Frequently Asked Questions

Q: What is long-term care?

A: Long-term care provides assistance to people who are no longer able to live independently. This may be the result of a chronic illness like diabetes, a disability caused by a stroke, cognitive impairment such as Alzheimer's disease or simply growing old and becoming frail. It encompasses a variety of services including medical care provided by medical professionals and non-medical care provided by health care aides. Long-term care assists people with activities of daily living which are defined as bathing, dressing, eating, toileting, continence and transferring. It also assists people who need supervision or prompting due to cognitive impairment. Designed as custodial care long-term care is very different from traditional healthcare or Medicare which are curative or rehabilitative in design.

Q: What does long-term care insurance cover?

A: Almost all policies sold today are integrated plans which cover medical and non-medical services in a variety of settings including one's own home, adult day care, assisted living facilities, memory care communities and skilled nursing facilities. Many policies also cover hospice care. Contracts differ but most long-term care insurance policies will pay for assistance with activities of daily living. These include bathing, dressing, eating, toileting, continence and transferring. Also covered is supervision for cognitive impairment to keep the policyholder safe. If receiving care at home instrumental activities of daily living may also be covered. These include tasks like grocery shopping, meal preparation, light housekeeping and laundry. Care can be hands-on or standby assistance.

Q: Who needs long-term care?

A: Most of us think of long-term care as an end of life issue for the elderly. The U.S. Department of Health and Human Services projects by age 65 and older 70% of us will experience a long-term care event in our remaining years. Today, 43% of the 12 million Americans receiving long-term care in the U.S. are between the ages of 18 and 64. The primary reason for their care is motor vehicle accidents followed by spinal injuries. The need for long-term care could arise at any time.

Q: How much does long-term care cost?

A: The cost for long-term care varies depending on the type of care required and the geographical area. Today, the national median cost of non-medical home care is $24 per hour. An average of 44 hours of home care per week costs $54,912 annually. The national median cost for a private room in a nursing home is $290 per day or $105,850 annually. Costs have increased between 4% and 6% depending on the venue. You can review the current cost of care and project future costs in your area using the Genworth 2020 Cost of Care Overview.

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Q: Will Medicare or disability insurance pay for long-term care?

A: Original Medicare, Medicare supplements and other health insurance plans are designed to pay for curative treatments or short-term skilled rehabilitation services. Original Medicare may cover up to 100 days of long-term care if specific requirements are met which include being admitted to a hospital and requiring skilled care daily. Claims history indicates that Medicare pays for 22 days on average.

Beginning in January 2019, Medicare Advantage plans have the option to cover some home safety improvements and assistance with daily activities if health related. This is new and few insurers have included these options which can change annually.

Many people mistakenly think their disability insurance pays for long-term care. It does not. Disability insurance is designed to replace income. It does not cover long-term care expenses.

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Q: Who pays for long-term care services?

A: There are just three funding options available to most Americans: 1) self-fund expenses using income, savings and/or liquidating assets to pay for care, 2) private insurance or 3) qualifying for Medicaid which is government assistance. Private charities and other government agencies such as the Bureau of Indian Affairs and U.S. Department of Veterans Affairs pick up the remaining costs but most of us cannot qualify for these funding options. Today, private funding – income, savings, assets, insurance and charities -- pays for 28% of long-term care expense. Public funding – Medicare, Medicaid and other government agencies -- picks up the remaining 72%. These public programs are already stretched and this is well before the impact of aging baby boomers.

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Q: How does Medicaid work?

A: Medicaid is a state/federal welfare program funded through tax revenues. In most states Medicaid will fund long-term care in a skilled nursing facility. In some states Medicaid will also pay for home care or care in an assisted living facility. Medicaid is means-tested. To qualify financially for Medicaid, an applicant must meet government asset and income requirements.

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Q: Where do people receive long-term care?

A: Long-term care can be provided in a variety of settings. Most care is provided in the home of the person receiving care or in a community setting such as an adult day care center. If care requirements exceed what can be accommodated at home, the individual receiving care may move to a group home, an assisted living community, a memory care community or a skilled nursing home.

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Q: Who should buy long-term care insurance?

A: Consumers who have assets that they want to protect should become educated about long-term care issues and consider purchasing long-term care insurance. We define the market for long-term care insurance using two factors: age and wealth. This insurance is available to adults between the ages of 18 and 85 depending on the product and insurance company. The ideal age to buy long-term care insurance is between 45 and 65 for two reasons: insurability and affordability. At younger ages the premiums are less expensive and we tend to be healthier than in later years. Consumers with assets between $50,000 and $5,000,000, excluding their homes, should seriously consider purchasing long-term care insurance. In this wealth range, an average long-term care event could impact the family's wealth and standard of living.

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Q: How do I qualify for long-term care insurance?

A: The state of your health is the most important factor in determining if you can qualify for long-term care insurance. Long-term care insurance is underwritten based on your medical history, family health history, current health status and lifestyle. When you apply, you must be mentally fit and able to perform all activities of daily living which are defined as bathing, dressing, eating, toileting, continence and transferring. If you're in great health, don't use tobacco products and don't take any medications, carriers will be quick to insure you because you represent minimal risk. Certain health conditions could prevent you from qualifying for long-term care insurance.

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Q: If I move to another state will my policy pay for my care?

A: Yes. Policies sold today are portable which means they can be used anywhere within the U.S. Some carriers have policies that cover benefits outside of the U.S.

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Q: What discounts are available?

A: Long-term care insurance companies offer discounts for married couples and partners. Discounts are also available for applicants with preferred health histories. Additional discounts are available through affinity programs designed for members of professional associations and employee groups when long-term care insurance is offered as an employee benefit.

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Q: What are standalone products?

A: Today, less than 20% of long-term care insurance policies sold are of this standalone or pool-of-funds design. In designing these products we literally create a pool of funds using the daily benefit amount (how much coverage) and the benefit period (how long it will last). For example, $100 per day and 10-year benefit period would create a pool of $365,000 ($100 per day X 365 days X 10 years = $365,000). Most standalone products are tax-qualified which means benefits paid are not taxable and premiums may be deductible depending on how policyholders file taxes. These are integrated plans which cover services in all long-term care venues: home care, adult day care, assisted living, nursing home and hospice. Several top-rated carriers offer these highly customizable products. Contract provisions include many benefits. A wide range of riders is also available to fit the likes and needs of individuals, couples, small business owners, professional organizations and large employers. It is this product type that offers partnership policies that provide additional safeguards from Medicaid resource reduction requirements. Premiums are paid annually, semi-annually, quarterly or monthly. If clients need care, these policies end up being the least costly insurance solution.

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Q: What are hybrid products?

A: Life insurance and annuity based long-term care solutions are referred to as asset-based or hybrid products. These products have contract provisions that allow withdrawals to be used to pay for long-term care expenses. They are also referred to as linked products as the design may include an extension of benefits rider that is linked to the life insurance or annuity component. This extension rider will continue to pay for long-term care expenses after the death benefit or annuity funds are exhausted. Generally, a large single premium is required to fund these products. The premium creates the cash value and also earns interest which explains the asset-based design of this product. These, too, are integrated plans and cover services in all venues. Fewer options are available to customize these products. These products are more appropriate for people 65 and older for two reasons: 1) inflation protection becomes less critical when purchased at older ages, and 2) most carriers' underwriting guidelines are more

lenient. If the policyholder dies never having needed care the death benefit or annuity funds are paid to the policyholder's estate or beneficiary.

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Q: Can premiums increase?

A: It depends on the type of policy. Standalone or pool-of-funds products are classified as guaranteed renewable. This means the insurance company may increase premiums but only on an entire class of policies not on an individual policy. In order for this to happen, the insurance company must file a business case justifying the increase with each state's insurance commissioner in which it wants to increase rates. The increase may be approved, modified or rejected by the insurance commissioner. If approved, every policyholder that purchased the same class of policy within the state would receive the increase. Hybrid products are classified as non-cancellable which means that the insurance company cannot change the rates.

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Q: Can a child be held responsible for his/her parent's cost of care?

A: Much has been written recently about filial responsibility laws given a Pennsylvania court case that ruled a son was responsible for his mother's $93,000 nursing home bill. With the majority of states struggling with budgets and how to deal with mounting Medicaid costs, some are speculating that enforcement of filial responsibility laws may be the next strategy to shore up Medicaid budgets. More information about the 29 states with filial responsibility laws and the specific law for each state can be found here. These laws vary and can range from simple fines to civil remedies.

When To Buy Long-Term Care Insurance

Long-term care insurance policies are issued to applicants between the ages of 18 and 81 depending on the product and carrier. But the ideal age range is 45 to 65. We also have very attractive long-term care funding options for clients who are uninsurable and not currently in need of care. These funding options are available through age 99.

Think about people you know who have been in good health up until they had a major accident or the sudden onset of an illness that caused them to require substantial assistance from another person. These can include auto accidents, sports accidents, onset of Multiple Sclerosis, Parkinson's, a disability like a stroke or other medical conditions.

All of these events could cause a person to need long-term care. With the medical advances today people are living longer but sometimes with chronic health problems. The sooner you buy insurance, the better, because once you need it, it's too late!

Three Important Reasons Not To Wait

1. The longer you wait, the greater the chance you have of becoming uninsurable due to an illness, accident or disability. Your eligibility is based on your physical health and mental acuity at the time of application. Generally, we are healthier at younger ages.
2. Your long-term care insurance premiums are based on your age at the time of application. The earlier you apply, the easier it will be to get coverage and the less expensive it will be.
3. Once you're approved, your rate does not increase as you age or if your health deteriorates. However, an insurance company may increase premiums on some products if approved by your state's insurance commissioner.

TEST YOUR LONG-TERM CARE KNOWLEDGE

By Nicole GurleyUncategorizeddoes Medicare pay for long-term care, family caregivers, risk of needing long-term care

Chances are that you or someone you love will need care or become a caregiver. Just think about the reasons for needing care.

They range from cognitive diseases like Alzheimer's to physical limitations from accidents or medical conditions like ALS, cardiovascular disease, diabetes, MS, etc.

Here's a quiz to test your knowledge:

1. RISK: The government projections are that 70% of people age 65 and older will experience a long-term care event in their remaining years? True or False?
2. COST: The median cost of a private room in a nursing home in the U.S. is over $100,000 annually? True or False?

3. FUNDING: Most people believe that Medicare pays for long-term care. True or False?
4. CAREGIVERS: Today, 65% of older adults with LTC needs rely on friends and family for care? True or False?
5. LTCI: Only 7% of long-term care delivered in the U.S. is paid by private long-term care insurance? True or False?

We'll make it easy for you to score your awareness. All answers are True.

Do you have a plan for long-term care?

Have you thought about care venues? Or care providers? Do you know the costs associated with your preferences?

How will you pay for this care without compromising your family's standard of living or retirement portfolio? These three questions will help you plan for long-term care:

1. WHERE would you want to live if you needed care?
2. WHO would you want to provide your care?
3. HOW would you pay for the care you may need?

Consider two factors

We ask clients to consider two factors as they explore long-term care insurance:

1. HOW much of the potential expense do you really need to offset with insurance?
2. WHAT is a comfortably affordable premium budget?

Even a modest policy offers protection for important assets. The new normal is "some coverage is better than none."

CCRCS ARE NOT CREATED EQUAL

By Nicole GurleyUncategorizedage in place, CCRC, continuing care retirement community, life-care

Among options for retirement living is the continuing care retirement community or CCRC. These communities provide a combination of two or more venues that include independent living along with assisted living, memory care and/or skilled nursing usually on one campus.

The intent is to provide the services residents require to age in place. As personal and health care needs change, services are available to enable residents to remain at the retirement community.

What's not to like?

The range of housing on one campus might include townhouses, cottages, assisted living apartments, memory care and skilled nursing. Services usually include nursing and other

health care services, meals, housekeeping, emergency assistance, personal care needs, wellness programs, recreational and social activities, 24-hour security, building and grounds maintenance. Worry-free living. What's not to like?

Today, there are approximately 1900 CCRCs in the United States located in a range of geographical areas from urban to suburban even rural. Roughly half are faith-based with the majority, 82%, not-for-profit sponsorship. Most have fewer than 300 units.

Contracts differ …

CCRCs come in three forms: Type A, Type B and Type C. Costs and contracts vary by type and it is important to be clear about which services are included in the fees and which services are available at additional cost.

Some offer insurance to cover healthcare needs. Others require residents to have insurance. Still others require pre-payment arrangements for care costs. And some guarantee only the availability of care resources which means that all costs must be paid by the resident.

Here's a brief description of each contract type:

Type A – Extensive or Life-Care. This type requires a substantial entry fee and ongoing monthly fees. A resident can move from independent to assisted living and has access to care for little or no extra fees. But fees may increase based on inflation or the operating costs of the CCRC.
The contract generally provides for a resident to receive the appropriate level of care on campus or at an accessible off-campus location. With this contract type the CCRC bears the majority of the financial burden for the resident's care.

Type B – Modified. This type may require an entry fee with ongoing monthly fees or charge by the month. Some long-term care may be provided. But this model is usually set up to provide rehabilitative care for a certain number of days at no extra charge and/or at rates that are discounted. It is not designed to provide chronic care.
The CCRC covers the care expense during the covered period but the financial responsibility shifts to the resident after the covered period.

For example, care might be provided for 90 days for someone rehabilitating from a stroke. Once the 90 days of covered services are exhausted, care costs are the responsibility of the resident. The CCRC may contract with care providers and pass along negotiated discounts to residents.

Type C – Fee for Service. This type may require an entrance fee or charge by the month. Here the resident receives priority admission to on-campus care venues but the resident is responsible for all care costs.

Is long-term care insurance redundant?

We are often asked by residents of CCRCs to evaluate their need for long-term care insurance (LTCI). In order to do so we need to read their insurance contract and the CCRC contract.

We find very few Type A or life-care contracts. The majority of CCRC contracts we've reviewed are Type B or Type C and provide care for a certain number of days and only in the property's care facility. This means the cost of home care in a resident's cottage or apartment is the responsibility of the resident. LTCI is important here.

Many CCRC contracts are more restrictive than LTCI contracts and limit the policyholder's flexibility. Additionally, care needs and covered venue choices may be at the sole discretion of the property's medical director.

Many CCRCs require a new separate care contract when a resident moves from independent living to one of its on-campus care facility. If space is not available in the property's care venue a resident can be moved to a facility that the CCRC has contracted with to provide care. Costs may be more than the property covers and the resident is responsible for the additional cost. LTCI is important here.

Read the contract …

Better yet, have an estate planning attorney familiar with CCRC contracts read the contract.

We view CCRCs as an option for financially secure seniors who seek a more carefree living environment. Entry fees can be hefty ranging from $50,000 to over $1,000,000 depending on location. Add monthly fees of $1500 to $5000 or more and care costs not covered by the service contract, and a CCRC can be a very expensive retirement venue.

What we've learned …

- Applicants don't understand the contract. Most think the CCRC is a Type A life-care contract and assume all care needs are covered by entry fees and/or monthly fees. Very rarely is this the case in our experience. We're yet to read a contract that covers any home care in independent living.
- Applicants overlook the financial risks if the CCRC falls on hard times. Like many other sectors of our economy, the CCRC sector was affected by the economic challenges that began in the fourth quarter of 2008. Payment defaults on debt have occurred for some CCRCs and several have filed for bankruptcy protection.
- Applicants don't know that a health assessment is required. An applicant will be required to pass a physical and mental health exam. This helps the CCRC to assess the kind of care that may be needed in the future.
- Applicants may not understand what is involved in the financial assessment. An applicant will need to show proof of financial ability to pay the entrance fees if applicable, monthly charges and care expenses.

Most CRCCs will require applicants to show proof of Medicare Part A (hospital insurance) and Part B (medical insurance) coverage, a Medicare supplement and long-term care insurance.

Considerations …

Here are four key considerations to understand as you evaluate a CCRC:

- Contract. Type A – Life-care, Type B – Modified or Type C – Fee for Service. This will determine the care services you can access and who is responsible for the expense of care provided.
- Costs. Will you have an entry fee and is it refundable? What are ongoing monthly fees and what do they cover? What happens to costs if one spouse of a couple needs care?
- Health care services. What levels of care services are provided on campus? Is memory care provided on campus? Can the CCRC require that you move off-campus if health needs warrant or if space is not available? Who makes the decision? Who pays for off-campus care expenses?
- Financial stability. Review financial statements. Understand how the care expenses are funded.

The CCRC can be an attractive option for senior living. But it's very important to understand the contract details. Is it really aging in place?

Key advisors like financial planners, CPAs, estate planning attorneys and LTCI consultants are valued resources in helping you decide if a CCRC is a prudent option for you.

WEAR PURPLE

By Nicole GurleyUncategorizedlong term care, wear purple

Sneakers, t-shirts, head bands, belts, leggings, skirts, shirts, shorts, socks. Whatever your style or desire. Wear purple on June 20 in support of Alzheimer's and Brain Awareness Month.

Dementia remains the number one cause of long-term care insurance (LTCI) claims. A major LTCI insurer has reported that two-thirds of new claims for facility care are tied to dementia. Another has reported that the cost of dementia claims comprises $0.51 of every $1.00.

Facts and stats

From the Alzheimer's Association:

Prevalence

- Today, 5.8 million Americans are living with Alzheimer's or another form of dementia
- By 2050 that number is expected to increase to 14 million
- Every 65 seconds someone in the U.S. is diagnosed with dementia

Deaths

- One in three seniors die with Alzheimer's
- Alzheimer's is the sixth leading cause of death in the U.S.

- Alzheimers kills more than breast and prostate cancer combined

Cost of care

- This year the cost to the nation for Alzheimer's care is estimated to be $305 billion
- The cost is estimated to be $1.1 trillion by 2050
- Today, 16 million people provide unpaid care for a loved one with dementia
- Unpaid care totals 18.6 billion hours annually and is valued at $244 billion

We need to do more

Now consider that 50% of primary care physicians think that the medical profession is unprepared for the growing number of people with Alzheimer's.

In a TED presentation, Lisa Genova, author of *Still Alice* and a neuroscientist, stated if you don't have it, you will be a caregiver for someone who does.
If we can fast-track a vaccine for a coronavirus, why haven't we been able to find a cure for dementia?

If we can invest trillions in economic stimulation packages, can we invest more in research to find a cure for dementia?

WHAT ARE ACTIVITIES OF DAILY LIVING?

By Nicole GurleyFavorite articlesADLs, cognitive impairment, trigger to LTC benefits
Have you ever thought much about your morning routine? Probably not. Most of us are on automatic pilot at wakening.

Some mornings my little seven-pound Shih Tzu wakes me with a toy in her mouth ready for playtime. But most mornings I get out of bed and walk to the bathroom to empty my bladder. Then I splash a handful of warm water on my face and wash away sleepy seeds.

Next I head to the kitchen to brew a pot of coffee. Steaming java in hand it's back to the bathroom to shower, decide what to wear and get dressed. Lastly I walk back to the kitchen to eat a quick bite of breakfast and then I'm off to the office.

Seems simple, right? It is if you don't need assistance. Those simple tasks of a typical morning routine account for the six activities of daily living (ADLs): bathing, dressing, eating, toileting, continence and transferring.

Needing assistance with two of the six activities of daily living defined by HIPAA will trigger benefits of tax-qualified long-term care insurance policies. Requiring supervision due to cognitive impairment is another trigger to benefit eligibility.

How would your morning change if you needed help doing one or more of these activities? What if you were unable to walk from your bed to the bathroom on your own or bath and dress yourself without assistance?

These ADLs are just one reason why we all need a plan for long-term care. None of these ADLs are considered curative or rehabilitative – short-term care that helps us recover or recoup – and therefore are not covered by healthcare or Original Medicare and Medicare supplemental insurance after about 100 days.

The other trigger to tax-qualified long-term care insurance benefit eligibility is cognitive impairment which encompasses many forms of dementia including Alzheimer's.

For the purposes of long-term care cognitive impairment is defined as a loss of short- or long-term memory; difficulty knowing people, places or the time or season; loss of the ability to make good decisions; or loss of safety awareness.

Cognitive impairment is the primary cause of long-term care insurance claims today and comprises about 35% of claims. These claims can last for a very long time.

If family is not available to help with these activities, how would you pay for assistance provided by a formal caregiver?

Just three funding options for most Americans

Many are in denial that they will ever need long-term care. Consider the government projections on the risk of needing care. It is estimated that 70% of people age 65 and older will experience a long-term care event in their remaining years.

If you fall into the 70%, how will you pay for care? Many people assume Original Medicare is the answer but it's not.

Original Medicare may cover costs up to 100 days providing certain requirements are met which include being admitted and hospitalized for three days and needing skilled care on a daily basis.

The Centers for Medicare and Medicaid recently allowed insurers offering Medicare Advantage plans to include some benefits to assist beneficiaries needing custodial care to remain in their homes.

That leaves most Americans with three funding options to consider:

1. Self-fund: Use your income, savings and potentially liquidate your retirement portfolio to pay for care.
2. Medicaid: Qualify for government assistance. Income and assets must meet government requirements.
3. Long-Term Care Insurance: Transfer the risk to an insurance company. There are several products available today. The right one will depend on your health history, affordability and financial goals.

A bigger problem is the magnitude is not recognized

The SCAN Foundation focuses entirely on improving the quality of health and life for seniors. Its president and CEO, Dr. Bruce Chernof, also served as the chairman of the federal 2013 Commission on Long-Term Care.

At that time, SCAN reported the annual price tag for long-term care was about $725 billion and well before baby boomers impacted costs.

Chernof stated that a more troubling issue than the cost of long-term care is that the magnitude of the problem is not recognized.

He cites the “70-70-70” long-term care problem:

- 70% of people over 65 will need some level of care (true)
- 70% of people don’t think they will ever need long-term care (false)
- 70% of people think Medicare will pay for long-term care (false)

Can you maintain your family’s standard of living, the financial obligations you’ve made and afford the additional cost of long-term care? That’s really the key question and why having a plan for long-term care is so important.

If you have questions about products, cost or coverage, give us a call and let’s discuss your situation. Our exclusive focus is long-term care expense planning. It’s all we do.

FUNDING OPTIONS FOR LONG-TERM CARE

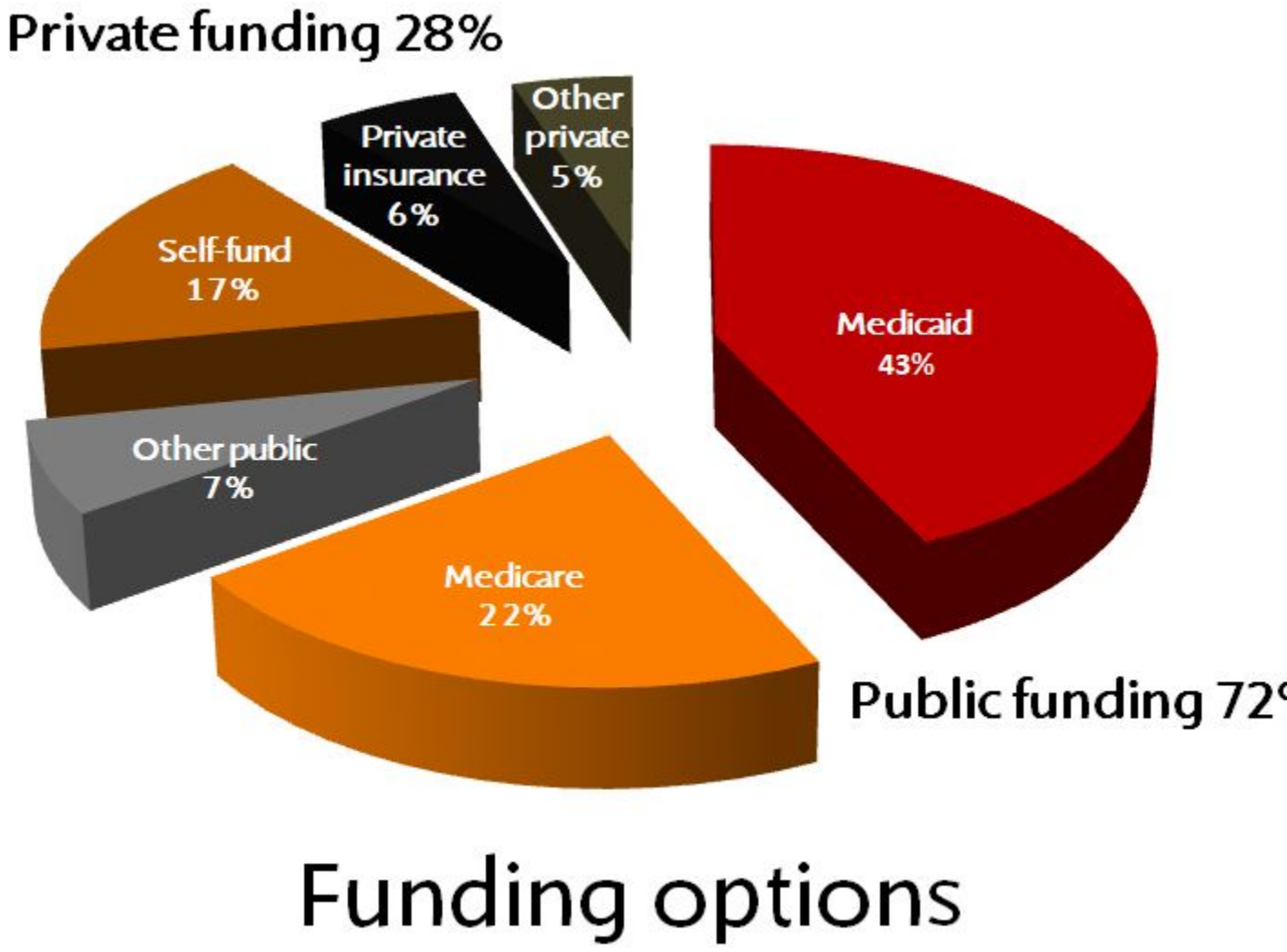
By Nicole GurleyUncategorizedlong-term care insurance, Medicaid not Medicare, self-fund

For most Americans there are just three funding options to pay for long-term care expenses. Original Medicare, even with a Medicare supplemental policy, is not one of them.

Recent changes allowed by the Centers of Medicare and Medicaid (CMS) for Medicare Advantage plans may cover some custodial needs if health related, but consumers need to understand how these plans work year after year.

Don’t count on Original Medicare to pay for LTC

While Original Medicare may cover up to 100 days of custodial care if specific requirements are met, it should not be considered a funding option.



If Original Medicare is not a funding option, how do Americans pay for long-term care? One way is to self-fund using income and savings or liquidating assets. About 17% of the cost of long-term care is paid using personal income and savings.

Another way is to transfer the risk of this expense to an insurance company. Currently, only 6% of the cost of long-term care is paid by private insurance. That’s because so few have planned for long-term care expense.

Longevity brings new requirements

Think about this: Longevity is new to humankind. It's two or three generations old. Longevity brings with it new requirements like retirement financial planning and long-term care expense planning.

The third way to pay for long-term care is to qualify for government assistance. It is Medicaid not Medicare that provides long-term care, which is designed to be custodial care. Medicaid is the primary funder of long-term care expense in the country and picks up 43% of the cost.

In some states, the Medicaid programs are known by different names. For example, in California, it is known as Medi-Cal. And in Arizona, it is known as ALTCS, Arizona Long Term Care System.

Medicaid is a means-tested program. Learn more about qualifying for Medicaid here. Medicare picks up 22%. Other public funding agencies pay 7% and private charities pay 7%.

The government is currently funding 72% of long-term care costs through Medicaid, Medicare and other public agencies.

We know that these programs are already stretched and this is well before the impact of aging baby boomers.

In his article, "Finding money for long-term care," Jim Miller provides information about some of the other public and private funding sources.

GIVE ME A BREAK

By Nicole GurleyUncategorizedbed reservation, family caregivers, home care, long-term care insurance benefits, respite care

When we work with clients on long-term care expense planning, the initial focus is cost and coverage. It doesn't matter if the funding option is insurance or another product. Basically, clients just want to know how much expense they can afford to transfer to an insurance company or another funding resource.

As a result, meaningful provisions of these long-term care funding contracts are frequently left to the policy delivery conversation. One of the most important provisions is respite care.

Our service-for-life profile includes helping our clients file the initial claim for benefits. When the health decline has been gradual, as in the case of dementia, family members may have been caregivers for a very long time. Sometimes years.

By the time we get the call for assistance, family members who have been providing care are exhausted. See the story about Claire and Elizabeth.
Electing to file a claim can be a difficult decision to make. It signals loss of independence. Oftentimes, end of life. Family members may feel a sense of failure that promises made to care for a loved one at home are no longer realistic given the level of care or hours required.

Family caregivers need R & R

One of the very meaningful benefits of long-term care insurance policies is respite care. Unpaid family caregivers or friends often need a break from the stress of caregiving. Long-term care insurance provides short-term relief known as respite care.

Respite care will pay for out-of-pocket expenses, up to the maximum daily benefit amount of the policy, for temporary confinement in a facility or care received in the policyholder's home.

This allows the family to hire a temporary caregiver for a certain number of days every year. Most policies allow between 21 and 30 days per year. And, this benefit is not subject to the elimination period (deductible). As soon as eligibility is confirmed, the respite benefit is available.

Other provisions include bed reservation and more

Modern long-term care insurance contracts have a bed reservation provision.

If the policyholder is residing in an assisted living community or nursing home and temporarily leaves the facility, the policy will continue to pay for the apartment or room when unoccupied so that it is not given to someone else.

A temporary absence could be the result of being hospitalized. Some policies will cover any temporary absence which could include being well enough to travel to visit family. Others require an absence must be health related. This provision is generally for a 30-day period every calendar year.

Many contracts will cover services provided outside of the United States or its territories. These are usually limited to a percentage of the daily or monthly benefit amount for a shortened benefit period.

Very important to those who wish to remain in their own homes are a number of stay-at-home provisions. These may include caregiver training for family members, durable medical equipment, home modification and even medical alert systems.

Today, insurers provide a care coordinator at no cost to the policyholders. This is a valuable service to policyholders and family members. Coordinators assist with eligibility requirements, developing a plan of care, identifying qualified care providers and filing claims.

Are you caring or coping?

Many caregivers are managing all on their own without the assistance of insurance benefits or care coordinators and don't know that respite care may be available to them through church or government programs.

Social workers and geriatric care managers suggest that family caregivers explore respite options as soon as they begin caring for a loved one. While it may be uncomfortable initially to engage temporary services, a break can help family members be better caregivers.

WHICH LTCI PRODUCT IS RIGHT FOR YOU?

By Nicole GurleyUncategorizedlong-term care funding options, long-term care insurance products, reverse mortgage

For most Americans there are just three funding options for long-term care.

1. You could self-fund using income, savings, liquidate investments or perhaps do a reverse mortgage. (We like reverse mortgages but mainly for other financial strategies.) Basically, we just don't like self-funding as an option. It's expensive!
2. You could transfer the risk of the expense to an insurance company. This is our favorite option! Why pay dollars when you can pay pennies? (Yes. We are a bit biased.)
3. You could qualify for government assistance through Medicaid. We really don't like this option. Depending on assets and income, it could be quite expensive. And care venues could be limited depending on your state's Medicaid program.

Pennies for dollars

Keep in mind that the risk of needing long-term care is high. And it's expensive.

If you like the idea of paying pennies in premiums for dollars in benefits, insurance will be your funding solution.

There are basically three long-term care insurance products in the market today: standalone, life insurance based and annuity based. Each is priced and underwritten differently.

All can be customized to meet your desired expense offset and/or your premium budget. Find out more about each product design here. Which is most attractive to you?

News Brief February 2018

This newsletter is the third in our series on long-term care insurance. LTCI 101 covered definitions. LTCI 201 reviewed optional riders.

In this newsletter, LTC 301, we look at contract provisions that are common to most long-term care insurance policies in the market today.

What's a provision?

When we work with clients who are exploring long-term care insurance, in almost all cases the initial focus is on cost and coverage issues. Review of contract provisions usually takes place when the policy is delivered. These are additional benefits that are part of the policy.

Think of a provision as an obligation on the part of the insurance company that is included in the base cost of your policy. Some provisions are regulatory requirements.

An example of a regulatory requirement is that a tax-qualified long-term care insurance product has two triggers to eligibility of benefits. (See LTC 201 for details.)

An example of a provision that may be included but not required is international coverage. Some policies will pay for care abroad. Some may pay a reduced benefit for a specific period of time like 75% of the nursing home benefit for one year. Others may not cover any care received outside of the U.S.

Common inclusions

Facility and community-based care. Most of our clients want to remain in their own homes if care is needed. Integrated policies, which comprise about 99% of policies sold today, pay for care in a range of care venues.

These include the policyholder's home, adult day care center, assisted living community, nursing home and hospice.

Alternate plan of care. Long-term care services continue to evolve. The policy language may not specifically list a future service or treatment. With many policies, if the policyholder is working with a care coordinator who recommends an alternative venue or service, the insurer will provide benefits.

An example is a group home. Many carriers will cover care services provided in a group home which has fewer beds than an assisted living community even when the term "group home" is not specifically listed in the contract.

Care coordination. We all know how complex it is to figure out the level of care required along with appropriate care venues and trained and trusted home care agencies. That's why almost all carriers provide care coordination.

Utilizing the services of a care coordinator or case manager makes this process easier for policyholders, families and insurers alike. Oftentimes, additional benefits are provided when a care coordinator is utilized.

Care coordinators generally are nurses, social workers or geriatric care managers who understand care needs, know care venues and can recommend reliable care providers.

Bed reservation. This benefit will continue to pay for an apartment in an assisted living community or room in a nursing home if the policyholder is hospitalized. Usually limited to 30 days a year, this is a very significant benefit.

Just think if you resided in an assisted community, were hospitalized and when released you needed to find a new place to reside. Or alternatively, pay for your accommodations even if you are residing elsewhere. This provision eliminates those worries.

Respite care. It is our experience that by the time a policyholder calls for help filing a claim, the family caregivers are exhausted. Assistance was probably needed months ago and family members have been pitching in to provide care.

This benefit provides a third-party or temporary replacement to relieve family caregivers. Respite for the policyholder could be at home or in a facility. This

provision can range from a couple of weeks to up to a month each year.

The elimination period does not have to be met for this benefit to be available.

Premium waiver. The application of this benefit varies by insurer and product design. This feature waives future premiums for the duration of a claim. Usually the elimination period must be fulfilled.

Think of it this way. Money flows in only one direction. If the policyholder is paying premiums, the insurer is not paying benefits. And vice versa. If the insurer is paying benefits, the policyholder is not paying premiums.

Discounts. Premium discounts vary by product and carrier. Most will provide a discount for preferred health. Many others will provide discounts if residing with another in a committed relationship. Other insurers allow a parent and child to share a policy even if they reside in different states. Lots of opportunities to be aware of here.

Payment options. If your policy has ongoing premiums, most insurers will offer annual, semi-annual, quarterly or monthly payment options.

Depending on the product, some insurers still offer single-pay, 10-pay or 20-pay options so that once the last payment is made the policy is paid up.

An attractive feature here is that you can design premium payments to coincide with retirement. In other words, get all the premiums paid while still working and receiving employment income.

Lots more. There are many more provisions of contracts. Among these are lapse notification, guaranteed renewable, nonforfeiture and more. A valuable resource is the *Buyer's Guide to Long-Term Care Insurance* which is published by the National Association of Insurance Commissioners.

30-Day free-look period. To be sure that consumers are confident about the insurance coverage they have purchased, policyholders have a 30-day free-look period to review cost, coverage and the contract language.

The 30-day period begins once the policyholder has received the policy. If the policyholder decides for any reason that the policy is not right for them, they can return it within the 30-day period and receive a full refund of any premium paid.

There are also exclusions

While we are focusing on contract inclusions in this newsletter, it is also important to note that most contracts have exclusions as well.

For example, benefits would not be paid for care paid by Medicare or care required due to an intentionally self-inflicted injury. The same applies to care required as the result of participation in a felony, riot or insurrection.

Most policies also exclude payment for care provided in a treatment facility for alcoholism or drug addiction.

News Brief January 2018

This newsletter is the second in our series on long-term care. If you missed LTC 101, you can access it here.

In LTC 101 we defined long-term care, Medicare, Medicaid as it relates to long-term care, and the key components of LTCI including benefit amount, benefit period, elimination period and inflation options.

One of the complaints we hear from consumers and financial advisors alike is that long-term care insurance (LTCI) is just too complex.

This education series is designed to help financial advisors, their clients and consumers understand the components of LTCI insurance, contract provisions and product designs.

In this newsletter, we cover tax-qualified, Partnership and optional riders along with stats and facts about the risk of needing care and the cost of care venues.

Decide if you are really at risk

The government projections are that by the time we reach age 65, 70% of us will need some level of long-term care in our remaining years.

In our opinion, that's pretty significant. In fact, some industry pundits suggest that LTCI is no longer a risk management strategy. Today, they consider it an expense transfer strategy.

Costs vary depending on the level of care required and the care venue. For example, the national median cost of four hours of non-medical care received at home daily totals about $49,192 annually today.

But if you plan to self-fund that expense, you need to plan on $59,522 for the first year. Yes. That's a 21% increase. And it's based on a 15% tax rate on the liquidated assets and a 6% opportunity loss on those assets.

Add to those costs a 3% annual increase in the cost of care each year and you need to set aside $249,019 to self-fund a claim lasting four years which is the average duration of about 60% of claims today.

Decide if you can self-fund this potential expense

Using the same assumptions, 20 years from now the cost to self-fund four years of non-medical home care is projected to total $449,756.

Self-funding 24/7 medical care in a skilled nursing facility nearly doubles these numbers today and in the future. Today, the national median cost of a private room in a nursing home is $97,455 annually.

Again using the same assumptions, four years in nursing home care costs $493,336 today. In 20 years, that costs is projected to be $891,019. And that's per person!

Tax-qualified policies

Almost all traditional, standalone products sold today are tax-qualified. Some riders on asset-based products may also be separate tax-qualified policies.

Tax-qualified was defined by the HIPAA legislation formally known as the Health Insurance Portability and Accountability Act of 1996.

The advantages of a tax-qualified policy are twofold. One is that benefits paid are not taxable as income.

The second benefit is that the age-based eligible premium allowed by the IRS may be included as medical expenses if policyholders itemize deductions on federal taxes. About 30% of taxpayers itemize federal taxes. If medical expenses exceed a certain percentage of adjusted gross income (AGI), a deduction may be possible.

Additionally, 33 states allow a deduction or a credit on state taxes.

If you purchased your LTCI after 1997, your policy is most likely tax-qualified. Additionally, HIPAA legislation allowed policies sold prior to 1997 to be grandfathered and considered tax-qualified if not materially changed.

Tax-qualified policies have two triggers to eligibility of benefits. A policyholder must need assistance with two activities of daily living (bathing, dressing, eating, toileting, continence and transferring) or substantial supervision due to cognitive impairment.

Non-qualified policies have a third trigger to eligibility of benefits which is defined as "medically necessary." While this is potentially an easier trigger to eligibility of benefits, few carriers offer non-tax-qualified policies today.

To date, the U.S Treasury has not ruled as to whether benefits paid will be treated as income. Nor has it ruled on premium deductibility.

Partnership policies

The value of Partnership is that it helps to manage the financial impact of Medicaid eligibility requirements. On a dollar-for-dollar basis, a Partnership policy will protect assets from Medicaid resource reductions requirements.

In most states if you are a single individual qualifying for government assistance for long-term care through Medicaid, you are allowed to retain $2000 in countable assets. But if you have a Partnership policy that paid $250,000 for your care, you would be able to retain $252,000 in assets - the $250,000 that your policy paid and the $2000 entitlement.

A Partnership policy must be tax-qualified and have age appropriate inflation protection as defined by the National Association of Insurance Commissioners.

If you are younger than 61, your policy must include compound inflation. Between ages 61 and 75, your policy must have inflation but it can be simple of compound. At 76 and older ages, inflation is not required to qualify as a Partnership policy.

Depending on health, wealth and financial goals, having a Partnership policy may be critical to your decision-making and financial security.

Today, Partnership policies are offered in all but four states - Alaska, Hawaii, Mississippi and Utah.

You can share benefits

One of the most popular optional riders on traditional products is a shared benefit rider available when couples apply together. This rider combines the separate pools of funds available to each spouse/partner into one resource that can be shared.

If each partner has four years of coverage, a shared rider combines the pools to create eight years of coverage. If one partner dies without using any benefits, the surviving partner has access to all eight years.

Alternatively, if one spouse needs six years of coverage, the spouse needing care could continue to tap the combined pool of funds to cover care needs.

This is a design that allows for more coverage for less premium. Policies must be identical for this rider to be offered.

This shared strategy is also available on joint life insurance and annuity product designs.

You can save on premiums down the road

A provision of traditional policies is a waiver of premium when the policyholder is eligible for benefits and has fulfilled the elimination period.

A spousal or joint premium waiver rider waives the premium on both partners' policies if only one is on claim for the duration of the claim.

This optional rider is offered by a number of carriers and can result in premium savings down the road.

A survivorship rider is another way to potentially save premium dollars. It is especially attractive to younger applicants.

A survivorship rider may result in a paid-up policy. Upon the death of the first spouse or partner, the survivor has a paid-up policy and no future premiums are required. The policy remains in force with all design components.

Most carriers require a policy to be in force for 10 years without claim for this rider to become effective.

The industry as a whole experiences most claims between ages 80 and 85. Just think of the relief a surviving spouse would experience with a paid-up policy following the death of his/her spouse.

The primary objection of traditional LTCI is the "use it or lose it" proposition of this insurance. We buy insurance to offset risk, yet most of us don't know if we will need custodial care as we age. The odds are great that we will. But what if we don't?

Asset-based products address this issue and, as a result, have grown in popularity. If care is never required the death benefit of a life insurance policy or the cash value remaining in an annuity is refunded to the estate or beneficiary(s). And many guarantee a return of premium if the policyholder quits the policy.

It's different with traditional policies. With some carriers, a return of premium (ROP) rider is a contract provision and will refund premiums paid, less benefits paid, if death occurs before a specific age. With others, a ROP rider can be added as an optional rider.

But keep in mind, with almost all of the traditional products, the policyholder must die for this to be effective. It does not return premium if you just decide you don't need or want the coverage any longer.

More to come ...

Planning for long-term care is about dealing with the reality of needing assistance as we age. We'll be the first to acknowledge this is not a fun conversation. But ignoring information to avoid the reality of needing long-term care is not a solution.

LONG-TERM CARE FUNDING FOR THE UNINSURABLE

By Nicole GurleyFavorite articleshome care membership services, LTC Benefit Plan, single premium immediate annuity, SPIA

A Long-Term Care Benefit Plan is an irrevocable FDIC-insured account administered by a third party. Proceeds from a life settlement transaction are used to fund the plan.

I just hate these phone calls. They're heartbreaking. The event has happened.

It's one thing when it's a client who has long-term care insurance and the plan is in place to fund quality care. That's bad enough.

It's worse when the call is from someone who has been referred to me and has no insurance as was the case in the phone call I just received.

A sixty year old vibrant attorney has suffered a major stroke. Cognitive skills intact. Total paralysis on left side. He cannot perform any activities of daily living – bathing dressing, eating, toileting, continence, transferring – without hands-on assistance.

He's been in skilled nursing and rehab hospital for four months and will be released to return home in a few days.

It was his wife who called. She works. No kids. She is exploring home care agencies to provide care while she is working. Every agency she has called has asked if she has long-term care insurance.

The benefits manager at her husband's employer has referred her to me. She is calling to inquire how quickly she can get this insurance in place because he's coming home at the end of the week.

There are options for those uninsurable

For most Americans there are just three funding options:

1. Self-fund: Use your income, savings and potentially liquidate your retirement portfolio to pay for care.
2. Medicaid: Qualify for government assistance. Income and assets must meet government requirements.
3. Long-Term Care Insurance: Transfer the risk to an insurance company. There are several products available today. The right one will depend on your health history, affordability and financial goals.

But there is good news for those who are uninsurable. Some may find themselves in this situation because they waited too long and have aged out of insurance options. Depending on carrier and product long-term care insurance is available from age 18 through 85.

Others may have an uninsurable medical diagnosis. Conditions like dementia, muscular sclerosis, Parkinson's and many autoimmune diseases fall into this category.

And still others have experienced a disabling event that has rendered them uninsurable like the attorney. Motor vehicle accidents are right at the top of the list as the cause of disability for working age adults.

Long-Term Care Benefit Plan

Thankfully, funding strategies like a Long-Term Care Benefit Plan are available and provide additional funding options for those who can no longer qualify for insurance.

This is a very good reason to hang on to that life insurance policy that you've been thinking of canceling.

A Long-Term Care Benefit Plan is a unique, tax-advantaged funding option. It allows the owner of a life insurance policy to sell the policy at fair market value to fund long-term care expenses.

Because the value of the sale is based on the death benefit and not on the cash value of the policy, any form of life insurance can be used including term, permanent or group.

The Benefit Plan is an irrevocable FDIC-insured account administered by a third party. The account is set up to make payments directly to the care provider. Funds will pay for all care venues.

A funeral benefit is preserved and upon death any unpaid account balance goes to the designated beneficiary(s).

All health conditions are accepted, there are no deductibles, no care restrictions or requirements to be terminally ill.

This funding strategy can be accomplished quickly. It is an option for people who are receiving care or will need care soon.

Care payments are tax-free. There are no triggers to eligibility. All medical conditions qualify and there are no elimination periods to fulfill.

Fortunately, the attorney had a significant group life insurance policy through his employer and we were able to set up a benefit plan to pay for his care.

Home Care Membership Services

Another funding option for those who find themselves uninsurable is a home care membership service. This is not insurance.

It's a membership program. No underwriting. No claim forms. No triggers to eligibility. No deductibles. No co-pays. And, no age limits!

Members can purchase a set number of hours from 150 hours up to 1000 hours and renew hours up to nine times if more care is required.

This is deeply discounted home care. For example, the median hourly cost of non-medical home care in the nation today is $22 per hour. A thousand hours of home care at $22 per hour would cost $22,000. With this membership 1000 hours runs $5700 or $5.70 per hour.

Because members are buying hours instead of dollars there is a built-in inflation component.

If hours are used today the value of one hour is $22. But if care is not needed for 10 years and the cost of non-medical home care increases to $30 per hour, the value of the hour would be $30 in 2029.

Home care membership service is a funding strategy put in place in advance of needing care.

If care is not needed in a given year a 10% discount is applied to the premium year after year for four years. In other words, members can receive up to 40% off of the original annual premium until the time that care services are engaged. Then premiums reset to the original amount. If hours are exhausted the membership hours can be renewed nine times.

A home care membership service is a funding strategy put in place in advance of needing care. If care is not needed a 10% discount applies to the premium year after year for four years.

For older clients who can no longer qualify for insurance because of their age this can be a very effective strategy. We have also put this in place for clients who currently have no care needs but have an uninsurable medical diagnosis.

Membership pays for home care services provided by contracted home care agencies or an approved friend or neighbor selected by the member. (The caregiver just cannot be a family member or anyone that resides in the member's home at the time of application.)

This is field issued. It is not medically underwritten. The only eligibility requirement is that member cannot need home care when he/she applies.

Single Premium Immediate Annuities

These annuities have traditionally been the long-term care funding mainstay for the uninsured or the uninsurable. Income can be used to pay for care expenses or any other purpose.

There are two designs – medically underwritten and non-medically underwritten. Both can be designed to provide an income stream guaranteed for a certain period of time and/or for the lifetime of the annuitant.

The income from a medically underwritten single premium immediate annuity is greater than one that is not medically underwritten. That's because insurers are underwriting shortened life expectancy.

These are taxable funding options and usually require substantial premiums to fund meaningful long-term care benefits.

This funding strategy is designed for people who may need care now.

Help is a phone call away…

With more options comes more confusion to an already complex issue. We can help with pros and cons of each long-term care funding strategy and provide the information you need to determine what is best for you based on your health, affordability and financial goals.

WASHINGTON CARES FUND DOESN'T CARE

By Nicole GurleyUncategorizedinsurance, long term care, tax, wa, washington


PUBLI
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MAKE YOUR CHO

As one financial advisor commented this week, most Washingtonians haven't a clue about this new tax. And they won't until they see it in their paychecks.

As Steve Moses of the Center for Long-Term Care Reform has so aptly opined, the WA Cares Fund is what happens when the Keystone Kops design a long-term care insurance plan.

Many have written about the ineptness of the legislators who designed what I call a "tax grab." I'm waiting for the class action suit to be filed. Does anyone have the guts to file?

The legislation was meant to heighten awareness about the risk of needing long-term care and the cost of care in hopes that WA residents would purchase private insurance rather than rely on Medicaid to pay for their care. It is Medicaid not Medicare that pays for long-term care services. This was thought to be a way to shore up the state's Medicaid funds.

Medicaid is the fastest growing line item on most states budgets

So, what does this ill-conceived legislation do? For starters, if you are a W2 employee and have not purchased private long-term care insurance (LTCI), you will be taxed at a rate of .58%.

Think about this. You are 17 and a W2 employee at your local bodega. You don't have LTCI and you can't buy it. Insurance carriers won't sell a policy to a 17-year-old. Most won't sell to anyone under 35 or 40.

Now, if Washingtonians have a policy and file for an exemption by November 1 they can opt out of the tax. The exemption is a one-time requirement. Additionally, self-employed or 1099 independent contractors can also opt out – or in for that matter, but why would they?

The maximum coverage is $36,500 and you won't have access to it for years if you qualify.

So, what have we seen in the market? Carriers have been bombarded with applications for minimum coverage just so the applicant can get the exemption. Premiums in many instances are less than the tax. And applicants plan to quit the policy as soon as they get their one-time exemption.

Should I stay or should I go

This totally inadequate coverage is not portable. It's only good in WA.

Whether or not inflation will apply to the benefit is undefined.

The program does not qualify for Partnership status which protects assets and income from Medicaid spend-down requirements.

The triggers to eligibility are three of 10. LTCI triggers to eligibility are two of six.

And to top it all off, the legislature can make changes to benefits and eligibility triggers twice a year.

What will the benefit be when you need care? No one knows. Or, how much it will have cost beneficiaries.

Would it surprise you that no LTCI experts or carriers were consulted by the legislature?

What to do

Check to see if your employer offers an employee LTCI program. These programs may insure those 18 and older.

See if you can legally be paid as a 1099 (independent contractor) versus a W2 (direct employee).

Figure out what you will pay in taxes. Does it make sense to go along with the tax grab? For some it will. For some there will be no option.

Move to another state.

Do meaningful long-term care expense planning now. The deadline is November 1 to have a policy in force.

Carriers are experiencing huge surges of new applications. These applications are medically underwritten. People can be declined based on health history. It can take 60 days for an underwriting decision to be made.

It can take that long for you to learn what you need to know to make a prudent decision about this insurance. How much do you need? How much can you afford?

We tend to think about long-term care as an end-of-life issue for the elderly. Today, 43% of those receiving care are working age adults between the ages of 18 and 64. The primary reason for their care is motor vehicle accidents followed by spinal injuries.

What's my point? The need for long-term care could develop at any time. And the younger you are the least costly this insurance will be.

LATEST FACTS AND STATS

By Nicole GurleyUncategorizedcoverage, covid, insurance, long-term care, premium


MORE
INFO

For those of us who work in this narrow but important insurance niche, we wait each year for our assumptions to be validated or tweaked by the annual LTCI survey published by Brokers World.

Now in its 22nd year, we find few carriers participating in the "2020 Milliman Long Term Care Insurance Survey." Below are highlights followed by thoughts about the impact of COVID-19 on the industry.

Highlights

- Fifteen carriers reported sales of 54,563 policies with annualized premiums of $170,770,732 in 2019. That's a 3.1% decline in new policies but a 0.6% increase in annualized premiums from 2018.
- The average premium per new policy increased to $2551 in 2019 from $2507 in 2018, an increase of 1.7%. Included in the increase was a higher initial monthly benefit amount, an older issue age and a longer benefit period.
- The average maximum monthly benefit amount increased to $4882 in 2019 from $4763 in 2018.
- Most, 52.1% of applicants, chose a three-year benefit period.
- Most, 32.7% of new policies, included 3% automatic compound inflation up from about 21% in 2018 and by far the most popular option.
- The issue age increased slightly with about 50% of sales to those between the ages of 55 and 64. The average issue age was 57.7 years.
- Placement rates increased to 59.2%, a slight increase from 58.8% in 2018.
- Premium stability is considerably better than in previous years based on more conservative assumptions including better underwriting, product redesign and lower interest rates.
- In 2019, almost 82% of applicants purchased coverage when their spouse/partner was declined.
- Lapse rates on in-force policies dropped for the fifth straight year in a row and remained less than 1%.

For more information and details go to www.BrokerWorldMag.com.

Thoughts About COVID-19

- With higher death rates we may see fewer claims and shorter average length of claims.
- Fewer claims for home care may result as policyholders are reluctant to have home care providers visit their homes. Family members may end up providing more home care during the pandemic.
- The impact of the economic shutdown may influence some to reconsider LTCI instead of self-funding.

- Since the second quarter we've seen an increased interest in long-term care insurance primarily from those aged 65 and older and with underlying medical conditions.

THREE LONG-TERM CARE INSURANCE OPTIONS

By Nicole GurleyFavorite articlesannuity based, hybrids, life insurance based, standalone LTC products
We're often asked what long-term care insurance product we like the best or recommend. Our response is always, "It depends." We're not trying to be evasive. It just depends on each client's health, wealth and financial goals.

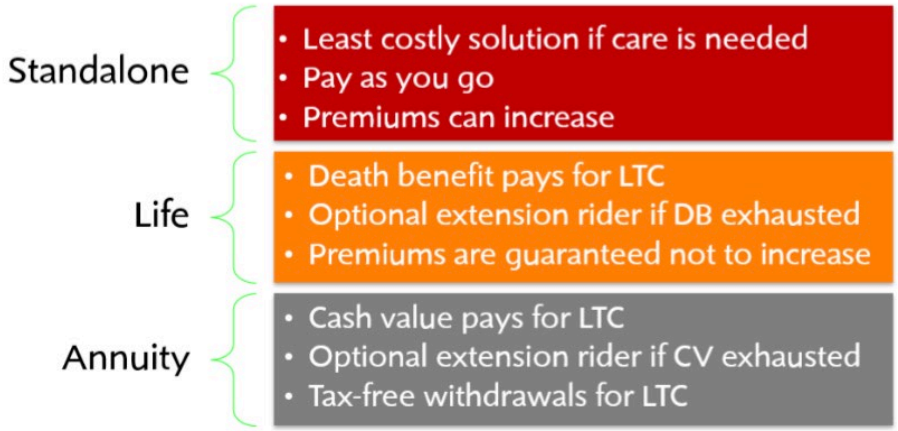
Currently, there are three long-term care insurance (LTCI) products in the market: standalone or traditional, life insurance based and annuity based. All have design variations. All have pros and cons depending on your perspective. All safeguard income and assets from the risk of long-term care expense.

Some products place all the risk with the insurer. Others require the policyholder to share in the risk. Some are pay as you go. Others require a large single premium. Some require that you are pretty healthy. Others have more lenient underwriting requirements. So you see why we say it depends.

Standalone or traditional pool-of-funds products are appropriate for younger, healthy applicants because the insurance company assumes all the risk.

Asset-based products are designed for an older market segment and may have more lenient underwriting requirements because risk is shared between the policyholder and the insurer.

Health, Wealth and Financial Goals Determine Product



Standalone designs let you pay as you go

About 20% of long-term care insurance policies sold today are of the traditional, standalone design.

Think of this design as you do your auto or homeowner's insurance. You figure out the amount of coverage you need, what you want your deducible to be and you pay premiums hoping that you'll never need the benefits of the policy.

The premiums you pay are a sunk cost. In other words, the money is gone. You don't expect to get your premium dollars back.

Most of these traditional products are designed to be tax-qualified which means benefits paid are not taxable and premiums may be deductible depending on how policyholders file taxes.

These are integrated plans which cover services in all long-term care venues: home care, adult day care, assisted living, nursing home and hospice.

About a dozen carriers offer these highly customizable products. Optional riders include many benefits such as a shared rider that enables a couple to share coverage and a 0-day home care elimination period waiver that covers home care services the first day that care services are engaged. These products also have a wide variety of inflation options.

A standalone product may also qualify as a partnership policy providing additional safeguards from Medicaid resource reduction requirements.

Most carriers offer these products to those aged 18 through 79. These products have the strictest underwriting requirements. However, a few carriers will issue policies to less healthy applicants at higher than standard premiums or with limited coverage.

These policies are guaranteed renewable which means the policy cannot be canceled unless the policyholder fails to pay the premium when due. Rates can increase in a specific state if the increase is approved by the state's insurance commissioner.

However, the Society of Actuaries published a report recently that stated there was less than a 10% probability of a rate increase on standalone products sold since 2014 and later given changes in the design.

If clients need care, these policies almost always end up being the least costly insurance solution.

Link life insurance with long-term care insurance

Life insurance based long-term care solutions are referred to as asset-based or hybrid products.

They ride on a whole life or universal life chassis with long-term care riders (options). Most require a substantial premium to fund a meaningful long-term care benefit. The premium creates cash value and also earns interest which explains the asset-based design of this product.

These, too, are integrated plans and cover services in all venues. Fewer options are available to customize these products compared to standalone designs.

Some carriers offer these products to those 20 through age 80. Others target an older audience of 35 through 80.

Those 65 and older may be drawn to this product for two reasons:

1. Inflation protection which is a costly option becomes less critical when purchased at older ages
2. Underwriting guidelines are more lenient

Consumers who are insurance averse may like this product design because it eliminates the "use it or lose it" proposition of the traditional standalone products.

We like to say, "Live, die or quit, there's a benefit." If you need long-term care you can accelerate the payment of the death benefit while living to pay for long-term care.

If you die never having needed long-term care your estate or beneficiary(s) is paid the death benefit.

Most of these products have a crediting interest rate and a guaranteed return of premium. If you quit the policy you get your premium back or the cash value whichever is greater.

Many find this a more attractive long-term care funding solution. However, it is a more expensive solution if care is needed.

Many insurance companies offer these products and there are two different designs. One simply uses the death benefit to pay for long-term care expenses.

For example, a death benefit of $100K could be accelerated at 2% creating a long-term care benefit of $2000 per month until the death benefit is exhausted. If the death benefit is not exhausted, any remaining amount would be paid to the insured's beneficiaries.

The other design accelerates the death benefit and also extends benefits when the death benefit is exhausted. With this design there are two funding resources for long-term care expenses: 1) the death benefit and 2) the extension of benefits rider.

Product designs differ. Some extension riders are purchased as separate policies and bound to the life insurance policy.

Others are integral to the product design and leverage the single premium to enhance the long-term care benefit pool. These are called linked benefit products. Benefits paid from the death benefit and the extension rider are tax-free.

These policies are often funded with a 1035 exchange from an existing permanent life insurance policy. Under Internal Revenue Code 1035 an individual can transfer the cash value from a life insurance contract to a long-term care contract without incurring a taxable event.

Annuities as tax-advantaged LTCI funding solutions

Annuity based long-term care solutions must be Pension Protection Act (PPA) compliant. These annuities are medically underwritten and carriers offering these products must have claims departments and be in the business of paying long-term care benefits. There are only a few of these products in the market today.

These, too, are integrated plans and cover services in all venues. As with other asset-based products, options are limited. These products are designed for an older client between ages 40 to 85 and have the most lenient underwriting requirements.

As with life insurance, provisions of the PPA allow a 1035 exchange of cash value from a non-qualified deferred annuity to a compliant annuity. Funds used to pay for long-term care are no longer viewed as taxable income but considered a “reduction of cost basis.”

A reduction of cost basis means that distributions from the policy are non-taxable and reduce the owner’s cost basis in the contract. Even gain in the old annuity is considered non-taxable if the withdrawal is made to pay for covered long-term care expenses. Withdrawals for other purposes are taxable.

PPA annuities have two designs. One uses the annuity fund to pay for long-term care expenses and credits withdrawals for covered expenses at a higher interest rate than funds withdrawn for other purposes.

Funds withdrawn for care expenses are tax-free. Withdrawals for other purposes are taxable. An extension of benefits rider can be added to this design to continue benefits once the annuity is exhausted.

In the second design the extension of benefits component is integral to the product design and funded with a single premium. This allows greater leverage of the premium to create a more robust long-term care benefit.

If clients need care, annuities are the most costly insurance solution but often the best solution for older clients with health challenges as underwriting is quite lenient.

It all depends…

We're really not trying to be evasive about which product we like the best and recommend. It just really depends on a client's health, wealth and financial goals.

What's important is that all of these products safeguard income and assets from the risk of long-term care expense.

MY GREATEST FEAR…

By Nicole GurleyUncategorizedAlzheimer's research funding, brain health, dementia is costly

Friends and business colleagues know that my number one fear is dementia. It's my sister's, too. And, my brother's, too. We've seen it first-hand. Our sweet mother needed prompting and then hands-on assistance for about 14 years.

Dementia consumed every family conversation and gathering

Mom died in 2012. We were concerned that dad might die before mom. Even with long-term care insurance, dad was mom's primary caregiver for most of her illness. We saw the toll it took on him. Today, he is vibrant, productive, physically robust and a very lucid 98 years old. Living independently, tending his organic garden, cheering for the Texas Rangers, volunteering and enjoying life. But that was not always the case.

For over a decade every family conversation was about dementia. Was mom better on the new medication? Should mom and dad move closer to one of the kids? How was dad coping? Was the new caregiver companion working out?

There are around 5.8 million people in the United States living with Alzheimer's disease, the most common form of dementia in older adults. But new research into biomarkers suggests that the actual number may be closer to 11 million when including those who are not yet symptomatic. Frightening thought.

Dementia, including Alzheimer's, is the number one cause of long-term care insurance claims comprising about 34% of claims but 50 cents of every insurance dollar spent on care. Yet less than half a cent of every dollar spent on care is spent on research. Upside down priorities?

Evidence and interventions promising but inconclusive

A recent extensive review commissioned by the National Institute on Aging concluded that although encouraging the evidence was inconclusive as to the effectiveness of cognitive training, hypertension management and exercise on mild cognitive impairment or dementia.

I find presentations on dementia depressing. Not hopeful or helpful. That is until recently when I attended a luncheon and learned about glutamate and rigorous novelty. The lecture was by Dr. John DenBoer, a leading neuropsychologist in the area of early stage dementia and detection.

What do you know about glutamate? I'm not talking about MSG, the additive in some Chinese food. Glutamate is the major excitatory transmitter in the brain and is involved in most aspects of normal brain function including cognition, memory and learning. That's about as technical as I'm going to get.

What's exciting, at least to me, is that when the brain learns new and challenging information it releases glutamate. Glutamate plays a key role in keeping the brain strong and healthy. And, it prevents memory loss!

Dr. DenBoer gives lectures all over the Phoenix area. If you or someone you care about is concerned about cognitive decline, I urge you to attend one of his lectures.
Visit www.smarbrainaging.com to learn more.

More funding is needed

Remember back in the 1960s when it was not uncommon for Americans to die of heart attacks in their fifties or sixties? Today, the effects of smoking, cholesterol, diabetes, high

blood pressure, obesity and physical inactivity on the development of heart disease are well established. Advanced technologies continue to improve diagnosis and treatment.

Since 2000, deaths from heart disease have decreased 14% while deaths from Alzheimer's have increased 89%. Yes, it took decades to get where we are today with heart health. But shouldn't we look at brain health as we did heart health decades ago? Shouldn't we fund more than pennies on research for the dollars spent on care? After all, this is the disease that is likely to affect us all in some way.

Is there a distinct correlation between research efforts and reduced mortality? Most would say yes. The more funding focused at a specific disease the better the resulting diagnoses and treatment as we've seen in breast cancer and HIV.

Why then do we not allocate more funding for research at the problem that has increased due to longevity and aging baby boomers?

The cycle from submission to funding of a research project at the National Institutes of Health is approximately one year if the project is lucky enough to receive funding on the first try. The time frame doubles if additional submissions are needed. The research proposed projects can last up to five years.

Simple logic suggests that if fewer projects are funded because of insufficient research funds, there will be fewer opportunities for success in biomedical research.

Dementia is costly to society

The costs of health care and long-term care for individuals with dementias are substantial.

Total payments in 2019 for all individuals with dementia including Alzheimer's are estimated at $290 billion. Medicare and Medicaid are expected to cover $195 billion, or 67 percent, of the total health care and long-term care payments.

Health care costs increase with dementia because:

- People with dementia have twice as many hospital stays per year as other older people.
- Medicare beneficiaries with dementia are more likely than those without dementia to have other chronic conditions.
- People with dementia comprise a large proportion of all elderly who receive adult day care and nursing home services.

Not included in these numbers are the 16 million family members and friends who provide unpaid care, a contribution valued at $234 billion last year.

The total annual payments for health care, long-term care and hospice care for people with dementia are projected to increase to more than $1.1 trillion in 2050. This dramatic rise

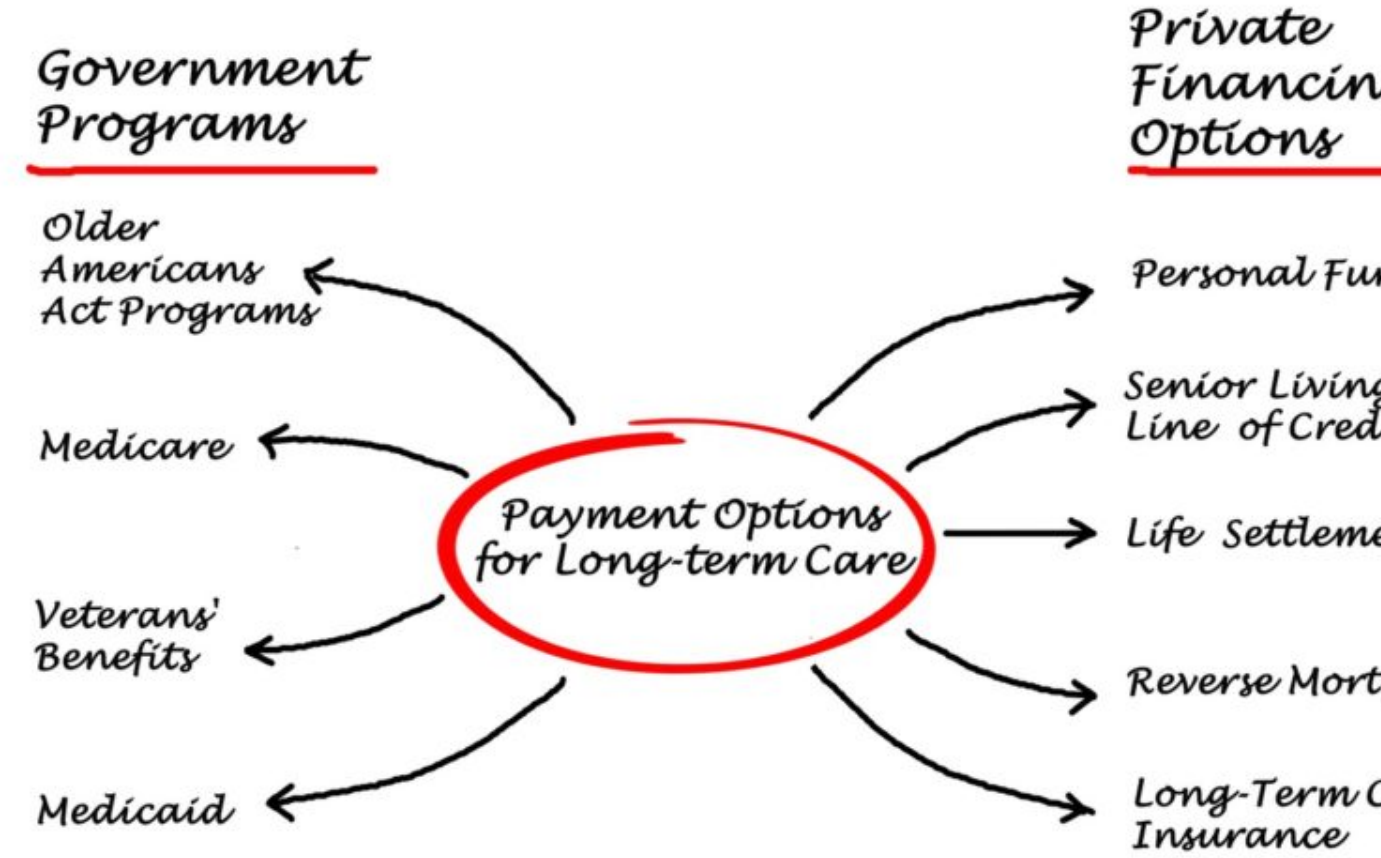
includes more than four-fold increases both in government spending under Medicare and Medicaid and in out-of-pocket costs.

The financial costs alone to our families, states and country will be enormous as baby boomers age. Add to that the emotional, physical and psychological cost of caring for a loved one who is cognitively impaired.

If you know someone concerned about dementia, tell them about www.smartbrainaging.com and www.brainuonline.com.
Find pathways to rigorous novelty for brain health. I'm signing up for Spanish lessons and resuming piano lessons. Taking up piano again would please my mom who was a concert pianist. Listening to her play was a joy.

WHAT'S YOUR LONG-TERM CARE FUNDING PLAN?

By Nicole GurleyUncategorizedcosts to family caregivers, long term care funding, LTC funding options



In his 2019 industry update, Jesse Slome, executive director of the American Association for Long-Term Care Insurance, reported that LTC insurance claims paid in 2018 totaled $10.3 billion.

Insurance pays a fraction of LTC costs

Sounds like a lot, doesn't it? Well, it's not. It's barely a fraction of the estimated costs.

According to a report published by the SCAN Foundation, private long-term care insurance accounted for less than 1% of the nearly $725 billion spent annually on long-term care.

State and federal government programs through Medicare, Medicaid and other government agencies fund about 29%.

Families' out-of-pocket costs and unpaid expenses fund the remaining 70%.

Why family caregivers face significant risks

- 62% spent savings and retirement funds to pay for care needs
- 77% of those employed missed work
- Missed hours equated to seven per week or 18% of a 40-hour work week
- Average lost income was 33% every year of caregiving

We could go on and on. As baby boomers age, it's only going to get worse without a plan to fund long-term care expense.

For most Americans there are just three funding options: self-fund, private insurance or government assistance. Read more about funding here.

WORRIED ABOUT OUTLIVING YOUR MONEY?

By Nicole GurleyUncategorizedmaximize Social Security income, retirement income, when to retire, why buy long-term care insurance

Boomers and Gen Xers may have retirement money worries in common. They both voice concerns about outliving income, but for different reasons.

In his article about retirement decisions, Steve Vernon reports on several research studies about retirement income. How to maximize Social Security income? Should retirement be postponed? How to manage medical costs and more.
Perhaps the most significant risk to financial security in retirement is the cost of long-term care.

Outliving income now the #1 retirement concern

Over the past 17 years we've heard many reasons why clients choose insurance as their funding option for long-term care. You can read about the top four reasons here.
But today, the number one reason that clients cite for buying long-term care insurance is different. It is the fear of outliving income.

We read a lot about retirement preparedness today. The 2016 National Retirement Risk Index reported that 50% of households were at risk of being able to maintain their standard of living in retirement.

The risk of needing long-term care is high – 70% for those of us age 65 and older.

And it's expensive – annual national median cost of home care $50,336, assisted living $48,000 and nursing home $100,375.

Yet, less than 10% of Americans age fifty and older own long-term care insurance!

WOMEN NEED LONG-TERM CARE MORE THAN MEN

By Nicole GurleyUncategorizedfamily caregivers, gender-based premiums

A few years ago, most long-term care insurance carriers introduced gender-based pricing. What does that mean? Women pay more for this insurance. Why? Because we live longer, use more insurance benefits and cost the insurer more money than men.

Carriers are pricing to their risk

Traditionally in our country, long-term care has been provided at home by family members – wives, daughters and daughters-in-law. But over the past two or three generations our society has changed significantly.

Today, women represent more than half of the work force. We have high divorce rates, especially among the graying population. Additionally, we're having smaller families, which results in fewer members to help with care needs. And, families are spread geographically

throughout the country. Relying on family to provide care is not the option that it once was and why being able to pay for care is more important and ever before.
The article, "Long-Term Care Planning is Important for Women," states that about 80% of care is still provided at home by unpaid family caregivers.

Do you really want your kids to take care of you?

Consider the financial impact on the financial future of women who become hands-on caregivers for elderly loved ones.

Potentially already at a disadvantage in earnings, time away from work or quitting all together impacts wages, retirement funding including employer contributions and Social Security income.

We're wired to take care of everyone else but neglect ourselves. A plan for long-term care should be a priority. Yes, long-term care may cost more today with gender-based premiums but it can still be affordable. Some coverage is better than none.