# Choosing a Long-Term Care Policy


Assessing the need for long-term care (LTC) insurance is an important part of any risk management program. The heavy economic burden of paying for such care should be measured against your available resources. If you need LTC for even a short period of time, what effect will that have on your estate and any legacy you may wish to leave to your heirs? The decision to purchase LTC insurance, either individually or under a group plan, generally must be made while you are still healthy. Once a disabling condition occurs, it is too late to act.

## Common Elements in Long-Term Care Insurance Policies

- **"Qualified" LTC policies:** If a LTC policy meets certain criteria established by the federal government, the premiums for the policy are considered "medical care" and thus qualify for the medical expense itemized deduction. Federal law limits the amount of qualified LTC premiums that may be deducted each year.[1]
- **Amount of the benefit:** A policy will generally specify the maximum dollar benefit payable. A survey of local nursing homes can help determine the amount needed.
- **How benefits are paid:** LTC benefits are generally paid under one of three methods:
  - Reimbursement (expenses-incurred) method – pays the lesser of the actual expenses incurred or the dollar limit specified in the policy.
  - Indemnity (or "per-diem") method – the entire daily benefit is paid as long as the insured requires and is receiving LTC services, regardless of the amount spent.
  - Disability method – once the eligibility criteria have been met, the full daily benefit is paid, even if no LTC services are being provided.
- **Inflation protection:** Since costs inevitably increase, a policy without a provision for inflation may be outdated in a few years. Of course, an additional charge is incurred for this protection.

[1] The discussion here concerns federal income tax law; state or local income tax law may vary.

- **Guaranteed renewability:** Almost all long-term care policies sold today are guaranteed renewable; they cannot be canceled as long as you pay the premiums on time and as long as you have told the truth about your health on the application. The fact that a policy is guaranteed renewable does not mean that the premiums cannot be increased; insurers typically reserve the right to raise premiums for an entire class or group of policyholders. Some policies sold in the past were not guaranteed renewable and a few of these policies may still be in force.
- **Waiver of premium:** Some policies will waive future premiums after you have been in the nursing home for a specified number of days, e.g., 90 days.
- **Prior hospitalization:** This policy provision requires one to be hospitalized (for the same condition) prior to entering the nursing home or no benefits will be paid under the policy. Although prior hospitalization clauses have been prohibited in all states, some older policies still in force may contain this provision. Policies currently sold do not contain prior hospitalization clauses.
- **Place of care:** Does the policy require that the nursing home be licensed or otherwise certified by the state to provide skilled or intermediate nursing care? Must the facility meet certain record keeping requirements?
- **Plan of care:** A plan of care is part of the health care claims process. It is the result of an assessment prepared by the insured's physician, and a multi-disciplinary team, including practical nurses, social workers, and other health care professionals. The plan outlines the appropriate level of care needed to assist the insured in performing the activities of daily living.
- **Level of care:** There are three generally recognized levels of care in an institutional setting:
  - **Skilled care:** Daily nursing and rehabilitation care under the supervision of skilled medical personnel, e.g., registered nurses and based on a physician's orders.
  - **Intermediate care:** The same as skilled care, except it requires only intermittent or occasional nursing and rehabilitative care.

  - **Custodial care:** Help in one's daily activities including eating, getting up, bathing, dressing, use of toilet, etc. Persons performing the assistance do not need to be medically skilled, but the care is usually based upon the physician's certification that the care is needed.

- **Pre-existing conditions:** Depending on the state, a policy may limit coverage of pre-existing conditions to discourage persons who are already ill from purchasing a policy. Many policies will provide benefits if the pre-existing condition was overcome six months or more prior to applying for the policy. Also, some policies will not pay benefits if the pre-existing condition re-occurs within six months after the effective date of coverage.
- **Deductible or waiting period:** Most LTC policies require you to "pay your own way" for a specified number of days (generally ranging between zero and 120 days) before the insurance company will begin to pay benefits. Of course, the shorter the waiting period, the higher the cost will be. This is usually referred to as an "elimination period."
- **Alzheimer's disease:** Most policies now include coverage for organic brain disorders like Alzheimer's disease.
- **Home health care (home care):** Many long-term care policies can provide coverage in the insured's home. It is most often offered as a rider (requiring an additional premium) to nursing facility coverage, and reimburses the cost of long-term care received at home.
- **Rating the company:** Companies should be financially sound and have a reputation of treating policyholders fairly.

## Seek Professional Guidance

A perfect LTC policy does not exist. Many policy features must be compared and weighed. As a general rule, the more benefits included in a policy, the higher the premium will be. Professional guidance is extremely important in this complicated area.