Financial Ratings Series

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Consumer Guide to Long-Term Care Insurance

SPRING 2024

GREY HOUSE PUBLISHING

What Our Ratings Mean

A **Excellent.** The company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, we believe that this company has the resources necessary to deal with severe economic conditions.

B **Good.** The company offers good financial security and has the resources to deal with a variety of adverse economic conditions. It comfortably exceeds the minimum levels for all of our rating criteria, and is likely to remain healthy for the near future. However, in the event of a severe recession or major financial crisis, we feel that this assessment should be reviewed to make sure that the firm is still maintaining adequate financial strength.

C **Fair.** The company offers fair financial security and is currently stable. But during an economic downturn or other financial pressures, we feel it may encounter difficulties in maintaining its financial stability.

D **Weak.** The company currently demonstrates what, in our opinion, we consider to be significant weaknesses which could negatively impact policyholders. In an unfavorable economic environment, these weaknesses could be magnified.

E **Very Weak.** The company currently demonstrates what we consider to be significant weaknesses and has also failed some of the basic tests that we use to identify fiscal stability. Therefore, even in a favorable economic environment, it is our opinion that policyholders could incur significant risks.

F **Failed.** The company is deemed failed if it is either 1) under supervision of an insurance regulatory authority; 2) in the process of rehabilitation; 3) in the process of liquidation; or 4) voluntarily dissolved after disciplinary or other regulatory action by an insurance regulatory authority.

+ The **plus sign** is an indication that the company is in the upper third of the letter grade.

- The **minus sign** is an indication that the company is in the lower third of the letter grade.

U **Unrated.** The company is unrated for one or more of the following reasons: (1) total assets are less than $1 million; (2) premium income for the current year was less than $100,000; or (3) the company functions almost exclusively as a holding company rather than as an underwriter; or, (4) in our opinion, we do not have enough information to reliably issue a rating.

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Part I:
Answers to Your Questions About Long-Term Care Insurance

When you hear the words "long-term care," what do you think of? Do you think about medical care or equate the term with "nursing home care?" While long-term care often does include medical care, it also includes a range of health, personal care, and social and supportive services provided by non-skilled medical staff in a variety of settings. Although younger people can need long-term care, nearly half of all newly started long-term care insurance claims begin for policyholders age 86 or older[1]. Roughly half of newly opened claimants received benefits for covered home care services with the rest paying for care in assisted living communities or skilled nursing homes[1]. As you can see, long-term care does not only take place in a nursing home. The options available to you today are both broader and more flexible than strictly nursing home coverage, including:

- limited in-home services – housekeeping, cooking, serving meals, etc.
- nursing and therapeutic services provided in the home or at a center on a part-time or intermittent basis – physical therapy, speech therapy, injections, etc.
- personal assistance with everyday life in a residential setting where you can live independently, with some oversight
- Plus, of course, 24-hour medical care in a nursing home

Much of this needed care and the associated costs will become an uninsured private responsibility falling to you and/or your family. In 2020 the average daily rate for home care services was $158.[2]

Long-term care insurance is one of several options that could both help pay for some of these costs and relieve the burden of care from your family when you can no longer perform normal activities of daily living.

[1] American Association for Long-Term Care Insurance (http://www.aaltci.org/long-term-care-insurance/)

[2] Genworth December 2020

What are the Types of Long-Term Care Needs and Services?

Custodial care, or supportive care, is by far the most common type of care in the U.S. Someone without medical training helps you with activities such as getting out of bed, walking, eating, and bathing. Homemaker services can provide companionship and assist with activities such as shopping, transportation, light housekeeping, or similar tasks.

Intermediate care is more serious and includes occasional nursing and rehabilitative care supervised by skilled medical personnel. It also includes basic medical procedures that are required sporadically and not on a 24-hour basis.

Skilled care is the highest level of care and the most expensive. A doctor prescribes care by a skilled nurse or therapist on a 24-hour per day basis.

You can receive these three levels of care in many forms, including:

- **At Home.** Most people prefer to stay at home as long as possible. If you have the financial resources, you can receive custodial, intermediate, and skilled care at home.
- **In An Adult Day Care Center.** The concept of adult day services is similar to that of child day care. Seniors are dropped off at the facility in the morning where they participate in activities and needed therapeutic services so their adult children can keep their full-time jobs.
- **In Assisted Living Facilities.** The philosophy of assisted living is to allow you the right to make choices about your health and safety. These facilities emphasize supervision and assistance as needed rather than on a scheduled basis. They typically provide help with activities of daily living, and if private nursing duty is needed, you can arrange and pay for it yourself.
- **In Nursing Homes.** Nursing homes can be either skilled nursing facilities or intermediate care facilities. Skilled nursing facilities, in which registered nurses provide 24-hour nursing services, emphasize medical care with restorative, physical and occupational therapy. Intermediate care facilities provide less intensive nursing care by registered and practical nurses along with social and rehabilitative services. In a long-term care facility, patients receive

assistance with activities of daily living such as bathing, dressing, eating, toileting, transferring in and out of chairs and beds, and/or have cognitive limitations.

- **Through Hospice Care.** This type of care is provided in your home or in a hospice facility and is exclusively to manage pain and symptoms of terminally ill patients. Medicare covers hospice care provided in your home only.
- **In Continuing Care Retirement Communities.** These types of communities combine housing, healthcare, and social services across a continuum of independent living to nursing home care. Three types – all inclusive, modified, and fee-for-service – provide various levels of care at varying costs.

WARNING: Among the 50 states, no consistent definition exists for adult day care centers, assisted living facilities, or other community-based facilities. When you're shopping for a long-term care policy, get the definitions of the various facilities from the insurer whose policy you are considering. Then visit the facilities in your area to make sure they meet the definitions.

Ask Yourself the Following When Considering Long-Term Care Insurance

1. **Do you want to leave an inheritance?**

   If not, allocate your savings or assets to cover long-term care expenses and then, if necessary, purchase a long-term care policy for remaining needs. If so, a long-term care policy will help prevent your assets from being depleted by the costs.

2. **Do you have family who can take care of you?**

   If you have an adult child or other family member that could act as a caregiver, you may not need the coverage of a long-term care policy or can purchase one with fewer benefits at a cheaper price.

3. **What is your medical history?**

   Much depends on your health status, the medical history of your family, and your lifestyle. If you're concerned you may get a chronic health condition, then long-term care is likely.

4. **Can you afford it?**

   To answer this one, you've got to know your current budget and have a handle on your future financial situation as well.

   Hint: It's easier to plan if you have a fixed retirement income. Assuming inflation doesn't pop up again between now and then, a fixed income helps you know ahead of time if you can cover the premium payments. Otherwise, you could wind up paying premiums on a policy for years, be forced to stop when you can't afford it any longer, let the policy lapse, and then lose everything you've paid into it.

   A simple rule of thumb: If you have to use your savings or make significant lifestyle changes to pay the premiums, don't do it. It probably means you can't afford it. Each person's situation is unique and other factors including personal experiences, family support, where you reside, and potential tax breaks available in your state should be taken into consideration.

5. **What about Medicaid?**

   The Medicaid program was designed to serve those who cannot afford to pay the expenses of long-term care themselves. Medicaid will cover your nursing home expenses if your assets and income are below the level defined in your state. If you're not already at that level, you can get there by spending down your assets or transferring them to someone else. In 2006, legislation was passed that would create a five-year look-back period for all transfer of assets. Under the prior law, there was a five-year look-back period for transfers to certain trusts and a three-year look-back for all other transfers. More importantly, the penalty period of ineligibility does not begin until a person applies for Medicaid and is determined eligible. Under the old rules, the penalty period would begin from the month of transfer.

   Under the prior law, there was a five-year look-back period for transfers to certain trusts and a

three-year look-back for all other transfers. More importantly, the penalty period of ineligibility does not begin until a person applies for Medicaid and is determined eligible. Under the old rules, the penalty period would begin from the month of transfer.

Going on Medicaid, however, is not something we recommend if you can avoid it. In general, it's not a good idea to deplete all your assets, and the quality of care you would receive through Medicaid is questionable.

In order for Medicaid to pay for nursing home care, the facility must be a certified Medicaid provider in the state. You may have more choices of nursing homes as a private pay patient. Many nursing homes are reluctant to accept Medicaid patients because the reimbursement rate is lower than what the nursing home charges private pay patients.

If you live in Connecticut, Indiana, New York or California, your access to Medicaid is easier. These four states have formed Partnership Programs whereby, you can purchase certain approved long-term care policies; once you have exhausted the benefits from the policy, Medicaid takes over. In these states, you can retain your assets, up to the value of the policy, provided you meet all other Medicaid eligibility criteria. Legislation enacted in 2006 allows states across the nation to make LTC partnership plans available to residents. Most states are considering this option and may be a good alternative for you to consider. If you reside in one of the states that already have a partnership program in place, refer to the Appendix of this guide for numbers you can call for information.

6. Does your employer or association offer a group policy?

You should check into them, but they are not often the best deal. True group policies do not require any medical underwriting therefore in order to cover possibly large claims they are priced higher than what you could get an individual policy for if you are in good health. Also you will only get a small benefit selection that may not fit your needs. However, some employers or other groups offer individual policies which are medically underwritten, but you get a group discount with the carrier plus all the benefit choices that would normally be available.

7. Do I need a tax-qualified long-term care policy?

Not necessarily. Benefits you receive on qualified policies, up to a certain limit, are nontaxable. The limit in 2023 is $420 per day or up to $135,360 annually[3], and it goes up every year with the medical portion of the consumer price index. You can also deduct the premiums you pay each month. However, there are two restrictions. First, the premiums and other medical expenses have to exceed 10% of your adjusted gross income. Second, there's a limit on the total long-term care premium that you can deduct depending on your age:[3]

For the 2023 tax Year, If you're	**You can deduct up to:**
40 and younger	$480
41 to 50	$890
51 to 60	$1,790
61 to 70	$4,770
71 and older	$5,960

Is your policy qualified for all these tax deductions? If you bought it before January 2, 1997, yes. If not, it must meet certain federal requirements:

- The coverage kicks in only when: 1) you're unable to perform at least two activities of daily living ("ADLs") without substantial assistance from another person. These generally include bathing, dressing, eating, using the toilet, and moving from place to place. Or 2) you're experiencing severe cognitive impairment.
- A physician certifies that the disability(ies) for which you need care are expected to last at least 90 days. See the Appendix for a comparison of tax-qualified and non-qualified policies.

[3] Note: These dollar limits are indexed according to increases in the medical care component of the consumer price index.
Source: https://www.irs.gov/pub/irs-drop/rp-21-45.pdf

8. Is the use of a Reverse Mortgage an option?

There is a good chance that the equity you have in your home is the largest single asset you have. A reverse mortgage is a way of tapping into home equity without creating monthly payments like a home-equity loan, and the money is not required to be paid back during your lifetime. Instead of making payments, the cash flow is reversed and you receive payments from the bank. If you do not pay the interest, it will accrue against the value of the home. Any interest paid is deductible against income, as would any mortgage interest. The loan is not due and payable until you sell, move out permanently, or pass away. At such time, the balance of borrowed funds is due with any additional remaining equity belonging to you or your beneficiaries.

The cash flow from a reverse mortgage may provide some or all of the income needed to cover long-term care services, or you could choose to use them to pay the premium on a long-term care policy.

Work with a reverse mortgage advisor to find out more about this financing option and how to qualify.

What About Medicare? What Does it Cover?

Medicare is not meant to be used to cover long-term care needs. Most of the nursing home care it covers is for short-term stays following hospitalization and for some home health care. Here's what Medicare does cover:

Skilled Nursing Care

To qualify for skilled nursing benefits under Medicare Part A, you must:

- Require daily skilled care which can only be provided in a skilled nursing facility on an inpatient basis.
- Be in the hospital for at least three consecutive days (not counting the day of discharge) before entering a skilled nursing facility that is certified by Medicare.
- Be admitted to the skilled nursing facility for the same condition for which you were treated in the hospital.
- Generally be admitted to the facility within 30 days of your discharge from the hospital.
- Be certified by a medical professional as needing skilled nursing or skilled rehabilitation services on a daily basis.

Medicare pays all expenses for the first 20 days you stay in a skilled nursing facility. Then for the next 80 days, you must pay a daily coinsurance amount. After those 100 days, you are personally responsible for all charges. Medicare does not pay for any services beyond 100 days nor does it pay for services in a skilled nursing facility or nursing home that are primarily personal or custodial care such as bathing, eating, and dressing. These, unfortunately, are the services most needed by elderly Americans.

Home Health Care

Medicare pays the full amount of home health visits certified as medically necessary and provided by a Medicare-approved home health agency. A home health agency provides skilled nursing care, physical therapy, speech therapy, and other therapeutic services. It also provides personal care services as long as you need one or more skilled services at the same time.

Access to Medicare home health care is restricted with the intent of only covering acute-care recovering patients. To qualify for home health care benefits under Medicare Part A, you must meet all four requirements:

- Need frequent skilled nursing care, physical therapy, or speech therapy
- Be confined to your home
- Be under a physician's care
- Receive services from a Medicare-certified home health agency

You do not have to pay a deductible or coinsurance, and no prior hospitalization is required before receiving home health care benefits. Medicare also covers a portion of the cost of durable medical equipment like wheelchairs and hospital beds that are provided and supervised by a physician.

Hospice Care

Hospice care is a program in which terminally ill patients are cared for. Caregivers make no attempt to cure the illness or disease but instead provide pain management and counseling services. Medicare pays for all hospice care provided in the home by a Medicare-approved hospice under Part A, including:

- Physician services
- Nursing care
- Medical appliances and supplies

- Drugs (for pain and symptom management)
- Short-term inpatient care – (a maximum of five days respite care to relieve the primary caregiver)
- Medical social services
- Physical therapy, occupational therapy, and speech/language pathology services
- Dietary and other counseling

You pay no deductible for these services. The only co-payments required are a maximum $5 payment for each prescription drug and an approximate $5 per day (depending on the area of the country) charge for respite care in the hospice facility.

Will Medigap Insurance Cover Your LTC Needs?

Many people choose to purchase *Medicare supplement insurance*, or *Medigap*, to fill in the gaps of coverage in Medicare. However, Medigap primarily covers the deductibles and coinsurance amounts for Medicare-approved benefits only. With the exception of preventive screenings and foreign travel emergency benefits, Medigap does not cover types of services beyond those not covered by Medicare.

With respect to long-term care services, some standard Medigap plans cover only two types of services.

- **Plans C, D, F, and G** cover the daily coinsurance amount for skilled nursing facility care for the 21st throughout the 100th day you are in a skilled nursing facility only. Plans K and L cover a portion (50% and 75%, respectively) of the coinsurance amount.
- **Plans D, and G** had an at-home recovery benefit up until June 2010, typically up to $40 per visit, up to seven visits a week for a maximum of eight weeks after your Medicare-covered home health care visits stop. The maximum benefit per year is $1,632 and to qualify for the at-home recovery benefit you must receive Medicare-covered home health care services after an illness, injury, or surgery. The services covered by the Medigap policy must be ordered by your doctor. The at-home recovery benefit is not available to new plan holders.

Part II:
Steps to Follow
When Selecting a
LTC Insurance Policy

What You Need to Know About Long-Term Care Insurance Policies

Long-term care insurance is a very complicated product. With so many benefit options to select from, there are hundreds of possible combinations and premium choices. Educating yourself before seeking assistance from an insurance specialist is essential. You need to understand the most often used terminology so that you can ask the right questions and understand what you are purchasing. Follow these steps when selecting a long-term care insurance policy:

1. **Determine the coverage you want.** Most people want to stay at home as long as possible and stay out of a nursing home. Because of this, very few policies are nursing home only policies. Comprehensive plans include benefits for services at all levels including facility care, home care, and community-based care. If you expect that your family will be able to provide home health care services, then seek out a policy that considers them eligible and will pay benefits for their services. Coverage for homemaker or companion services (ie. light housekeeping, transportation, meal preparation) may also be important to you and could relieve some of the burden from your family.

2. **Understand the core components of a LTC policy.** All policies include three basic components. How these are structured and defined will greatly affect your policy coverage and the premium you will pay.

- The **daily benefit** – the amount the policy will pay for each day of covered services. The best way to determine what you will need is to contact some local nursing homes, assisted living facilities, and home health agencies and ask them what their average daily cost is. According to the Genworth 2020 Cost of Care Survey, the average cost of a private room in a nursing home is $290 per day and a home health aide averages $24 per hour. The amount you will need depends upon your location and the type of facility or service you choose.

While all the policies call it a daily benefit, it is becoming common to offer variations such as weekly or monthly pay outs which offer you greater flexibility. For example, with a daily benefit of $100 you will be paid up to $100 for any given day you have care. But a weekly benefit of $100 per day is $700, which would allow for reimbursement of expenses up to $700 for the week no matter how much was incurred on any one day during that week. Some policies list separate and independent benefit amounts depending on the service – usually split between facility and home-care/community-based care. You will want to pay particular attention to where assisted-living facilities fall within these categories.

- The **benefit period** – the length of time the policy will pay benefits or the maximum value of benefits to be paid. Without a crystal ball, you can't know how long you'll need benefits. A combination of home care, assisted living, and nursing home care could easily add up to a five- or six-year period of time. Keep in mind that if you have family members or friends to help you at home you may not need as much paid care benefits as you would otherwise. Your safest bet is to pay for lifetime benefits but, depending on your financial situation, you may not be able to afford the premiums for such a policy.

  Many plans are considered "pool of money" contracts. These policies extend your benefits past the benefit period if there are still unused funds. Unused funds accumulate from those days in which no benefits were paid or where the full daily benefit was not paid out. For example, if you have a daily benefit of $100 but incur only $60 in expenses you would have $40 of unused funds still available. To calculate your total pool of money, multiply the daily benefit by the number of days in the benefit period. For instance, at a $100 daily benefit for four years (1,460 days) the pool of money or funds available to you equals $146,000. "Stated period" policies will only pay out for the specified benefit period, regardless if you used the full amount available.

- The **elimination period**, or deductible period – the amount of time you pay for services before insurance takes over. What you choose for this depends entirely on your financial situation and how long you can afford to pay for your own care without depleting your assets. Typically, the

longer the elimination period, the lower the policy's premium. You can usually select from 0, 30, 60, 90, or 180 days depending on the policy and insurance company. But you must find out exactly how the elimination period is satisfied. Let's say, for example, you need care on days 1, 4, and 10. With some policies, that would be counted as only THREE days toward your elimination period. With other policies, it would be counted as TEN days, which would mean you would start collecting the benefits much sooner. Pay close attention to how the policy defines the elimination period.

- The **eligibility triggers**, or ADL triggers – the events that need to occur before benefits can be accessed. You are required to meet a specific level of disability in activities of daily living before becoming eligible to receive benefits. Most policies will qualify for you if (1) you are unable to perform a certain number of activities of daily living or (2) you have severe cognitive impairment. ADLs include bathing, dressing, eating, toileting, continence and transferring. The way insurers assess people for an ADL disability varies from one company to another.
- The **reimbursement method** – the benefit payout definition once eligibility has been established. As mentioned above, the "daily benefit" may be reimbursed in daily, weekly, or monthly amounts. Benefits may be paid out in one of two ways. With the claims-based method, every expense must be submitted for reimbursement. Under this method, only eligible expenses will be paid and only up to the amount incurred. Under an indemnity-based method, once you qualify for benefits, you don't submit claims but instead receive a check for the maximum allowable benefit. You can use the money to pay your costs, and if any is left over, pay for items not covered under the policy. Or you can save the extra to pay for future costs.

3. **Determine what extra benefits you would like to have.** Companies selling long-term care policies offer a vast number of extra features, some of which are very good and others that may not be worth the extra cost. They include:

- **Inflation protection.** As with anything, the cost of long-term care will increase at least as rapidly as inflation. So the cost of care by the time you actually need it may far exceed today's costs. If you're purchasing insurance ten or twenty years before you expect to use it, without inflation adjustments your benefits may do very little to pay your actual costs.

We highly recommend you consider purchasing this option. You can choose between a *simple* and *compound* benefit increase. Under a simple increase, your benefit will go up by a specific percentage of your *original* daily benefit each year. With a compound increase, your benefit will go up by a specific percentage of your *previous year's* benefit each year. The percentage is usually five percent. Another type of inflation protection is where the plan offers an increase, usually fifteen percent, every three years. The addition to coverage is charged at your current age and is added to the existing premium. If you fail to choose an increase over a certain number of consecutive offers, the policy feature is usually rescinded. This feature is risky since you may forget to elect the increase and it could be very costly.

- **Waiver of premium.** After you receive long-term care services for a designated period of time, some policies waive payment of your premiums while you receive benefits. Other companies waive your premium forever once you've been in a nursing home for a certain period of time, even if you completely recover. Many companies break this benefit down between nursing home care and home health services. This is an important feature to have and is often bundled into a policy rather than being sold separately.
- **Nonforfeiture.** Chances are very good that you will never need the benefits provided by a long-term care policy. Recognizing this, you may stop paying premiums if, at some point, you decide that they are too high or that you won't need insurance any longer. Some companies offer a benefit where you can receive a partial refund of your premiums if you cancel the policy or you die. Other companies reduce your benefit period or benefit amount if you cancel because of increased premiums. This non-forfeiture feature alone increases the cost of your premium so you are better off purchasing an affordable policy at the outset. Some states require that policies include a non-forfeiture benefit, sometimes referred to as contingent benefit on lapse (CBL), that is triggered when a consumer stops paying premiums following the notice of a rate increase. The person retains some policy benefits that are equal to the premiums they have paid up to that time.
- **Restoration of benefits.** Some policies will restore your full benefit period if you go without using long-term care benefits for six full months. For example, if your policy has a three-year benefit period and you spent one year in a nursing home, your full three-year benefit would be

restored if you spent the next six months without care. This type of situation is very unusual. Consequently, you should not base your decision to purchase a policy on the availability of this extra feature.

- **Spousal discount.** If both you and your spouse purchase a policy from the same company, the company will often give you each a discount on your annual premium. Some companies require the policies to be exactly the same. However, men usually have different long-term care needs than women, since women tend to live longer and be alone in their later years. If the company you are considering provides a discount when your policy is different than your spouse's, it's worth considering.
- **Payment discount.** Some insurers prefer you pay the premium on a monthly basis while others prefer annual. Find out if they provide any discounts for paying based on their preferred method.
- **Bed reservation.** If you are staying in a nursing facility or other type of facility, times may arise when you have to leave temporarily to enter a hospital or to visit family. So that you won't lose your room at the facility, your policy will pay for the room while you are gone.
- **Alternate care plan.** This feature allows you to choose the care and setting appropriate to your needs. Unfortunately, many companies word the policy language so that it really means that if, at the time you need care, you want something that the policy doesn't cover, we'll consider it….but no guarantees. Consequently, this benefit is only as good as the company's willingness to use it.
- **Guaranteed Renewable.** This means that the insurer may not cancel your coverage for any reason except for nonpayment of premiums. Your coverage may not be cancelled because of your age or your health, but the insurer does have the right to increase premiums.

4. **Compare the premiums of various policies.** Four things go into the premiums set by a long-term care insurer: the amount of benefits provided in the policy, the underwriting standards, the distribution costs of selling the policy, and the margins to fund future growth. As a potential policyholder, you usually do not know the details of each of these four items, but you can get good information about the first three.

You'll know the types of benefits offered in the policy as compared to other policies-all else being equal, the more benefits provided the higher the premium. Be sure to read the details of any policy. Some policies may look very similar but slight variations may explain the difference in the premium being charged. Make sure to check the criteria that trigger the benefits, definition of facilities, any available discounts, how the elimination period is satisfied, and if the policy is tax qualified. Take particular note of the way benefits are reimbursed. Do you receive the full daily benefit despite the actual costs incurred (indemnity) or are you reimbursed based on actual expenses and allowed to use the extra funds at another time?

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Be aware that if the health exams administered by the company are not very rigorous or they disregard much of the medical information provided by policyholders, the company is most likely bringing in as many policyholders (and premiums) as it can up front. Down the road, it will typically have a high claim denial rate to make up for its poor underwriting standards. This practice is generally more expensive and riskier for the insurer. Thus, premiums are higher to make up for that additional risk.

You typically don't know what it costs for the company to distribute its product. However, the largest part of that distribution cost is the commission paid to the agent who sells you your policy. You are perfectly within your right to ask your agent what his or her commission will be on the product. He or she will most likely have a slick non-answer for you, but be persistent.

The bottom line is that you should be skeptical of policies that have comprehensive benefits, loose underwriting standards, high agent commissions, *and* low premiums. It's the old adage: if it sounds too good to be true, it probably is!

5. **Ask Questions.** Insurance agents can be intimidating for many people. If yours makes you uncomfortable, don't hesitate to go to another agent. There are plenty to choose from. Don't be afraid to ask questions! It's your money and your future! Here are a few key questions to ask:

- **What percentage of applicants does the company decline?** On average, companies reject about 8 to 25 percent of applicants with 15 percent being the average. If the company to which you're applying has an above-average rejection rate, your chance of being rejected is higher if you have pre-existing conditions.
- **What percentage of customers are rated less than standard?** Companies usually have three classes of rates: preferred, standard, and substandard. Most people are considered "standard." Those with superior health are considered "preferred" and receive lower rates, because they are less likely to require expensive care. Likewise, those with chronic health problems who are likely to use a lot of health services are considered "substandard." Some companies play games with these labels so make sure you know what the various classes are. If the company rates the majority of its policyholders substandard, does it have a class lower than substandard or is it very strict with underwriting?
- **What is the company's safety rating?** We recommend that the company have a B+ or higher Weiss Safety Rating if you are purchasing insurance that you don't expect to use in the next ten years. A "B+" or higher rated company is more likely to be around for many years from now. If you plan to use your insurance in less than ten years, you may want to weigh the possibilities of going with a company that has a "B" or "B-" Safety Rating.
- **How long has the company been selling long-term care insurance?** Companies with several years of experience in writing long-term care policies have also had experience in paying claims which means their ability to accurately price their coverage may be better. This means you are less likely to be hit with a rate increase down the road.

- **Has the company ever raised the premiums on this policy?** Most companies will give you a resounding no. Don't be satisfied there. Typically when a company applies to its state regulators to raise the premiums on a policy, it will also change the identification number of the policy. This technically makes it a new policy. So it may by nearly or exactly the same as the previous policy but have a new premium.

The company or agent can technically tell you that the premiums have never been raised on the existing policy. You should ask specifically if the company has ever raised premiums on *this type of policy*.

Long-Term Care Insurance Planner: help guide you through some of the questions you need to ask yourself and your agent, we have included our Long-Term Care Insurance Planner in the Appendix of this Guide. The Planner will help you to narrow down the choice of features you want included in a policy and it provides assistance in identifying the policy that best meets the criteria you outlined.

Alternatives to Standard Long-Term Care Insurance

The structure and benefits we have described thus far are typical of a stand-alone long-term care insurance policy. However, as the need for these benefits grow so does the number of insurance alternatives available. At least for now, most people would not find these options suitable – either the cost would be too high, the benefits too limited, or the medical underwriting too strict. In brief, you may hear about:

Life insurance with an accelerated death benefit – where the policy pays part of the death benefit for terminal illness or doctor-certified, terminal, long-term care confinement while you are alive. A long-term care insurance rider can also be added that includes benefits that are similar to those in stand-alone LTC insurance policies which are typically paid out after the accelerated payment for the death benefit has been exhausted.

Another way to package LTC insurance is as an "either/or" feature in life insurance. If you need long-term care, specified benefits are paid instead of life insurance. If all the benefits are not used, a reduced amount at death would be paid out.

An **annuity** can also be combined with a LTC insurance rider where the benefits are paid only after the cash value of the annuity are used.

A **disability income policy** could also be packaged with long-term care benefits. Prior to age 65, the policy can only be used for disability income and then after 65 provide long-term care coverage.

Other alternatives and benefit designs will continually be in the pipeline. If you decide to put aside your decision to purchase long-term care insurance until a future time, you should seek these out to find the most suitable product for your needs.

Part III:
LTC Premium Rates

The following long-term care premium rates have been prepared to give you an idea of the range of premiums you are likely to encounter based on your age and desired level of coverage.

Benefits Provided Under Policies in Scenario I
Basic Coverage

Nursing Home Care in a licensed facility that provides 24-hour services at the level needed by the individual:

> **Skilled care** by medical personnel such as registered nurses or professional therapists that follow a treatment plan prescribed by a doctor.
>
> **Intermediate nursing care** ordered by a physician and supervised by registered nurses on less than a 24-hour basis.
>
> **Custodial care**, also known as "personal care," by non-medical personnel who assist in performing activities of daily living. These activities include bathing, eating, dressing, walking, moving from bed to chair, toileting, and maintaining continence.

Assisted Living in a residential setting that provides continuous care to meet the needs of those with cognitive impairment or an inability to perform activities of daily living.

Elimination Period during which no benefits are paid toward the policyholder's long-term care expenses. This is also called the "waiting period" and is comparable to the deductible on a regular health insurance policy. The elimination period for this scenario may vary up to 90 days.

2-Year Benefit Period which is the maximum length of time that the policy will pay its daily benefit.

$100 Daily Benefit which is the maximum amount paid by the company per day toward covered care.

Scenario I

Premium Amount Without Inflation Protection Option

Age	Average Premium	Lowest Premium	Median Premium	Highest Premium
30	$421	$285	$433	$791
35	$444	$314	$433	$851
40	$456	$314	$433	$898
45	$516	$371	$464	$1,005
50	$586	$428	$519	$1,106
55	$721	$570	$616	$1,283
60	$917	$684	$781	$1,608
65	$1,275	$998	$1,116	$2,102
70	$1,881	$1,311	$1,680	$3,385
75	$2,904	$2,138	$2,707	$5,019

Premium Amount With Inflation Protection Option

Age	Average Premium	Lowest Premium	Median Premium	Highest Premium
30	$1,142	$810	$1,095	$3,238
35	$1,173	$863	$1,124	$3,384
40	$1,222	$892	$1,170	$3,523
45	$1,359	$1,028	$1,307	$3,625
50	$1,485	$1,134	$1,456	$3,783
55	$1,712	$1,323	$1,682	$4,133
60	$1,984	$1,515	$1,948	$4,836
65	$2,495	$2,030	$2,454	$5,754
70	$3,166	$2,534	$3,107	$7,875
75	$4,595	$3,635	$4,463	$10,241

Benefits Provided Under Policies in Scenario II
Intermediate Coverage A

Nursing Home Care in a licensed facility that provides 24-hour services at the level needed by the individual.

In-Home Care up to 24 hours a day at the level needed by the individual, including respite care for a short period of time, at home or in a facility, designed to provide relief to the primary caregiver.

Community-Based Care up to 24 hours a day at the level needed by the individual. Types of community-based care include:

> **Hospice Care** for terminally ill patients who have usually been diagnosed with six months or less to live.
>
> **Adult Day Care** in a facility on less than a 24-hour-a-day basis for personal care services or assistance with activities of daily living such as bathing, walking, and eating.

Assisted Living in a residential setting that provides continuous care to meet the needs of those with cognitive impairment or an inability to perform activities of daily living.

Elimination Period during which no benefits are paid, also called the "waiting period." This is comparable to the deductible on a regular health insurance policy. The elimination period for this scenario may vary up to 90 days.

Benefit Period which is the maximum time that a company will pay your daily benefit. The benefit period for this scenario may vary up to 6 years.

$200 Daily Benefit which is the maximum amount paid by the company per day toward covered care.

Levels of care dictated by the individual's needs include:

> **Skilled care** by medical personnel such as registered nurses and professional therapists that follow a treatment plan prescribed by a doctor.
>
> **Intermediate nursing care** ordered by a physician and supervised by registered nurses on less than a 24-hour basis.
>
> **Custodial care**, also known as "personal care," by non-medical personnel who assist in performing activities of daily living. These activities include bathing, eating, dressing, walking, moving from bed to chair, toileting, and maintaining continence.

Scenario II

Premium Amount Without Inflation Protection Option

Age	Average Premium	Lowest Premium	Median Premium	Highest Premium
30	$2,481	$2,124	$2,478	$2,840
35	$2,851	$2,401	$2,847	$3,286
40	$3,251	$2,709	$3,247	$3,771
45	$3,754	$3,148	$3,748	$4,386
50	$4,333	$3,663	$4,325	$5,094
55	$5,214	$4,478	$5,202	$6,179
60	$6,674	$5,764	$6,656	$7,965
65	$9,167	$7,888	$9,142	$11,019
70	$13,496	$11,481	$13,459	$16,360
75	$20,369	$17,206	$20,307	$25,094

Premium Amount With Inflation Protection Option

Age	Average Premium	Lowest Premium	Median Premium	Highest Premium
30	$15,781	$12,378	$15,755	$19,338
35	$14,998	$11,716	$14,974	$18,368
40	$14,203	$11,031	$14,182	$17,371
45	$13,524	$10,508	$13,505	$16,533
50	$13,050	$10,173	$13,031	$15,940
55	$13,132	$10,427	$13,108	$16,037
60	$13,894	$11,346	$13,863	$16,968
65	$16,316	$13,332	$16,279	$19,972
70	$20,990	$17,021	$20,942	$25,782
75	$28,002	$22,812	$27,929	$34,686

Part IV: Index of Long-Term Care Insurers

Following is a reference list of long-term care insurers with their Weiss Safety Rating, corporate address, phone number, and the states in which they are licensed. Although this list includes all insurers identified by Weiss Ratings as being licensed to do long-term care insurance business in some part if the country, it does not mean all companies are currently offering new policies.

Important Warnings and Cautions

1. A rating alone cannot tell the whole story. Please read the explanatory information contained in this publication. It is provided in order to give you an understanding of our rating philosophy, as well as paint a more complete picture of how we arrive at our opinion of a company's strengths and weaknesses.
2. Weiss Safety Ratings represent our opinion of a company's insolvency risk. As such, a high rating means we feel that the company has less chance of running into financial difficulties. A high rating is not a guarantee of solvency nor is a low rating a prediction of insolvency. Weiss Safety Ratings are not deemed to be a recommendation concerning the purchase or sale of the securities of any insurance company that is publicly owned.
3. Company performance is only one factor in determining a rating. Conditions in the marketplace and overall economic conditions are additional factors that may affect the company's financial strength. Therefore, a rating upgrade or downgrade does not necessarily reflect changes in the company's profits, capital or other financial measures, but may be due to external factors. Likewise, changes in Weiss Ratings' indexes may reflect changes in our risk assessment
of business or economic conditions as well as changes in company performance.
4. All firms that have the same Weiss Safety Rating should be considered to be essentially equal in safety. This is true regardless of any differences in the underlying numbers which might appear to indicate greater strengths. Weiss Safety Rating already takes into account a number of lesser factors which, due to space limitations, cannot be included in this publication.
5. A good rating requires consistency. If a company is excellent on four indicators and fair on one, the company may receive a fair rating. This requirement is necessary due to the fact that fiscal problems can arise from any one of several causes including speculative investments, inadequate capital resources or operating losses.
6. We are an independent rating agency and do not depend on the cooperation of the companies we rate. Our data are derived, for the most part, from annual and quarterly financial statements that we obtain from federal banking regulators and state insurance commissioners. The latter may be supplemented by information insurance companies voluntarily provide upon request. Although we seek to maintain an open line of communication with the companies, we do not grant
them the right to stop or influence publication of the ratings. This policy stems from the fact that this publication is designed for the protection of the consumer.
7. Affiliated companies do not automatically receive the same rating. We recognize that a troubled company may expect financial support from its parent or affiliates. Weiss Safety Ratings reflect our opinion of the measure of support that may become available to a subsidiary, if the subsidiary were to experience serious financial difficulties. In the case of a strong parent and a weaker subsidiary, the affiliate relationship will generally result in a higher
rating for the subsidiary than it would have on a stand-alone basis. Seldom, however, would the rating be brought up to the level of the parent. This treatment is appropriate because we do not assume the parent would have either the resources or when there is a binding legal obligation for a parent corporation to honor the policy obligations of its subsidiaries, the possibility exists that the subsidiary could be sold and lose its parental support. Therefore, it is quite common for one
affiliate to have a higher rating than another. This is another reason why it is especially important that you have the precise name of the company you are evaluating.

What Our Ratings Mean

A Excellent. The company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, we believe that this company has the resources necessary to deal with severe economic conditions.

B Good. The company offers good financial security and has the resources to deal with a variety of adverse economic conditions. It comfortably exceeds the minimum levels for all of our rating criteria, and is likely to remain healthy for the near future. However, in the event of a severe recession or major financial crisis, we feel that this assessment should be reviewed to make sure that the firm is still maintaining adequate financial strength.

C Fair. The company offers fair financial security and is currently stable. But during an economic downturn or other financial pressures, we feel it may encounter difficulties in maintaining its financial stability.

D Weak. The company currently demonstrates what, in our opinion, we consider to be significant weaknesses which could negatively impact policyholders. In an unfavorable economic environment, these weaknesses could be magnified.

E Very Weak. The company currently demonstrates what we consider to be significant weaknesses and has also failed some of the basic tests that we use to identify fiscal stability. Therefore, even in a favorable economic environment, it is our opinion that policyholders could incur significant risks.

F Failed. The company is deemed failed if it is either 1) under supervision of an insurance regulatory authority; 2) in the process of rehabilitation; 3) in the process of liquidation; or 4) voluntarily dissolved after disciplinary or other regulatory action by an insurance regulatory authority.

\+ **The plus sign** is an indication that the company is in the upper third of the letter grade.

– **The minus sign** is an indication that the company is in the lower third of the letter grade.

U Unrated Companies. The company is unrated for one or more of the following reasons: (1) total assets are less than $1 million; (2) premium income for the current year was less than $100,000; or (3) the company functions almost exclusively as a holding company rather than as an underwriter; or, (4) in our opinion, we do not have enough information to reliably issue a rating.

Company	Domicile State	Phone	Safety Rating
AMERICAN FAMILY LIFE INS CO **Address** 6000 AMERICAN PARKWAY, MADISON, WI 53783 **Licensed**	WI	(608) 249-2111	A+
AUTO-OWNERS LIFE INS CO **Address** 6101 ANACAPRI BOULEVARD, LANSING, MI 48917 **Licensed**	MI	(517) 323-1200	C+
BANKERS CONSECO LIFE INS CO **Address** 350 JERICHO TURNPIKE SUITE 304, JERICHO, NY 11753 **Licensed**	NY	(317) 817-6100	D
BANKERS LIFE & CAS CO **Address** 111 EAST WACKER DRIVE STE 2100, CHICAGO, IL 60601 **Licensed**	IL	(312) 396-6000	D+
BLUE CROSS BLUE SHIELD OF KANSAS INC **Address** 1133 SW TOPEKA BOULEVARD, TOPEKA, KS 66629 **Licensed**	KS	(785) 291-7000	C+
COUNTRY LIFE INS CO **Address** 1701 N TOWANDA AVENUE, BLOOMINGTON, IL 61701 **Licensed**	IL	(309) 821-3000	A+
FEDERAL LONG TERM CARE PARTNERS **Address** 100 ABORETUM DR, PORTSMOUTH, NH 03801 **Licensed**	NH	(800) 582-3337	
FORETHOUGHT LIFE INS CO **Address** 300 NORTH MERIDIAN ST STE 1800, INDIANAPOLIS, IN 46204 **Licensed**	IN	(317) 223-2700	B
GENWORTH LIFE INS CO **Address** 2711 CENTERVILLE ROAD STE 400, WILMINGTON, DE 19808 **Licensed**	DE	(804) 662-2400	B
GENWORTH LIFE INS CO OF NEW YORK **Address** 600 THIRD AVENUE SUITE 2400, NEW YORK, NY 10016 **Licensed**	NY	(212) 895-4137	C+
JOHN HANCOCK LIFE & HEALTH INS CO **Address** 197 CLARENDON STREET, BOSTON, MA 02116 **Licensed**	MA	(617) 572-6000	B
JOHN HANCOCK LIFE INS CO (USA) **Address** 201 TOWNSEND STREET SUITE 900, LANSING, MI 48933 **Licensed**	MI	(617) 572-6000	B-
KNIGHTS OF COLUMBUS **Address** **Licensed**	CT	(203) 752-4000	C+

Safety Rating: A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak; F = Failed; U = Unrated

Company	Domicile State	Phone	Safety Rating
LIFESECURE INS CO **Address** 10559 CITATION DRIVE SUITE 300, NEW HUDSON, MI 48165 **Licensed**	MI	(810) 220-7700	B
MADISON NATIONAL LIFE INS CO INC **Address** 1241 JOHN Q HAMMONS DRIVE, MADISON, WI 53717 **Licensed**	WI	(800) 356-9601	B
MASSACHUSETTS MUTUAL LIFE INS CO **Address** 1295 STATE STREET, SPRINGFIELD, MA 1111 **Licensed**	MA		B-
MEDAMERICA INS CO **Address** 651 HOLIDAY DRIVE FOSTER PLAZA, PITTSBURGH, PA 15520 **Licensed**	PA	(585) 238-4351	C
MEDAMERICA INS CO OF NEW YORK **Address** 165 COURT STREET, ROCHESTER, NY 14647 **Licensed**	NY	(585) 238-4351	E+
MUTUAL OF OMAHA INS CO **Address** MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175 **Licensed**	NE	(800) 775-6000	B
NEW YORK LIFE INS CO **Address** 51 MADISON AVENUE, NEW YORK, NY 10010 **Licensed**	NY	(212) 576-7000	A-
NORTHWESTERN LONG TERM CARE INS CO **Address** 720 EAST WISCONSIN AVENUE, MILWAUKEE, WI 53202 **Licensed**	WI	(414) 271-1444	B+
RESERVE NATIONAL INS CO **Address** 601 EAST BRITTON ROAD, CHICAGO, IL 60601 **Licensed**	OK	(405) 848-7931	C+
SILAC INSURANCE CO **Address** 3 TRIAD CENTER, SALT LAKE CITY, UT 84111 **Licensed**	UT	(801) 579-3400	D+
THRIVENT FINL FOR LUTHERANS **Address** 4321 N BALLARD RD, APPLETON, WI 54919 **Licensed**	WI	(800) 847-4836	C+
TRANSAMERICA FINANCIAL LIFE INS CO **Address** 440 MAMARONECK AVENUE, HARRISON, NY 10528 **Licensed**	NY	(914) 627-3630	B
TRANSAMERICA LIFE INS CO **Address** 4333 EDGEWOOD RD NE, CEDAR RAPIDS, IA 52499 **Licensed**	IA	(319) 355-8511	B

Safety Rating: A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak; F = Failed; U = Unrated

Company	Domicile State	Phone	Safety Rating
UNITED OF OMAHA LIFE INS CO **Address** MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175 **Licensed**	NE	(402) 342-7600	**B**
UNITED SECURITY ASR CO OF PA **Address** 673 EAST CHERRY LANE, SOUDERTON, PA 18964 **Licensed**	PA	(215) 723-3044	**C**

Appendix

Tax-Qualified vs. Non-Tax Qualified Policies

Tax-Qualified Policies

- **Benefit Triggers:** You will qualify for benefits under two conditions:

  1) You are unable to perform at least two activities of daily living ("ADLs") without substantial assistance from another person or

  2) You are experiencing severe cognitive impairment. The terms "substantial" or "severe" are defined by the insurance company which may limit your ability to qualify for benefits. In order for you to receive benefits, a licensed healthcare practitioner must certify that you meet one of the above conditions.

- **Minimum Length of Care Required:** In the case of ADLs, a physician must certify that your care will last for at least 90 days. But a lot can happen in a shorter period of time like 30 or 60 days. Even short events or facility stays can be very costly and wipe out a big portion of your savings.
- **Tax-deductible premiums:** You can claim your policy premiums as itemized medical expenses as long as they, with other medical expenses, exceed 7.5 percent of your adjusted gross income. There is a limit on total long-term care premiums that you can deduct, depending on your age. You should consult with a tax advisor on this matter.
- **Nontaxable benefits:** Benefits you receive from a qualified policy are not subject to federal income taxation, subject to a dollar cap.

Tax-Qualified vs. Non-Tax Qualified Policies

Non-Tax Qualified Policies

- **No Standardization:** There is no standardization between policies. Read the policies carefully to determine exactly what will qualify you to receive benefits. Subtle differences in definitions can mean the difference between coverage or not.
- **Benefit Triggers:** Most policies will qualify you for benefits under at least two conditions:

  1) You are unable to perform activities of daily living ("ADLs"). Policies will differ on the number of ADLs needed to qualify for benefits and on what defines an ADL.

  2) You are cognitively impaired. Some plans also allow for a third trigger often referred to as a "medical necessity" trigger. This means a doctor determines that you need care due to an injury or sickness. Many people who require care qualify under this trigger. Make sure to determine if the policy requires you to satisfy more than one trigger or if each are independent of the other.

- **Minimum Length of Care Not Required:** Non-tax qualified policies do not require the care to last at least 90 days.
- **Tax treatment of benefits unclear:** The IRS has yet to clarify whether or not the benefits received from a non-tax qualified policy are treated as taxable income. You should consult with a tax advisor on this matter. Some insurance companies will permit the policyholder to convert to a tax-qualified version with no new underwriting when the IRS rules on the tax status of a non-tax qualified plan.

Long-Term Care Insurance Planner

This planner is designed to help you decide what kind of long-term care insurance is best for you and help you shop for the policy that meets your needs. Many insurers charge a lot more – or less – for very similar policies. So there's a great benefit to shopping around. No policy is exactly alike. However, if you follow these steps, it will be easier to compare policies side by side:

Step 1. Try to determine, ahead of time, what type of care you think you will need from others beyond the assistance your own family members may be able to provide:

	Yes	No
Custodial Care	[ ]	[ ]
Intermediate Care	[ ]	[ ]
Skilled Care	[ ]	[ ]

This isn't easy, because it's often hard to anticipate your future needs, but try your best to decide if you're going to want access to one of the following. Custodial care is provided by someone without medical training who helps you with daily activities. Intermediate care includes occasional nursing and rehabilitative care supervised by skilled medical personnel. Skilled care includes 24-hour care provided by a skilled nurse or therapist.

Step 2. Decide where you would most likely be receiving the care?

	Yes	No
In-Home Care*	[ ]	[ ]
Nursing Home*	[ ]	[ ]
Adult Day Care	[ ]	[ ]
Assisted Living Facility	[ ]	[ ]
Other _____	[ ]	[ ]

*Typically available with all three levels of care – custodial, intermediate, and skilled.

Most people prefer in-home care. However, if you have no family members to help you at home, in-home care could be prohibitively expensive, especially if it requires skilled care. Nursing homes are designed for 24-hour care and are best utilized for short-term stays. Adult day care is an option, but will probably require someone, such as a family member, who can drop you off and pick you up daily. Assisted living facilities are increasingly popular, offering a good balance between independence and assistance. Other types of care could include hospice care (for the terminally ill) or respite care (temporary assistance to help relieve family members).

Step 3. Check out the facilities in the area in which you plan to live, make sure you're comfortable with them, and find out much how they cost:

	Estimated Costs
In-Home Care	_____
Nursing Home	_____
Assisted Living Facility	_____
Adult Day Care	_____
Other	_____

The insurance company is going to pay you a daily benefit that will be applied toward the cost of your care. Most of the costs above that daily benefit will have to come out of your own pocket. Therefore, find a facility that you'd be comfortable with, and then try to get a general idea of how much it would cost. Each facility may offer a different rate schedule for each level of care it provides, so make sure you understand the differences. For care within your home, contact a home care agency and ask them about the going rates for home nurses and therapists. Also consider costs associated with any modifications that may be needed for your home, such as wheelchair accessibility, handicap rails, etc.

Step 4. Try to estimate how much of the long-term care expenses you will be able to pay on your own: $_____per month.

Your financial planner may be able to give you an estimate of your retirement income available for health care. However, even a good estimate can be off the mark, so make sure your policy covers enough to avoid being financially strapped by long-term care expenses.

Later, make sure your agent takes this information into consideration when he works out the terms of your policy. He should limit your out-of-pocket expenses to what you have indicated here.

Step 5. Try to arrive at a reasonable guess regarding when you might start using the benefits.

Again, it's hard to predict. But if you're in reasonably good health and you have a family history of longevity, that's something to consider. If you're already suffering from chronic health problems, you may need the benefits sooner rather than later. If it's more than 10 years from now, you can buy a long-term care policy with an optional inflation protection feature to help protect against the rising cost of health care. This can add significantly to the cost, but you get what you pay for. Typically, the insurance company will add an extra five percent to your daily benefit, compounded annually. Thus, if the policy provides a $100 daily benefit now, it would rise to $163 in 10 years.

Step 6. Determine whether you prefer a "tax-qualified" policy or a "non-tax qualified" policy:

	Yes	No
Tax-Qualified Policy	[ ]	[ ]
Non-Tax Qualified Policy	[ ]	[ ]

If you buy a tax-qualified policy, you will be able to claim the policy premiums as itemized medical expenses on your tax return. Furthermore, the benefits you receive will not be subject to federal income taxation, up to a dollar cap. If you purchase a non-tax qualified policy, you will not be able to itemize the premiums. As to the benefits, the IRS has yet to clarify whether or not they will be subject to federal income taxation. Do not assume that a tax-qualified policy will automatically be more beneficial. Reason: Typically, a tax-qualified policy will have stricter guidelines as to when you can access the policy benefits. You also may not be able to take advantage of the tax benefits. You may want to consult with a tax advisor on this subject.

Step 7. Find insurance agents in your area that specialize in long-term care policies:

Agent Name	Phone Number	Specialization in LTC?	Name of Insurance Company
_____	_____	(Y / N)	_____
_____	_____	(Y / N)	_____
_____	_____	(Y / N)	_____

Long-term care insurance is very complex. Therefore, make sure you work with an agent who specializes in long-term care policies, and don't limit your choices to someone you know or who is associated with your broker. The agent should be able to help educate you and clarify any questions you have – not only on policies he or she sells, but on others as well. Try to avoid agents that work strictly with one insurance company. Complete the remaining steps with the direct assistance of the agent you choose.

Step 8. Ask your agent for the names of at least three different policies, from different insurers, that you can compare.

	Policy A	Policy B	Policy C
Insurance Company Name	_____	_____	_____
Policy Name/Number	_____	_____	_____

Step 9. Have your agent check the safety rating for each company.

	Safety Rating
Policy A:	_____
Policy B:	_____
Policy C:	_____

It may be a long time before you begin to submit claims. Therefore, you will want to make sure your insurance company will still be viable at that time. If you use Weiss Safety Ratings, we recommend you favor companies with a rating of B+ (good) or higher, and we suggest you avoid companies with a rating of D+ (weak) or lower.

Step 10. Favor companies that have more experience with long-term care insurance.

	Years of experience with long-term care	Have they ever raised rates for existing policyholders?
Policy A:	_____	(Y / N)
Policy B:	_____	(Y / N)
Policy C:	_____	(Y / N)

This should not be a deal breaker. But you're better off with a company that has been offering long-term care policies for a while and has never raised rates for existing policyholders. In contrast, companies that are new in long-term care – or have a history of raising rates on existing policies – are more likely to raise your rates in the future.

Step 11. If you're considering buying a policy with your spouse, check how you qualify for a spousal discount.

Policy A: _____
Policy B: _____
Policy C: _____

In some cases, you may need to be married to qualify; in others you don't have to be formally married. Some insurers require that the policies be exactly the same, while others do not.

Step 12. Ask your agent for quotes on the monthly premiums. Make sure the quotes are based on the preferences and needs that you outlined in steps 1-6.

	Single Policy Premium	Combined Policy Premium	% Savings
Policy A:	_____	_____	_____
Policy B:	_____	_____	_____
Policy C:	_____	_____	_____

If you can buy your long-term care policy with a spouse or significant other, make sure you take advantage of spousal discounts, which can save you up to 20% on the combined premium.

Step 13. Find out exactly what each policy covers in addition to the basics that you require:

	Policy A	Policy B	Policy C
Custodial	(Y / N)	(Y / N)	(Y / N)
Intermediate	(Y / N)	(Y / N)	(Y / N)
Skilled	(Y / N)	(Y / N)	(Y / N)

The actual policies that your agent has suggested may differ somewhat from your wish list of benefits, including some that you did not ask for, or excluding others that you wanted. This may help explain some, but not all, of the price differences.

Step 14. Ask your agent to give you a list of the types of facilities that are included and how they are defined. Facilities may include nursing home care, in-home care, adult day care, hospice care, assisted living facilities, and other options.

Policy A _____

_____

_____

Policy B _____

_____

_____

Policy C _____

_____

_____

Step 15. Find out the basic terms of coverage and reimbursement, as follows:

Policy A: How the company calculates elimination period: _____

Facility of Care	Elimination Periods	Benefit Periods	Daily Benefit
In-home care:	_____	_____	_____
Nursing home:	_____	_____	_____
Assisted living:	_____	_____	_____
Adult day care:	_____	_____	_____

Policy B: How the company calculates elimination period:_____

Facility of Care	Elimination Periods	Benefit Periods	Daily Benefit
In-home care:	_____	_____	_____
Nursing home:	_____	_____	_____
Assisted living:	_____	_____	_____
Adult day care:	_____	_____	_____

Policy C: How the company calculates elimination period:_____

Facility of Care	Elimination Periods	Benefit Periods	Daily Benefit
In-home care:	_____	_____	_____
Nursing home:	_____	_____	_____
Assisted living:	_____	_____	_____
Adult day care:	_____	_____	_____

Elimination Period: This is similar to a deductible. It is the amount of time you pay for services out of your own pocket before the insurance policy takes over. Typically, you can select elimination periods of 0, 30, 60, 90, or 180 days, depending on the policy and insurance company. But you must find out exactly how the elimination period is satisfied. Let's say, for example, you need care on days 1, 4 and 10. With some policies, that would be counted as only THREE days toward your elimination period. With other policies, it would be counted as TEN days, which would mean you'd start collecting the benefits much sooner.

Benefit Period (or maximum): Some companies tell you the length of time the policy will be paid; others just tell you the maximum value of benefits to be paid. The benefit period can typically range from 2 to 5 years, and some may even have an unlimited lifetime period.

Daily Benefit: The amount the policy will pay for each day of covered services. Some plans offer a daily benefit reimbursable on a weekly or monthly basis giving you more flexibility. For example, if you selected a daily benefit of $100 reimbursable on a weekly basis you would be reimbursed for up to $700 dollars per week in expenses no matter how much you incurred on any one day.

Step 16. Determine if the policy is "a pool of money" contract.

Policy A:	(Y / N)
Policy B:	(Y / N)
Policy C:	(Y / N)

Most current policies will actually give you more time to collect the benefits than indicated by the benefit period. For example, in a four-year policy, if you need care on and off, you may not use up all your benefits in that four-year period. So you could continue to collect those unused benefits in subsequent years as well. These are called "pool of money" contracts. (To calculate your pool, just multiply the total number of days by the daily benefit.) Other policies will actually end at the end of the four years, no matter what.

Step 17. Check into the requirements needed to activate the policy.

Policy A: _____

_____

Policy B: _____

_____

Policy C: _____

_____

You will need to meet what is referred to as "benefit triggers" before the policy can begin covering expenses, and these can vary from policy to policy. Under most policies, you will be qualified for benefits when you meet certain conditions, such as: 1) The inability to perform activities of daily living ("ADLs"), which typically include bathing, dressing, transferring, toileting, eating, continence, and taking medication on your own; and 2) cognitive impairment. Some plans require you to satisfy either condition (1) or (2); some require that you satisfy both conditions. Still others also allow for a third trigger, often referred to as "medical necessity." This means that a doctor determines if you need care due to an injury or sickness. Make sure you find out the precise requirements of each policy.

Step 18. Find out what other features are included (or can be added by a "rider") to the policy.

Your agent should explain any additional features that may be included in the policies you are comparing including the following:

	Policy A:	Policy B:	Policy C:
Waiver of Premium	(Y / N)	(Y / N)	(Y / N)
Nonforfeiture	(Y / N)	(Y / N)	(Y / N)
Restoration of Benefits	(Y / N)	(Y / N)	(Y / N)
Alternate Care Plan	(Y / N)	(Y / N)	(Y / N)
Bed Reservation	(Y / N)	(Y / N)	(Y / N)
Guaranteed Renewable	(Y / N)	(Y / N)	(Y / N)
Inflation Protection	(Y / N)	(Y / N)	(Y / N)

Your agent will explain the details. Just make sure that you actually need these additional benefits, because they can add substantially to your total costs.

Glossary of Long-Term Care Terms

Activities of Daily Living (ADL): The basic activities and functions performed on a daily basis that are usually done without any assistance. ADLs are defined as bathing, dressing, eating, toileting, continence, or transferring.

Additional Insured: An insured person specifically stated in an insurance policy.

Adult Day Care: A daily program made up of social and health-related services provided daily outside the home in a group setting to support weak, elderly, or other adults with impairment.

Adult Foster Care: A program which matches elders who are experiencing increased difficulty living safely alone with persons in the community who are willing to open their homes and function as caregivers. Most caregivers provide housing and appropriate care and also receive training and organizational support. Programs provide room and board and personal care services in a residential setting for elders who have sufficient functional impairment to require supervised living.

Age Limits: Stated minimum and maximum ages below and above that the insurance company will not accept policy applications.

Agent: A licensed insurance company representative who sells, negotiates insurance policies, and provides service to the policyholder.

Alternate Plan of Care: Benefit to cover alternatives not specifically noted in the policy. This feature gives the policyholder the maximum flexibility when needing care.

Ambulance Benefit: Ambulance transportation is paid for.

Amendment: A formal written document signed by both the insurance company and the policyholder, which changes the terms of the insurance policy.

Application: A signed statement of facts filled out by the person applying for the insurance policy, which is then used by the insurance company to decide whether or not to issue a policy. The application then becomes part of the policy.

Assessment: Determination of the person's level of physical ability or mental capability and the type and extent of services available and needed.

Assisted Living Facility: A facility which provides 24-hour, around-the-clock care to resident patients in need of any assistance with a number of ADLs.

Bed Reservation Benefit: When the consumer is being cared for in a nursing facility and then has a need to become hospital confined, this benefit makes certain the consumer will not lose his or her place in the nursing facility.

Benefits: Money paid by the insurance company to the claimant.

Benefit Limits: An amount that represents the daily benefit times the maximum number of days you can receive for all benefits combined under the policy.

Benefit Options: A set list of available benefits from the carrier. Each benefit has a price.

Benefit Period: The amount of time an insurance company will make payments to the individual after the deductible period has been satisfied.

Benefit Triggers: Specific situations that start payment of benefits.

Care Manager: A trained professional who is able to work with you and your family and your doctors to assess your situation and determine the appropriate plan of care. They will also help with finding the available care resources.

Care Management Services: A service in which a professional, typically a nurse or social worker, may arrange, monitor or coordinate long-term care services.

Caregiver Training Benefit: This benefit provides for training by a health care professional of an informal caregiver (family member, friend, or neighbor).

Chronically Ill: A condition that is verified by a physician that renders the individual unable to perform at least two of the activities of daily living (ADLs) for at least 90 days. It requires the individual to have substantial supervision to protect themselves from threats to health and safety.

Cognitive Impairment: Loss of rational comprehensive thought processes due to a degenerative disease or disorder.

Covered Nursing Care Facility: A signed statement of facts filled out by the person applying for the insurance policy, which is then used by the insurance company to decide whether or not to issue a policy. The application then becomes part of the policy.

Community-Based Services: Services designed to help older people stay independent in their own homes.

Congregate Housing: Non-institutional residents in a shared-living environment with supportive services for residents, offering an alternative to nursing home placement for persons who have experienced some functional impairment but do not require constant supervision.

Conservator: Court-appointed custodian of property belonging to a person determined to be unable to properly manage his or her property.

Custodial Care: Non-medical care in which the patient receives help with his or her ADLs. Providers of this care do not need to be professionally trained nurses or therapists.

Daily Benefit Period: The length of time which your daily benefits cover.

Daily Benefit Rate: The rate predetermined by your policy provider to cover your daily benefits.

Effective Date: The date on which the insurance policy begins.

Elder Care: A wide range of services provided at home, in the community, and in residential care facilities, including assisted living facilities and nursing homes. It includes health-related services such as rehabilitative therapies, skilled nursing, and palliative care, as well as supervision and a wide range of supportive personal care and social services. Typically, elder care is provided over an extended period of time to people who need another person's assistance to perform normal ADLs because of cognitive impairment or loss of muscular strength or control. Regardless of where it is provided, most elder care is custodial care, the type of care that is not paid for by Medicare.

Elimination Period: The number of days that you have to pay expenses before your coverage begins to pay for benefits; also known as a deductible period.

Emergency Response Systems: 24-hour monitoring and response to medical or other emergencies.

Gross Premium: The premium paid by the policyholder.

Guaranteed Rate Policy: Written agreement stating premium rate will not increase over time.

Guaranteed Renewable Coverage: Coverage cannot be canceled because of age or changes in health.

Health Care Proxy: A written instrument which names another person, called the "agent," to make health care decisions for him or her when a doctor certifies in writing that the person can no longer make health care decisions for himself or herself. This document becomes operative only when the person becomes incapacitated, in the attending physician's opinion, and unable to understand the nature and consequences of health care decisions. A person may revoke a health care proxy verbally or in writing.

HIPAA (The Health Insurance Portability and Accountability Act of 1996): This act became a law on January 1, 1997. The act states the requirements that a long-term care policy must follow in order that the premiums paid may be deducted as medical expenses and benefits paid be considered as taxable income.

Home Health Care Coverage: Services provided through home health agencies that are licensed by the state. Services are provided by health care professionals such as nurses (registered or licensed vocational), trained home health aides under the supervision of a registered nurse, occupational therapists, physical therapists, medical social workers and respiratory therapists. Agencies may be "certified" (meet Medicare standards and must be utilized for this payer source) or "licensed" (meet state standards of care and may be utilized by other payer sources).

Homemaker Services: Household services done by someone else because you are unable to do them yourself. These include nursing services, personal hygiene, house chores, errands, and preparation of meals, laundry and house maintenance.

Hospice Care Services: Outpatient services provided by a licensed hospice provider to help ease the pain of terminally ill patients in the last stages of their disease. They also provide support to the primary caregiver and the family.

Immediate Family: The person's spouse, children, parents, siblings, grandchildren or in-laws.

Incurred Services: Services received from providers.

Independent Caregiver: A person who provides home health care services or hospice care who:

- Is licensed to provide the care he or she is giving and is working independently from a home health care agency. He or she must be licensed in the state in which he or she is working.
- Is chosen by the consumer and has been qualified under the Independent Caregiver Certification Benefit.
- Is not a member of immediate family living with the consumer.

Inflation Protection Option:

- **Periodic Inflation Additions:** Additional insurance coverage available for purchase by the policyholder each year at amounts based on increases in the Consumer Price Index. The extra coverage increases the policy's daily and lifetime benefit maximums. The cost will depend on how much coverage is added, policyholder's age, and the time it is done.
- **5 Percent Compound Inflation Protection:** Benefits increase by 5% compounded annually for as long as the policy remains in force. An additional premium is charged for this benefit.

Informal Caregiver: An unpaid individual who takes on the responsibility of providing care for the individual in question, usually a spouse or relative.

Instrumental Activities of Daily Living (IADLs): Activities such as shopping, telephone use, housekeeping, laundry, taking medications, and managing finances that if can't be done determine an individual's physical and mental impairment.

Intermediate Nursing Care: This care is provided to those who do not need care on a 24-hour basis. A skilled care person on a non-continuous basis provides the nursing care.

Lapse: The ending of the insurance policy due to the non-payment of a premium.

Licensed Health Care Provider: A doctor, or health care professional, who certifies every 12 months that you are continuously ill and in need of support.

Maintenance or Personal Care Services: Ongoing care necessary as the result of a chronic illness or disability.

Maximum Lifetime Benefit: The total amount the carrier will pay you in your lifetime for all benefits provided under your policy.

Mode of Premium: The schedule of payment of premiums, monthly, quarterly, semiannually, or annually.

Money-Back Guarantee: A feature that allows the policyholder to return the policy within 30 days of receipt and notify the company to cancel the coverage. The policy would be void from its inception and all payments made would be refunded.

Named Insured: The person in whose name the insurance policy is issued.

National Association of Insurance Commissioners (NAIC): A national organization made up of state officials who are in charge of regulating insurance. They have considerable influence and strive to promote national uniformity in insurance regulations.

Nonforfeiture Option: A feature through which protection is continued at a reduced coverage even if the consumer stops remitting payment. The policyholder typically must have paid premiums for an allocated number of years consecutively before this benefit would trigger.

One-Time Benefit Waiting Period: The period of time during which the consumer must pay for care expenses out of his or her own pocket before the policy benefits begin.

Payment of Claim: Timely payment, generally monthly after services have been given to patient and the filed claim is proven valid.

Plan of Care: A program of care and/or treatment that is set up with your licensed physician and approved in writing before the start of care.

Policy Term: The length of time the insurance policy provides coverage.

Portability: Feature that allows you to take the LTC policy from job to job and into retirement.

Proof of Loss: Documents, such as bills that show the breakdown of money spent on services provided.

Waiver of Premium: Feature whereby premiums are waived once you are receiving benefits for nursing facility, home, or community-based care and have completed the waiting period. Premiums will again become payable when the benefits have stopped for a certain number of days.

- **Waiver of Premium for Home Health Care:** Feature whereby premiums are waived once you are receiving home health care benefits This feature can begin immediately or may be delayed by 30, 60, or 90 days depending on the policy language.
- **Waiver of Premium for Nursing Facility Care:** Feature whereby premiums are waived once you are receiving nursing home benefits This feature can begin immediately or may be delayed by 30, 60, or 90 days depending on the policy language.

Protection against unintentional lapses: Feature whereby the policy will be reinstated if protection lapses because of nonpayment of premiums attributable to severe cognitive impairment. The reinstatement will be within a certain number of months of the date of lapse if the policyholder or policyholder's representative submits proof of impairment and all past-due payments.

Respite Care Benefit: A benefit that pays other caregivers when the informal caregiver needs time off for him or herself. In the early stages of certain medical conditions or in the case of more easily managed medical conditions, it is common for loved ones to be care for by an informal caregiver such as a family member or close friend. The benefit is usually limited to a certain number of days or

weeks per year and provides coverage in the home or in a facility.

Rest Homes: A program that provides home and/or community-based assistance for primary caregivers of severely disabled persons to enable informal caregivers to work or to provide them with relief from the stress of full-time care. Services include homemaker, home health aide, social day care, adult day health, nursing, foster care, and companions.

Restoration of Benefits: A feature whereby the maximum benefit amount is restored to the full amount covered by the policy even if a claim has been paid. This applies after the policyholder has had the need for care and collected benefits under the policy and has recovered, no longer requiring care for a period of time (usually 6 months).

Return of Premium at Death: A feature that provides a refund of premiums to your estate, minus any benefits you have used, in the event of your death. You usually have to pay premiums for a certain number of years, and your death generally has to occur before a certain age, for example 65 or 70. This feature holds some appeal for people who think they may never have a need for the coverage. However, it does add to the premium.

Rider: Written contract agreement between insurer and insured which changes the policy or certificate.

Severe Cognitive Impairment: A loss or breakdown of the mental capability that is similar to Alzheimer's disease and other forms of dementia. It is measured by clinical evidence and standard tests that provide valid information regarding the patient's impairment which includes (1) memory both short-term and long-term, (2) orientation to people, places, or time, and (3) deductive or abstract reasoning.

Shared Care: Gives the policyholder the ability to share the policy benefits with his or her spouse in the event the spouse exhausts the policy benefits and continues to need care.

Skilled Nursing Care: The highest level of care provided by a registered nurse (R.N.) or a Licensed Practical Nurse (L.P.N) 24 hours a day. It is prescribed by a physician for the most severely impaired person who cannot perform his or her own personal needs.

Substantial Supervision: Continuous supervision provided to those who have severe cognitive impairment, which threatens their health and safety.

Survivor Waiver of Premium: A policy benefit that is triggered when one of the spouses passes away after both policies have been in force for at least 5 years. The surviving spouse will have no further premiums to pay on the policy, except for any increase in benefits that is applied for and approved.

Tax-Qualified (TQ) Policies: Long-term care policies designed after January 1, 1997, that meets certain requirements to qualify for favorable tax treatment. Buyers of these plans may deduct the premiums if they itemize their deductions on their federal tax return. Premiums are treated as medical or health insurance expenses and must be equal to or more than 7.5% of adjusted gross income. Also, benefits received from a tax-qualified plan (TQ Plan) are not taxable up to $320.00 a day.

Transition Expense: Expense incurred during the time you are waiting for home health care.

Transition Expense Allowance: Set amount of funds paid during the waiting period, which may be used for in-home equipment.

Underwriting Process: Steps through which an insurance application is reviewed by a licensed insurance counselor to become approved for insurance.

Validity of Claim: Judgement passed on claim from in-house claims department, which verifies that the claim is accurate and truthful.

Waiver: An agreement attached to the policy that exempts from coverage specific disabilities and injuries that normally would be covered under the policy.

Reference Organizations

Agencies on aging

National Association of Area Agencies on Aging
1730 Rhode Island Ave, NW Suite 1200
Washington, DC 20036
202-872-0888
Email: info@n4a.org
www.n4a.org

National Council on the Aging
251 18th St South Suite 500
Arlington, VA 22202
571-527-3900
www.ncoa.org

Federal help available on the Internet

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
877-267-2323 or 410-786-3000
www.cms.gov

Medicare
www.medicare.gov

Insurance Department

Department of Insurance
www.naic.org/state_web_map.htm

U.S. Department of Health and Human Services
205 Independence Ave SW,
Washington, DC 20201
887-696-6775
www.hhs.gov

Organizations Available to Counsel You

American Association of Homes and Services for the Aging
2519 Connecticut Ave, NW
Washington, DC 20008
202-783-2242
email:info@leadingage.org
www.leadingage.org

AARP
601 E. Street, N.W.
Washington, DC 20049
888-687-2277
http://www.aarp.org

American Health Care Association
1201 L Street, N.W.
Washington, DC 20005
202-842-4444
email:help@ltctrendtracker.com
www.ahcancal.org

America's Health Insurance Plans
601 Pennsylvania Ave, NW
South Building, Suite 500
Washington, DC 20004-2601
202-778-3200
email:ahip@ahip.org
www.ahip.org

Medicare Rights Center
266 West 37th Street 3rd Floor
New York, NY 10018
800-333-4114
212-869-3850
www.medicarerights.org

National Adult Day Services Association
11350 Random Hills Rd, Suite 800
Fairfax, VA 22030
Email: info@nadsa.org/memberservices@nadsa.org
877-745-1440
www.nadsa.org

National Association for Home Care & Hospice

228 Seventh Street, S.E.
Washington, DC 20003
202-547-7424
www.nahc.org

Aging Life Care Association

3275 West Ina Road Suite 130
Tucson, AZ 85741
520-881-8008
www.aginglifecare.org

National Consumers League

1701 K Street, N.W. #1200
Washington, DC 20006
202-835-3323
Email: info@nclnet.org
www.nclnet.org

National Hospice and Palliative Care Organization

1731 King Street
Suite 100
Alexandria, VA 22314
703-837-1500
email:nhpco_info@nhpco.org www.nhpco.org

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