CALIFORNIA HEALTH ADVOCATES

An Overview of Long-Term Care Insurance

Long-Term Care (LTC) insurance policies only pay for long-term care costs. Most long-term care benefits are in freestanding long-term care insurance policies that don't provide any other benefits. Life insurance policies and annuities can also contain benefits for long-term care but are not covered in this fact sheet. If you are considering one of those complicated financial planning products, please see a trusted financial advisor or an elder law attorney.

Long-term care usually means a person needs supervision or assistance with everyday tasks like bathing and dressing. This kind of care does not require a licensed person to provide those services. Long-term care insurance is designed to reimburse the cost of this kind of care. Freestanding long-term care policies are designed in 3 different ways. Some only pay for care in institutional settings such as a nursing home or an assisted living facility. Others only pay for home care. Comprehensive policies pay for care in a nursing home, assisted living facility, at home, or in community settings like adult day care.

If you are considering buying LTC insurance, you will need to do some research to find the best set of benefits for your particular circumstances, and the best company to provide those benefits. You will also need to consult your accountant or tax advisor to understand any tax issues that might affect you. Counselors from the California Health Insurance Counseling and Advocacy Program (HICAP) can help you: sort through some of these issues; understand how these benefits work; compare benefits and features of several policies; or compare policies from more than one company. To make an appointment for HICAP counseling, call 1-800-434-0222. However, only you can make the decision about which policy and package of benefits is best for you. HICAP counselors cannot advise you on which benefits to buy, which agent you should use, or which company to buy from.

Individual or Group Coverage

You can buy LTC insurance as an individual the same way you buy any other insurance, or you can buy it as a member of a group or faith-based organization or as an employee or family member of an employee. For instance, some people may be eligible to buy coverage through the California Public Employees Retirement System (CalPERS), or the Federal Employees Long Term Care Program (FLTCP) because of their, or a family member's, public employment or military service. Neither of these employer-based systems pay any part of the premium, but each sponsors its own LTC insurance program. Some private employers also sponsor this type of insurance, as do some associations and faith-based groups.

If you buy an individual LTC insurance policy in California, it will meet the current requirements of state law and exceed those of most other states. However, benefits purchased through a group may not meet all of those requirements. You need to ask about that before you buy. If you buy a life insurance policy or annuity that has benefits for long-term care services, those benefits will have to meet the current requirements of state law for those products.

For more information about CalPERS, call 1-800-982-1775 or visit their website at calpers.ca.gov. For more information about FLTCP, call 1-800-582-3337 or visit their website at ltcfeds.com.

Types of LTC Insurance Policies

Freestanding long-term care insurance policies in California are labeled according to where benefits will be paid. For instance, a **Home Care Only** policy will only pay for home and

community based care and must include benefits for home health, adult day health care, hospice, respite care, personal care and homemaker services. A **Nursing Home and Residential Care Facility Only** policy, however, will only pay for care in a nursing home and in a place that is licensed as a Residential Care Facility for the Elderly (RCFE), which is often called an assisted living facility. A **Comprehensive** policy will pay benefits in a nursing home, assisted living facility, and for home care and community care like adult day care.

Policies that are labeled as **"Partnership"** policies will allow you to keep more of the assets you would otherwise have to spend if you qualify for Medi-Cal later on.

The Partnership

The California Partnership for Long Term Care is a program of the California Department of Health Care Services (DHCS). This is an innovative partnership among consumers, the State of California and some private insurance companies, including coverage offered through the California Public Employees Retirement System (CalPERS). Each Partnership policy is tax qualified (TQ), includes an automatic 5% inflation protection and has a unique state guaranteed asset protection feature that allows you to retain a certain amount of your assets if you need to apply for Medi-Cal later on. Assets protected by this guarantee will not be counted if you apply for Medi-Cal, and can be used or left to your heirs as part of your estate. These policies also require that you buy at least a minimum daily benefit amount, 70% of the average daily cost of a nursing home care, to ensure that you will have adequate coverage to pay for your care.

Partnership policies can be purchased as a Comprehensive policy or as Nursing Home and Residential Care Facility Only policy. Companies that participate in the Partnership also sell long-term care policies outside of the Partnership with similar benefits but without the required minimum benefit and without the state guaranteed asset protection.

Partnership policies have met state insurance standards and additional rules established by the Partnership program. Only agents who have taken additional Partnership training can sell you one of these policies. Premiums should be the same, or nearly the same, for Partnership or non-Partnership policies from the same company if they have similar benefits.

For more information about the Partnership, call 1-800-227-3445 or visit their website at dhcs.ca.gov/services/ltc/Pages/CPLTC.aspx.

Tax Qualified (TQ) and Non-Tax Qualified (NTQ)

TQ policies allow the taxpayer to deduct some, or all, of their premiums from their federal and state income taxes as a medical expense. The amount of premium that can be deducted is based on your age combined with your medical expenses that exceed 7.5% of your adjusted gross income if you are 65 or older, and 10% if you are younger. Benefits paid under these policies won't be taxed as income.

Note: Tax law changes frequently. Consult your tax advisor for information about the amount of premium that can be counted as a medical expense for current tax purposes.

The premiums for NTQ policies can't be deducted and there is no guarantee that the benefits will be tax-free. However, few, if any, of these policies are currently available. In the past, these policies often had more generous standards for when benefits could be paid, and people could qualify for benefits sooner than they would with a TQ policy.

Premiums are based on choices you make when you buy a policy. You choose:

1. Which type of policy you want to buy;
2. The amount of the daily benefit that will be paid;
3. The number of years you want the policy to pay benefits;
4. The number of days (if any) before the company begins paying benefits after you qualify; and

5. The method and amount, if any, of inflation protection.

These 5 factors, combined with your age and gender when you buy the policy, determine the premium you will pay. Women generally will pay more than a man of the same age. Some companies will insure you if you have an existing health condition they choose to accept, but they may charge you a higher premium.

In general, premiums can range from a few hundred dollars a year, if you buy at age 45, to several thousand dollars a year, if you buy at age 75. In addition, each company calculates their costs differently and there can be substantial differences between premiums for similar benefits from different companies. To get an idea of how premiums differ from one company to another, go to the California Department of Insurance (CDI) website at: insurance.ca.gov to see rate comparisons for long-term care insurance. Premiums for the daily benefit are usually calculated for each $10 of the daily benefit you choose. For instance, if a company charges $95 for each $10 of daily benefit at your current age and gender for the benefits you selected, the premium for a daily benefit of $100 will cost $950 a year. There may be additional premium costs for other benefits or features.

When you buy a LTC insurance policy, the agent must give you a Personal Worksheet that, among other things, will tell you if that company has had a rate increase anywhere in the country since 1990. It will also tell you how much premiums increased, and in which states. You can also look on the CDI website, insurance.ca.gov, to see rate increases for every company that sells LTC insurance in California. If you have questions about the rate history, call CDI's Consumer Hotline at 1-800-927-4357.

Premium Increases

Premiums for these policies can increase, and some have gone up by 50% or more. California has tough laws that make it difficult for companies to get premium increases. Yet, in spite of this, some policyholders have received notices of substantial premium increases. In addition, some companies have stopped selling long-term care insurance.

However, the California Department of Insurance can require a company to allow you to stop paying your premium and keep benefits equal to the total amount of premiums you've already paid. If that protection applies to a particular company's rate increase, people who have that insurance will get a letter from the company telling them how to exercise this option. In most cases, the total amount of premiums you paid may only finance your care for a short period of time, but it means that you won't lose all of your benefits following a premium increase that you can't afford to pay. You may also be able to reduce some of the benefits in your policy in return for a lower premium. Some companies that have been the subject of a class action lawsuit may offer these or similar options to policyholders as part of the settlement agreement with the court.

If you receive a notice of a rate increase, you can call your local HICAP office at 1-800-434-0222 to find out more about these protections and decide what to do.

Health screening or medical underwriting is the process companies use to determine if they will sell you a policy. People who already need long-term care are not insurable. Some past or present medical conditions can automatically make you ineligible for one company's policy while another may accept you at a higher premium. Some companies will review the medical records of each applicant, others will do so only if someone is over a certain age when they apply for the policy, and some will do a phone interview or face-to-face interview when people are over a certain age. Increasingly companies will conduct a paramedic exam complete with blood work, or a mini mental exam to check for any cognitive disfunction. A few may rely on your answers to the health questions on the application when you apply for the policy. Some companies will sell a policy to a person who has certain acceptable health conditions, but they may charge them a higher premium.

Every company will ask you to sign a medical records release. Regardless of whether a company gets your medical records before they decide whether to issue you a policy, its likely they will request those medical records when you file a claim.

Things to Consider When Buying LTC insurance

Benefit Triggers

Before benefits will be paid, certain conditions must be met. A benefit trigger is usually met by measuring a person's ability to do one or more Activities of Daily Living (ADLs), such as bathing or dressing, or by testing their cognitive abilities. When a person can't do a specific number of ADLs, or has a cognitive impairment such as Alzheimer's Disease that requires assistance or supervision, benefits may be payable. In California, companies must pay covered benefits for nursing home care, assisted living or home care when a person can't do 2 of the ADLs listed in the policy, or when a person has a serious cognitive impairment or dementia like Alzheimer's. Tax Qualified policies must use a list of 6 ADLs: bathing, dressing, transferring, eating, toileting, and continence. Non-Tax Qualified policies can use a list of 7 ADLs, adding ambulating (walking) to the list and must use a separate more explicit set of definitions.

Assistance or Supervision

If a person needs help with an ADL, or can't do it at all, they may need someone to do it for them, or to stand by to prevent an injury (caused by a fall, for example). If a person has a cognitive impairment, they may need supervision to remind them when and how to do these things. Both stand-by and hands on assistance must be described in policies sold after 1998.

A "Waiting Period" is also called an "Elimination Period" or "Deductible Period" and works like a deductible. It is a specific period of time before a policy will begin paying benefits, after someone is eligible to receive them. Some people choose not to have a waiting period and these policies pay from the first day they are eligible for benefits. Other people decide to pay for their care for the first 30, 60, or 90 days. Their policies won't begin paying benefits until after the waiting period has ended.

Some companies have sold policies with a specific dollar amount as the policy deductible. When the insured person has met the benefit trigger for care and paid that dollar amount for care covered by the policy, then benefits can begin.

Be sure you know how a company will calculate a waiting period for the policy you are considering. Some companies count only the days you actually receive paid care against the waiting period (service day waiting period); others count every day from the first day you were eligible for care, regardless of how much or how little care you received (calendar day waiting period). Some companies require you to meet this waiting period only once in your lifetime; others require you to meet it within a specific number of days or months, or each time you qualify for benefits. Most companies will ***not*** count the care you receive from family members as part of the waiting period.

Waiting periods can be expensive. Be sure you can afford the cost of the waiting period you choose now and in the future. If you choose a 30-day waiting period and the company only counts the days you receive and pay for care toward the waiting period, the number of days before the policy actually begins paying benefits could be much longer than you expect. For instance, if you received home care for 3 days each week it could take 10 weeks, or 75 days before you meet a 30-day waiting period. If you needed care in a nursing home you would have to pay the first month's cost of care. The cost for nursing home care increases each year with inflation. According to one insurance company's study, nursing home costs over the last 9 years costs have gone up about 3.5% annually.

90-Day Certification

TQ policies require certification by a health care professional that your expected need for long-term care services will last at least 90 days. This is not a waiting period before benefits can begin, but instead is a way to verify that your expected

need for care isn't temporary. If you didn't need care for the full 90 days, it shouldn't affect any benefits that were owed to you during that same time period. And it won't delay your benefits if you chose a shorter waiting period.

Daily Benefit Amount

This is the maximum amount the policy will pay for each day of care. Some policies pay this daily benefit amount for care in a nursing home, but they pay a percentage of that amount, or fixed dollar amount for all other kinds of care. For instance, if the maximum daily benefit amount for nursing home care is $200, the daily benefit for assisted living must be no less than 70% of that amount in policies sold after 1999, and no less than 50% for home care. Some companies will pay up to 100% of the daily benefit in each place covered by the policy. Companies pay the daily benefit you choose or the daily cost, whichever is less. You can't collect more than the cost of care. Some also pay the home care benefit on a weekly or monthly basis so that care can be planned, scheduled, and paid for more efficiently and economically.

Duration of Benefits

Policies are typically sold to cover 12 months or more of care. You can buy a policy that only pays benefits for one year, or one that pays for 2, 3, or 5 years. Companies have stopped selling policies that pay benefits for as long as you live. The premium is usually based on the benefit package you choose for each year of coverage you buy, and other factors including your age and gender. Two years of benefits costs more than 1 year, and 5 years of benefits costs more than 3 years. Most people choose benefits based on the amount of premium they can afford.

Maximum Policy Benefits

This is the total dollar amount the policy will pay out once you trigger benefits, regardless of how you collect those benefits. In California, companies must use a "pool of money" method of paying benefits. For instance, if you bought a policy that paid $100 a day for 3 years, your maximum policy benefits would be $109,500. If you used your benefits at the full benefit amount every day, your total benefits would last 3 years. If, however, your care costs less, or you only used the home care benefit at $50 a day, your total benefits could last much longer than 3 years.

Inflation Protection

When you buy an individual LTC insurance policy in California, companies and agents have to offer you inflation protection and show you the cost of inflation over time. If you turn down this offer, you must sign a rejection notice acknowledging that you understand that your benefit will not keep up with the cost of care in the future. You should carefully weigh your ability to pay the difference between the daily benefit that you choose and the cost of care many years later. Benefits without this protection will steadily erode over time.

Companies are required to offer you no less than 2 ways to protect your original investment. In the first method, inflation protection is built into the policy at 5% compounded. Understandably, the premium will be higher than it would be without this protection. The second method offers you the right to add inflation protection at periodic intervals without any additional health screening. Your premium will go up each time you choose this option and will be based on your current age. As you get older you may find you can no longer afford to exercise this option because the premium to add inflation protection gets more expensive with each offer. If you do not take advantage of this option each time it is offered to you, you could eventually lose the right to choose it, often when you have turned it down a specific number of times.

Example: A $100 daily benefit with 5% compounded inflation protection will double to $200 a day in 14 years. Without this inflation protection that same benefit will only be worth half of its original value in 14 years, and you will have to pay the difference between that benefit and the cost of your care.

Assisted Living benefits must be paid in any facility licensed as a Residential Care Facility for the Elderly (RCFE). This includes small

neighborhood homes, often called Board and Care facilities, as well as retirement homes, and specialized community facilities for Alzheimer's patients. In addition, in policies sold in California after 1999, the daily benefit must be equal to at least 70% of the policy benefit for nursing home care, and the benefit trigger can be no greater than 2 ADLs or cognitive impairment.

Nursing Home benefits must include the cost of all long-term care services you receive, not just the charge for room and board. The benefit trigger can be no greater than 2 ADLs or cognitive impairment.

Home Care benefits must include services for skilled care, personal care and homemaker services, adult day care, respite care, and hospice care, and the benefit trigger can be no greater than 2 ADLs or cognitive impairment.

Benefit Changes

Companies must allow you to reduce your benefits in return for a lower premium, increase your benefits priced at your current age with a new health screening, or buy new benefits at your current age with a new health screening when the company develops and sells new benefits.

Agent Requirements

Agents are required to give consumers certain information about long-term care. They must give you a buyer's guide entitled *Taking Care of Tomorrow*, a completed Personal Worksheet, specific contact information for your local HICAP office, and a replacement notice with a comparison of coverage if you are replacing an existing LTC insurance policy. They must also give you an Outline of Coverage that summarizes the benefits and conditions of the policy you intend to buy.

The **Personal Worksheet** is a document that, in addition to revealing any past rate increases by the company you are applying to, asks questions about your planning for long-term care. Some of the questions ask for income and asset information so the company can be certain that you are an appropriate purchaser of this type of insurance.

If you are not comfortable providing that information to an agent, you can refuse to fill out that part of the worksheet. The company will contact you later to make sure that it was your choice to refuse this information. The agent should send one copy to the company, and retain one copy in their office files as proof that you were given the documents required by state law.

The worksheet also asks you to consider how you will pay premiums in the future if your income changes or the premium goes up. In addition, it asks you to consider how you will pay for any waiting period you've chosen, how that cost is calculated, and the effect of inflation on the costs you've agreed to assume.

Dealing with Agents

Most agents are professional, well-trained people who will not pressure you to buy benefits that aren't suitable for you or to make a decision to buy before you are ready. However, you should have some idea of what you want and a realistic idea of what you can afford before you buy this type of insurance. There are many agents selling LTC insurance and it's important that you deal with someone you can trust. If you are not comfortable with a particular agent, you should find someone else. You will need to contact your agent later if you want to change any of your benefits or if you have a claim. Your agent should be able to answer questions you have about your policy years later if needed, and be someone you trust and can easily reach. Look for an agent who has up-to-date training on LTC insurance, is in an established local business, and who will take the time to answer all your questions.

Ask your agent to go over each of the provisions of the policy and make sure that you understand each one. Remember, you have a 30-day free look to examine your new policy from the date it is delivered to you and get back any premium you paid. Take advantage of this time to get any help you need to understand how the policy works. If you decide not to keep the policy within this period, any deposit must be refunded to you. This type of insurance is an investment that you should plan on paying for over the rest of

your lifetime and it should be purchased from a solid company with experience insuring this kind of care.

More information can be found in *Taking Care of Tomorrow*, which an agent must give you when you talk to an agent about LTC insurance. You can also download this guide from the California Department of Aging's website at aging.ca.gov/publications/hicap/hicap_TCOT_main.asp. The California Department of Insurance's website at insurance.ca.gov also has a guide on LTC insurance or you can call the Consumer Hotline (1-800-927-4357) to get a copy. Insurance agents are required to inform you about HICAP's services so you can get unbiased information and counseling about LTC insurance. You can also get information about long-term care insurance from the National Association of Insurance Commissioners (NAIC), although it will not have information about specific requirements unique to California. You can download their Shoppers Guide at http://www.naic.org/store_pub_consumer.htm#ltc_guide.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call 1-800-434-0222 to make an appointment at the HICAP office nearest you.

Note: Online access to all CHA fact sheets on Medicare and related topics is available for an annual subscription. See cahealthadvocates.org/facts.html.