition of other optional benefits offered by various insurers (e.g., restoration of benefits, waiver of the elimination period for home health care, joint waiver of premium, survivorship paid-up, return of premium at death, non-forfeiture after three years, a limited premium payment period, indemnity benefit, cash benefit options.) You should, however, first focus on *the basics* and on those basics *structured competitively* in terms of *your* planning needs.

### Federal Income Tax Benefits

Traditional HIPAA qualified policies do provide *federal income tax free* benefits within a per diem limitation equal to *the greater* of a \$290 per day limit for 2010

or the actual costs incurred for qualified long term care services provided for you less any payments received by you as reimbursement for such services.

The *deductibility* of premiums you pay for your qualified long term care insurance for yourself, your spouse, or dependents is limited to an amount in excess of 7 1/2% of your adjusted gross income, and the premium amount that you can include in that calculation is itself limited to an age-graded amount. For 2010, the amount for *each* individual (yourself, spouse, dependent/s), based on the age of the insured at the end of the tax year, is \$330 for a person under age 41, \$620 for ages 41 through 50, \$1,230 for ages 51 through 60, \$3,290 for ages 61 through 70, and \$4,110 for ages 71 and beyond. The amounts are adjusted annually.

Premiums paid through the cash value of a life insurance or annuity contract under provisions of the Pension Protection Act effective January 1, 2010 are *not* includible as an unreimbursed medical expense for purposes of the 7 1/2% of adjusted gross income deduction calculation.

### **The Pennsylvania Long Term Care Insurance Partnership Program**

The Deficit Reduction Act of 2005, which became law on February 8, 2006, authorized the development by the states of a program which provides for certain benefits, chief among them *asset disregard*, to be available to individuals who receive benefits on claim from long term care policies or certificates that met specific criteria. Unfortunately, no in-force HIPAA Qualified LTC contracts were grandfathered by the DRA.

As of January 13, 2010 only 12 of the 80+ insurers offering long term care policies in Pennsylvania have had policies approved for sale by the Department of Insurance as Qualified Partnership contracts. 7 of the 12 are “A” rated or better for financial stability by at least two rating services.

The “partnership” is between Medicaid, the state’s Department of Public Welfare (DPW), the insurance company, and the insured. DPW will administer the Partnership Program.

- Medicaid and DPW hope to save money by providing an incentive to you to carry Partnership qualified long term care insurance and thus avoid or substantially reduce your need to rely on Medicaid benefits should the need for long term care arise.

- Your incentive to purchase a Partnership policy (or certificate under a group plan) is the expectation of being able to shelter some assets from Medicaid which would otherwise be subject to spend-down or estate recovery should you later need to financially qualify for medical assistance.

Practically speaking, the most significant requirement in a Partnership policy concerns the requirement for *inflation protection*.

- If you are 60 or younger at the time you apply for a Partnership policy, the policy must include provision for *compound* annual inflation protection at a rate equal to the Consumer Price Index (CPI) or at a fixed rate of not less than 3%.
- If your age is between 61 and 75, the policy must include *either* compound or simple annual inflation protection at a rate equal to the CPI or at a fixed rate of not less than 3%.
- If you are 76 or older at the time of application, inflation protection is *not* required.

It is important to understand that the qualification of a policy as a Partnership contract does not *in itself* add to the cost of a policy. However, the mandated inclusion of a level of inflation protection through issue age 75 does impact a policy's cost the same as the inclusion of inflation protection impacts the cost of a non-Partnership policy.

For the consumer, the singular, but, I think, potentially very significant bonus in a Partnership policy is *asset disregard*. The Deficit Reduction Act provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy, if the policy meets the essential elements of a Qualified Long-Term Care Partnership policy. 42 U.S.C. Sec. 1396p(b)(C)(ii)(II)

In other words, asset disregard provides that, should you need to receive care through Medicaid, assets which you would normally have to spend-down before financially qualifying for Medicaid benefits can be sheltered from the spend-down requirement in an amount *equal to* the dollar benefits you received from your Partnership policy.

In the event that you purchased a long term care policy in Pennsylvania on or *after* February 8, 2006 but *before* the date on which your company received approval to sell its policy or policies as a Partnership policy, your policy will still receive Partnership status if it, in fact, meets the requirements for a Partnership policy. Your company is obligated to provide you with a letter confirming your policy's Partnership qualification, *without* any additional cost or health underwriting. This is technically called the *Partnership exchange* provision although, as a practical matter, you will likely simply keep your policy and attach to it the Partnership status letter you receive from your insurer.

If you purchased your policy on or after February 8, 2006 and before the date on which your insurer received Partnership approval, but the policy does not, for example, contain the provision for inflation protection required for your original issue age, you may, subject to health underwriting and an additional cost for the added benefit based on your current age, be able to add such a benefit to your policy to qualify it as a Partnership contract.

At [www.futurecareassociates.com](http://www.futurecareassociates.com), you will find several articles focused on the Partnership Program. They were written for the Pennsylvania Bar Institute.

*A Pennsylvania Long Term Care Partnership Program Update*, April, 2009 discusses Pennsylvania Partnership Program policies, their potential value and limitations on claim, and notes important consumer protection caveats.

*The Tactical Use of Long Term Care Insurance in Planning Under the Deficit Reduction Act of 2005* provides a perspective on the importance and use of long term care insurance in the light of the Deficit Reduction Act. Examples of costs are provided using shared care at various issue ages without an inflation benefit as well as with a 5% simple and a 5% compound inflation provision.

This program is new in Pennsylvania. The Department of Public Welfare has yet, to my knowledge, to provide guidance or formal rule-making as to how the program will be administered although a great deal of discussion has taken place between the Departments of Insurance and Public Welfare and the insurance companies concerning the implementation of the Program, product approvals, and coordination of information between DPW and those insurers interested in offering qualified Pennsylvania Partnership Program policies.

Hypothetical issues, with real life consequences, have been raised prospectively in the elder law community concerning, for example:

- Which assets will be disregarded? Who decides?
- Can the potential waste of asset disregard between spouses be avoided?
- May asset disregard benefits be prospectively claimed?
- Do Partnership policy benefits received after Medicaid eligibility count for asset disregard purposes against a Medicaid estate recovery claim?

The bottom line, in my judgment, is that the Partnership status of a long term care policy should be viewed as a bonus, not a carrot. You should select a Pennsylvania Partnership Program Qualified long term care policy *so long as* the contract is offered by a well-rated and market experienced insurer that will provide favorable health underwriting for you *and* a benefit structure that meets your well thought out needs and likely future resources. In such a circumstance having the potential benefit of asset disregard at no additional cost simply seems to make sense. You may indeed and hopefully never need to apply for Medical Assistance, but if you do, the bonus of asset disregard may be financially very important for your spouse and family.

### **The Pension Protection Act of 2006**

This federal legislation created new sections of the Internal Revenue Code which did not become effective until January 1, 2010 and which will allow the tax favored treatment of HIPAA qualified long term care policies to apply even though the coverage is in the form of a rider on a life insurance or an annuity contract. Any premium charges associated with LTC insurance that are distributed from the cash value of a life insurance or annuity contract will *not* be treated as a taxable withdrawal.

Such withdrawals, however, will be applied as a reduction to your cost basis in such a contract until the cost basis is reduced to zero. And such payments will *not* be eligible for the age-graded medical expense deduction calculation noted above.

Your insurer will be required to file an annual informational return with the IRS disclosing the amount of such aggregate premium charges, the amount of the reduction of your investment in the life or annuity contract because of those charges, and your name, address, and taxpayer identification number as the holder of such a contract.

The Act has also expanded the definition of what constitutes a like-kind annuity or life insurance contract to “include a life or annuity contract that has a long term care rider (as long as it is *qualified* long term care coverage).”

Here’s the short of it:

“An existing life or annuity policy [will be able to be exchanged] into a hybrid version on a tax-deferred basis . . . although you still cannot exchange from an annuity policy to a life insurance policy, hybrid or otherwise.

“The new provisions under the [Internal Revenue Code] will also allow any life or annuity contract to be exchanged directly into a qualified long term care insurance policy.

Thus “[the owner] of an existing life insurance or annuity policy [will be allowed] to use the cash value as a single premium towards a qualified long term care insurance policy without recognizing any gains on the underlying life or annuity contract at the time of exchange.”

In the above comments I have paraphrased and specifically quoted, with permission, comments by Michael Kitces, Director of Research for Pinnacle Advisory Group, a private wealth management firm located in Columbia Maryland. Sources: Steve Leimberg’s Employee Benefits and Retirement Planning Newsletter #386 (September 26, 2006) at <http://www.leimbergservices.com> ©Leimberg Information Services, Inc. (LISI); The Kitces Report, August, 2009, [www.kitces.com](http://www.kitces.com).

*A caveat:* the devil is truly in the details—substantively and administratively—in the liberalization of premium payment resources and the expansion of tax free exchanges under the Pension Protection Act.

Mr. Kitces notes in his August Report that “the problem with the new rules on the tax treatment of hybrid long term care policies is the provision under IRC Sec 72(e)(11)(A) which stipulates that when the long term care costs come out of the hybrid life or annuity contract, the investment in the contract must be reduced (but not below zero).”

I urge you to weigh carefully with your tax advisor the possible long term tax impact of utilizing the opportunities presented by the Pension Protection Act. Be particularly cautious if you are evaluating the possibility of replacing an existing policy with a new hybrid version, not only from a tax perspective, but also in terms of benefits that may be of value to you which are available in a traditional policy but that are not available in a hybrid product.

I recently (December, 2009) spoke with in-house tax counsel for one of the pre-eminent LTC insurers. He shared with me the need expressed by the American Council of Life Insurers for *IRS guidance* on how the Pension Protection Act provisions impacting hybrid life and annuity policies offering LTC benefits, and how the expansion of the tax free exchange provisions of the Internal Revenue Code involving life-to-LTCI and annuity-to-LTCI contracts will be administered.

One very practical issue is, if the expanded changes are to be available to a broader market, will tax favored treatment be allowed on partial Sec. 1035 exchanges on a *periodic* basis? I am not aware, at least for Pennsylvania purposes, of any major LTC insurer that currently offers a *single* premium long term care insurance policy.

There *is* some sizzle to the proposition that a long term care benefit could be added to and paid for out of a life insurance policy or an annuity contract *without direct current out-of-pocket cost to you . . .* or that you could exchange a life or annuity contract *on a tax favored basis* for a long term care policy.

But you should consider

- whether you need the life or annuity product in the first place where a new purchase is proposed;
- whether the life or annuity contract you now own may still be needed for estate planning purposes where a tax-free exchange is proposed;
- the future benefits paid by the long term care rider *compared to* benefits available only in a stand-alone long term care product;
- the *impact on the future stability* of the life or annuity product where you use the cash value of the product to pay for the cost of the long term care rider;

- the *cost* of an individual long term care policy *compared to the loss of control* and *the net pure investment opportunity lost* in committing a large principal sum to a single premium life or annuity purchase,
- and whether the long term care rider will qualify for Partnership Program status (*not* likely under current regulations) if the potential asset disregard benefit is an asset protection device you value in your long term planning.

### Conclusion

*Take the time* to understand long term care insurance and the pros and cons of the stand-alone and hybrid benefit delivery options available from financially well-rated and market experienced insurers.

#### *Don't Let the Tail Wag the Dog*

- If LTCI is appropriate in some measure for you, be sure to first explore which insurers are likely to *treat your health history most favorably* by doing an anonymous, preliminary health underwriting with at least three well reputed companies.
- Then determine with your advisor/s what your *likely net future monthly shortfall* might be if you need long term care (crystal ball time, but it is akin to retirement planning . . . you make conservative assumptions and examine their consequences in terms of your risk tolerance and obligations.)
- *Only thereafter* would I consider the *alternative* benefit structures and current costs of the insurer/s who survived your preliminary underwriting inquiry.
- If you are considering a hybrid product or a Section 1035 exchange from a life or an annuity to a long term care policy, consider at least the questions I suggested a moment ago.
- When you arrive at a benefit structure which meets your concerns and budget, consider whether the insurer *offers* a Partnership Program

qualified policy, and whether the benefit structure *that fits your plan* qualifies for Partnership status.

- If so, I'd select the Partnership product because you've arrived at the policy appropriate for your needs without being shoe-horned into a possibly more expensive contract (compound or simple automatic annual benefit increase provision) *just to have* a Partnership qualified benefit.
- Having said that, I do think that the *shorter* the maximum benefit period you select (2 or 3 years, for example), the *more valuable* having a potential Partnership asset disregard benefit might be.

The long term care insurance industry is evolving, in my judgment, to provide more flexible and responsive resources to help us meet the future financial obligations we may face—obligations that will become more certainly personal—obligations that the government, the payer of last resort, will increasingly be less able to finance without the double edged sword of greater and more draconian preconditions and higher taxes.

Please do be in touch with us if you want to objectively examine whether long term care insurance may be available to you and how it might best be competitively structured to meet your concerns and foreseeable resources.