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Chapter 7

Long-Term Care Insurance

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SYNOPSIS

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7-1. What Is Long-Term Care?

To define long-term care (LTC), let us begin by explaining what LTC is *not*. Long-term care is not acute care, which is medical care intended to cure or treat an individual with a critical illness or injury. Acute care aims to restore the patient's health to the previous level of functioning. Typically, acute care is provided in a hospital, perhaps an intensive care unit, by skilled medical professionals. Acute care is financed primarily by private health insurance, or Medicare for those 65 years of age and older.

Long-term care is also *not* subacute care, which is less intensive than acute care. Subacute care is usually provided in a regular hospital inpatient unit, lasts for a limited period of time, and is intended to restore the patient's health. Subacute care may be provided instead of or after acute care. Like acute care, skilled medical professionals provide subacute care, and it is covered by health insurance or Medicare.

Long-term care is chronic care — care provided over an extended period of time without expectation of a cure. LTC services include medical and non-medical care, providing for the health or personal needs of the care recipient. Often times, LTC does not require skilled medical professionals, as many people begin by receiving care at home provided by family, friends, or neighbors. Loved ones acting as caregivers deliver custodial care, which may include assistance with household chores; providing transportation; shopping; managing finances; or helping with bathing, dressing, eating, using the restroom, or supervising one with dementia. When home care is not an option, LTC may be provided in formal (paid) settings such as adult day care centers, assisted living facilities, skilled nursing facilities, or hospice facilities. Because a medical professional is usually not required for supervising one with dementia, or bathing, dressing, or feeding a loved one, long-term care is not generally covered by health insurance or Medicare. The primary sources of funding for long-term care are private funds, Medicaid, and long-term care insurance.

7-2. Who Needs Long-Term Care?

Not everyone will need long-term care, but everyone needs long-term care planning. Reasonable people can agree with two important statements:

1) There is a good chance that I will live a long life, and the longer I live, the more likely it becomes that I will need long-term care. The care I need may be due to disease (*e.g.*, stroke, multiple sclerosis, Alzheimer's, cancer, etc.), frailty, or an accident.
2) If I need care, the emotional, physical, and financial consequences to my family and my retirement plan will be devastating. Therefore, I need a plan.

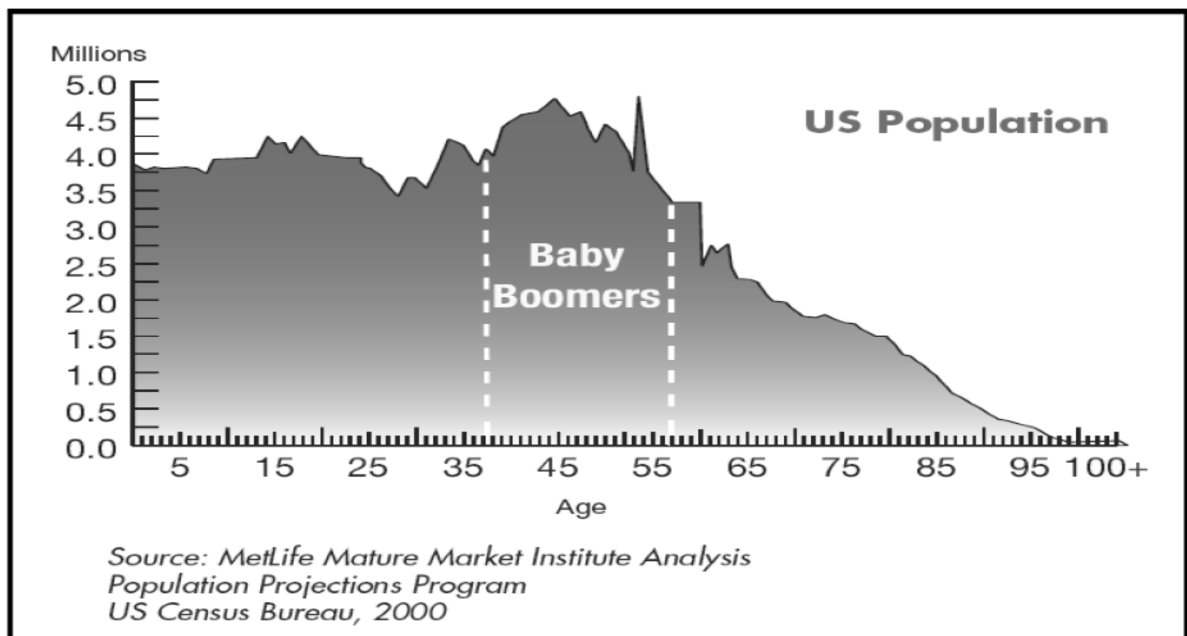
The need for care can strike at any age and may last a few weeks or months, or for a number of years. According to the National Clearing House for Long-Term Care Information (www.longtermcare.gov), nearly nine million Americans over age 65 will require LTC this year. About 70 percent of those over 65 will need some form of long-term care services at some point; 40 percent of those over 65 will spend time in a nursing home.

By 2020, approximately 12 million people will need LTC services. Unfortunately for the young, the need for LTC can occur at any age: nearly 40 percent of people receiving long-term care services today are 18 to 64 years of age.

The following information was taken from the *Long-Term Care Planning for Colorado Consumers*, published January 2006 by the Senior Health Insurance Assistance Program and Colorado Division of Insurance:

> [Sixty] percent of people who turn age 65 will need long-term care as they grow older and one in five who reach age 65 will spend more than two years in a nursing home. As our population ages the need for long-term care will increase, particularly for women. 22 percent of men and 41 percent of women can expect to have a nursing home stay longer than three months. At age 65, 14 percent of men and 31 percent of women are likely to have a nursing home stay longer than one year. Women are at most risk of a very long stay — 13 percent reportedly may have stays exceeding 5 years.

The graph that follows was published when the oldest baby boomer was 57, as indicated by the dashed line. Today, the leading edge boomers are turning 63. The message remains the same: a tidal wave of aging Americans are becoming more and more prone to needing long-term care.



Source: MetLife Mature Market Institute Analysis
Population Projections Program
US Census Bureau, 2000

7-3. Risk Factors

For some, an unhealthy lifestyle, such as a poor diet, smoking, lack of exercise, or obesity, increases the chance of needing long-term care. For others, good health may lead to longevity, and the longevity generally increases the likelihood of receiving care. It is common knowledge that women on average outlive men. To wit, more than 70 percent of nursing home residents are female (National Nursing Home Survey, 2004). According to the Rocky Mountain MS Center, Colorado has always been thought to have an extremely high incidence of multiple sclerosis, a disease in which 80 percent of patients develop the condition between ages 16 and 45 (www.mscenter.org/content/view/145/180/).

People living alone are more likely to need formal long-term care services from a paid provider. Some hereditary conditions may increase the risk of needing care. Finally, physically active adults may be more prone to an accident while skiing, cycling, or performing other activities.

7-4. Where Is Long-Term Care Received?

Most people who need long-term care will be cared for at home; family and friends are the sole caregivers for 70 percent of the elderly (www.medicare.gov/longtermcare/static/home.asp). Home care agencies can provide additional assistance with part- or full-time homemakers, home health aides, and nurses.

Other community-based services include adult day care centers, assisted living facilities and continuing care retirement communities (also known as life care communities). Respite care, which gives the primary caregiver a break from caregiving responsibilities, may be provided at home or in a facility. Skilled nursing facilities, often referred to as nursing homes, provide 24-hour care. Hospice care can be received in a nursing home, at home, or in a stand-alone hospice facility.

7-5. Cost of Long-Term Care Services

The following data was reported in the 2008 Genworth Financial Cost of Care Survey:

Type of Care	Area	Average Rate	Average Annual Rate	Five-Year Annual Growth
Nursing home private room	Denver	$198/day	$72,359	3%
	Rest of state	$206/day	$75,259	5%
Nursing home semi-private	Denver	$182/day	$66,427	6%
room	Rest of state	$176/day	$64,058	3%
Assisted living facility in	Denver	$3,392/mo	$40,703	6%
a private one bedroom	Rest of state	$3,105/mo	$37,261	7%
Adult day care	Denver	$50/day		n/a
	Rest of state	$63/day		n/a
Homemaker services	Denver	$19/hour		4%
(non-Medicare certified)	Rest of state	$18/hour		3%
Home health aide services	Denver	$21/hour		5%
(non-Medicare certified)	Rest of state	$19/hour		3%
Home health aide services	Denver	$36/hour		n/a
(Medicare certified)	Rest of state	$33/hour		n/a

Of course, the second component in the financial cost of LTC is the length of time care is needed. According to the *2008 Sourcebook for Long-Term Care Insurance Information*, published by the American Association for Long-Term Care Insurance, the average length of stay in a nursing home for females is 2.6 years and 2.3 years for males. The average stay for a female assisted living resident is 28.2 months, while men average 24 months. Scant reliable data exists to report an average length of need for home care, as much of this form of care is provided by family and friends. The financial costs can be enormous should one need care for a few years at home, then for two years in assisted living, and finally two years in a nursing home, not to mention the physical and emotional toll to the family.

7-6. Paying for Long-Term Care

Many Americans erroneously believe that Medicare will pay for long-term care services. Essentially, Medicare provides for rehabilitation by skilled providers. Most people who need LTC need personal or custodial care — that is, help with bathing, dressing, eating, etc., or supervisory care due to dementia. While it is true that Medicare can provide limited home health care and up to 100 days of nursing home care, it may prove costly to rely on Medicare to pay for any services. According to a Centers for Medicare and Medicaid Services report in 2002, the average number of days covered by Medicare was 23. Private or employer-based health insurance works much the same. The Department of Veterans Affairs (VA) may provide LTC for service-related disabilities or for certain eligible veterans. However, the availability of services and the location of participating facilities for veterans may be an issue.

Medicaid is the state/federal assistance program that will pay the LTC costs for needy persons. To be eligible, one must have very limited income and assets. Often times, financial eligibility is met by spending down non-exempt assets on long-term care, depleting one's estate, and preventing the passing of an inheritance to loved ones. Married couples may also see retirement plans and other assets depleted while paying for the care of one spouse, leaving little for the healthy, surviving spouse. Medicaid pays for nearly half of all LTC costs in the United States.

Most people pay privately for LTC until their funds are depleted. One solution is long-term care insurance.

7-7. Reasons People Purchase Long-Term Care Insurance

As Rosalyn Carter once said, "There are only four types of people: those who have been caregivers, those who are caregivers, those who receive care, and those who will be caregivers in the future!" People who execute long-term care planning have often times been through a care event with a loved one and wish to protect themselves and their family from the devastating consequences of long-term care.

Long-term care planning includes two basic goals:

1) Should I someday need care, keep me at home for as long as possible, without severely impacting the lives of my loved ones around me.
2) Preserve the retirement plan and life savings so they can provide for the continuing lifestyle and obligations of my spouse or partner, and preserve the inheritance for those to whom I wish to leave a legacy.

A long-term care insurance policy may be the most efficient method of accomplishing these goals. LTC insurance may also help a person avoid Medicaid, afford the facility of one's choosing, provide peace of mind, and allow family members to supervise care rather than provide care 24 hours a day, seven days a week.

7-8. Traditional Long-Term Care Insurance

Most modern LTC insurance policies offered today are comprehensive, paying for home care, adult day care, assisted living facilities, nursing home care, hospice care, and respite care from a single pool of funds (also known as the lifetime maximum benefit). In the past, many policies allowed for two pools of funds: one benefit account for care in a facility, and a second pool for care at home. This form of LTC insurance, still available from some insurance companies, may be less flexible than the comprehensive form: if the policyowner exhausted his or her home care benefit account, no further benefits were payable until the policyowner received care in a facility.

The vast majority of policies offered today include two standardized ways to trigger the benefits of the policy. One trigger starts the benefits should the policyowner need substantial supervision due to a cognitive impairment, such as Alzheimer's, dementia, or senility. The other trigger is satisfied once the policyowner has a certification from a qualified health care practitioner that he or she requires stand-by or hands-on assistance with two or more out of six activities of daily living (ADLs). The six ADLs are bathing, dressing, eating, toileting, transferring, or continence. The certification includes an expectation that the care need will last at least 90 days. The satisfaction of only one benefit trigger is required. Provided the policyowner triggers his or her benefits, a plan of care is written by a licensed health care practitioner, ensuring appropriate levels of care and care settings.

There are three forms of traditional LTC insurance: reimbursement, cash, and indemnity. The most common form of LTC insurance, reimbursement policies require that the claimant provides receipts for long-term care services covered by the policy. The insurance company then reimburses the claimant for actual expenses up to the daily or monthly maximum benefit of the policy at the time of claim. Reimbursement policies typically require that the care services be provided by someone other than a spouse or family member. Some policies allow for home care to be from unlicensed providers, including friends and neighbors. One advantage of reimbursement plans is that any unused daily or monthly benefit remains in the benefit account for future use.

Cash plans are the most expensive form of LTC insurance, but are also the most flexible. With a cash plan, the full daily or monthly benefit is paid to the policyowner regardless of who is providing the care, and regardless of whether care was received that day or month. No proof of covered services is required. No doubt, future technology will deliver LTC in ways we may not even fathom today (*e.g.*, robots, sensors, monitors, etc.) — a cash policy can be used to pay for these futuristic methods. Drawbacks of cash plans include premium levels that may be double that of reimbursement plans, benefits that may exhaust faster than reimbursement plans, and concern that the benefits paid out to a power of attorney or family member of the policyowner are actually used for his or her care needs.

Like reimbursement policies, indemnity plans require proof of covered services from a qualified provider other than a family member or spouse. Unlike reimbursement plans, indemnity policies pay the full daily benefit regardless of the actual cost of care. To illustrate, assume an indemnity policy has a daily benefit of $200. If the policyowner receives an hour of home care from an agency, the full $200 is paid to the policyowner, regardless of the cost of the hour of care. If the actual cost of the hour of home care was, say, $60, the policyowner pays the agency for the hour of care and has $140 left over to be used for any other

purpose. Like cash plans, indemnity plans are not as common as reimbursement policies, and the benefits may be paid out faster than with a reimbursement policy. The premiums for indemnity policies are not substantially higher than the premiums for reimbursement policies.

7-9. Policy Building Blocks

Traditional LTC insurance policies include four building blocks: benefit amount, benefit period, inflation protection, and an elimination period.

The benefit amount is how much per day, per week, or per month the policy pays for care. A monthly benefit is the most flexible form of benefit amount, as one's benefit does not have a daily maximum benefit, but rather a monthly maximum benefit. For most comprehensive policies, the benefit amount is the same for all types of care (*e.g.*, nursing home, assisted living, and home care benefit). Some policies allow for the home care benefit to be a percentage below or above the nursing home benefit.

The benefit period may be thought of as the minimum length of time the benefits last before the policy is exhausted. Choices may include one to six years, 10 years, or an unlimited or lifetime benefit period. Assume a client has purchased a five-year benefit period and a $200 daily benefit. The resulting lifetime maximum benefit is $365,000 (1,825 days multiplied by $200). If it is a reimbursement policy, the benefits would last at least five years. If the actual cost of care is less than $200 per day, the policyowner is reimbursed the lesser amount, and future benefits remain in the lifetime maximum benefit for future use. In this example, the benefits stretch beyond the five-year benefit period.

All companies in Colorado must offer inflation protection. Three of the most common offers are described here, although more choices exist. The 5 percent automatic compound inflation rider increases the benefit amount 5 percent each year of the previous year's amount. The 3 percent automatic compound works much the same, except the increases equal 3 percent each year. The 5 percent automatic simple inflation calculates 5 percent of the original benefit amount, then adds that same amount each anniversary date of the policy. The following table illustrates the future value of the benefit amount and lifetime maximum benefit over time using each of the three choices.

	5% Automatic Compound		3% Automatic Compound		5% Automatic Simple	
Year	**Daily Benefit**	**Max Benefit**	**Daily Benefit**	**Max Benefit**	**Daily Benefit**	**Max Benefit**
1	$200	$365,000	$200	$365,000	$200	$365,000
10	$310	$566,235	$261	$476,242	$290	$529,250
20	$505	$922,337	$351	$640,030	$390	$711,750
30	$823	$1,502,389	$471	$860,146	$490	$894,250
40	$1,341	$2,447,234	$633	$1,155,965	$590	$1,076,750

The elimination period is the number of days the policyowner receives long-term care before benefits begin. The elimination period might also be thought of as a waiting period or a deductible: the longer the elimination period, the lower the premium. Common choices include 30, 60, 90, 180, or 365 days. Most policies require that the claimant actually receive formal care from a covered provider on a given day in order for that day to count towards the elimination period. Available as a built-in feature in some policies or as a rider in others, a calendar day elimination period does not require that one receives care for that day to count. Instead, every day the insured is otherwise benefit eligible counts towards the elimination period, even if formal care services are not required or received. Today, most policies include a cumulative for life crediting method: if the policyowner meets a day of elimination period, he or she will never need to meet that day of elimination period again, even if a second care event occurs in the future.

One popular rider available from leading insurance carriers is called the waiver of home care elimination period rider. Assume a policyowner includes a 90-day elimination period and includes the aforementioned rider. The elimination period for care in a facility is 90 days, while the elimination period for home care is zero days. Typically, the number of days home care is received counts towards the elimination period in the facility. Therefore, should the policyowner need care for 90 or more days, there would be no elimination period to meet for home care or for facility care.

The most common elimination period choice is 90 days, as consumers feel secure that they can afford to pay for the first 90 days of long-term care. However, if the policyowner needs care in 20 or 30 years from the time of purchase, the cost of care may be several times more than the cost of care today. Consumers should carefully consider how much of their income and assets they wish to expose to this risk.

7-10. Other Popular Features and Riders

Couples may shop for a policy offering shared benefits, which allows two people to share policies. The availability of this option, along with higher premiums, has made the unlimited or lifetime benefit period less popular. Should both partners purchase a five-year benefit period, together they share a 10-year benefit period. One person could use all or a portion of the entire benefit account. One person might pass away without needing any benefits, leaving the remainder to the survivor. Some carriers stipulate that one spouse cannot completely exhaust policies.

A survivorship benefit allows the surviving spouse or partner to stop paying premiums upon the death of the first partner, provided the policy had been in force initially for 10 years without a claim.

Restoration of benefits allows for monies paid by the policy to be put back into the lifetime maximum benefit if the claimant recovers fully and no longer requires care for at least 180 consecutive days.

Most policies include a waiver-of-premium provision: premiums are waived as long as the policyowner is receiving benefits. Some older policies waive premiums only if the claimant is in a nursing home, or if the claimant has received benefits from the policy for at least 90 days.

Also included in most policies today is a care coordination or care advisory service, which assists with the development and coordination of the plan of care. Care coordination may help identify appropriate services and reputable providers of such services and help make arrangement for the services to begin.

All LTC insurance policies marketed must offer a nonforfeiture benefit rider, also known as the shortened benefit period. Should a policyowner with this rider surrender the policy after owning it for at least three years, the premiums paid into the policy will be available to pay for care some day in the future. Note that this is not a return-of-premium benefit, although return of premium at death is an optional rider on many policies.

7-11. Premiums

The premium one ultimately pays for an LTC insurance policy depends greatly on the choices concerning the four building blocks and optional riders described above. Other factors influencing the premium include:

- Age.
- Couples discount — married couples or those with a committed partner may save 30 to 40 percent on premiums if both apply and are approved. Many insurance carriers offer a 10 to 15 percent discount if only one spouse or partner applies or is approved.
- Health — most carriers offer a standard health rate as well as a 10 to 15 percent discount for excellent health.

Many Americans who purchased LTC insurance in the 1970s, ’80s, and ’90s have experienced premium increases. Such increases have been caused by underpricing of past policies, high persistency (low lapse rates) of in-force policies, and higher-than-expected claims. All LTC insurance policies are guaranteed renewable for life, meaning the policyowner is the only one who can cancel the policy. Furthermore, the insurance company cannot unilaterally change any provision of the contract while it remains in force. In other words, the carrier cannot harm the policyowner with a contractual change. The carrier can, however, add language to make the policy better or more valuable to the policyowner. The only detrimental change allowed by the carrier is to increase the premiums for an identified class of insureds. Any rate increase for a class of insureds must be approved by the state division of insurance. Upon receiving a rate increase, policyowners may elect to keep the policy as-is and pay the higher premium, reduce the benefits and the corresponding premium to a more affordable level, or surrender the policy.

Today, LTC insurance policies cost several times more than policies offered 10 to 20 years ago. While premium increases are never welcomed, consumers tend to hold on to policies purchased in the past, realizing that the premiums are a fraction of what a new policy would cost. Naturally, if one’s health has changed for the worse, it may be impossible to replace the coverage.

One way to insulate against future rate increases is by purchasing a limited pay rider, such as a 10-year pay rider. With a 10-year pay rider, the policyowner pays the premium for 10 years, after which time the premium is paid-up for life. It follows that the policyowner cannot be required to pay more premiums after year 10, even if others with the same policy series have an increase. For those under 56, a more affordable option is a paid-up at age 65 rider.

In the past, a few carriers offered a single-pay premium LTC insurance policy. While traditional LTC insurance carriers no longer offer a single-pay option, consumers may wish to consider a combination LTC insurance policy, as discussed in the following section.

7-12. Combination Long-Term Care Insurance Policies

Insurance carriers have heard the concern of many older adults who have one very important objection to traditional LTC insurance: *If I never need this policy, do I get my money back?* Unless a return of premium at death rider was purchased, the answer is "no." Indeed, most reasonable people would much rather pay the LTC insurance premiums and never need long-term care, rather than require care services for a period of years. Still, consumers in their 60s, 70s, and even 80s may find it more palatable to fund a long-term care plan with a combination LTC insurance policy, also known as a hybrid or asset-based plan.

A life/LTC insurance combination (LTCi) policy allows the insured to fund a life insurance policy with a single premium payment, which may be returned to the consumer upon cancellation of the policy. Premiums can also be paid with an annual premium payment, or for a limited time such as a 10-year pay. Should the policyowner pass away without needing care, an income tax-free death benefit is paid to the beneficiaries of the life insurance. Should the policyowner need LTC before passing, the amount that would have been the death benefit is paid out in the form of LTC benefits over two, three, or four years. If the death benefit is exhausted, a continuation of benefits rider, acting much like a traditional LTC insurance policy, will continue to pay benefits for a specified period of time (*e.g.*, two, three, or four years, or unlimited).

A second form of hybrid policies is an annuity/LTC insurance combination policy. This type of annuity is funded with a single premium or a rollover from another non-qualified annuity. The value of the annuity grows tax-deferred, and can be used to pay for long-term care over a specified or selected number of years. Should the policyowner use all of the funds in the annuity to pay for LTC, a continuation of benefits rider is activated, extending the LTC benefit for another specified period of time. If the policyowner passes away without needing care, the annuity value transfers to the beneficiaries. This form of LTC insurance involves self-funding, as the initial benefits are taken from the policyowner's annuity account. This fact allows the insurance carrier to be somewhat more lenient in underwriting the health of the applicant.

The Pension Protection Act of 2006 (PPA) encourages the purchase of combination policies through certain tax incentives. In an annuity that is not an annuity/LTCi combination policy, should a withdrawal be made from the annuity to pay for care, the withdrawal is taxed as income until all of the growth in the annuity has been withdrawn. Due to the PPA, funds withdrawn from the annuity account to pay for qualified LTC services are

received income tax free beginning January 1, 2010. In addition, the charges against the cash value of a life/LTCi combination policy to pay for the accelerated death benefit and continuation of benefits rider are no longer considered to be taxable withdrawals.

7-13. Partnership Plans

In the early 1990s, four states — California, Connecticut, Indiana, and New York — were part of a pilot project to promote the purchase of long-term care insurance. Known as the Original Partnership States, the program successfully encouraged consumers to take private responsibility for their LTC needs, and continues to do so to this day.

The Deficit Reduction Act of 2005 (DRA) was signed into law in 2006. Among other things, this federal law changed the look-back period for asset transfers from three years to five years and capped home equity at $500,000 for Medicaid eligibility. The DRA also enabled all remaining states beyond the original four to offer Partnership Plans. Beginning January 1, 2008, a traditional LTC insurance policy sold in Colorado may qualify as a Partnership Plan, which allows for special treatment of one's assets if LTC is needed some day. The stated goals of the Partnership program are (1) to assist the citizens of Colorado in planning for their future LTC needs through quality LTC insurance, (2) without depleting the consumer's resources and assets paying for care.

A Partnership Policy allows the policyowner to protect a dollar in non-exempt assets from Medicaid spend-down for every dollar the Partnership LTC insurance policy has paid out in benefits. This is known as dollar-for-dollar asset protection. Taking liberties to simplify the Medicaid qualification rules, an unmarried Colorado resident seeking to qualify for Medicaid to pay for long-term care can have a house, a car, and $2,000. His income must also meet strict qualification limits. Let us assume that our citizen also has $300,000 in non-exempt assets. Should our citizen suddenly suffer a stroke or other debilitating change in health, he must spend-down the $300,000 in assets before being eligible for Medicaid.

Now let us assume that our citizen purchased a Partnership LTC insurance policy. For every dollar the policy pays for qualified LTC expenses, Medicaid will disregard a dollar of his $300,000 in non-exempt resources when applying for Medicaid. If the policy paid $300,000 or more in benefits, all of the non-exempt resources may be disregarded. If the Partnership Policy paid out $200,000, and at the time of applying for Medicaid the remaining non-exempt assets were down to $200,000, our citizen could apply for Medicaid and disregard the $200,000 in assets. In addition, the disregarded assets are exempt from the estate recovery process at the Medicaid recipient's death.

To qualify as a Partnership Policy in Colorado, the policy must:

- Be approved by the Division of Insurance;
- Be a tax-qualified policy;
- Provide coverage to a person who was a resident of Colorado when coverage became effective;
- Have an effective date on or after January 1, 2008; and
- Meet certain inflation rider requirements based on age.

Partnership Policies do not cost more than non-Partnership Policies. Assuming the insurance carrier's policy has been approved by the state, the policy is automatically Partnership as long as the policyowner purchased inflation protection equal to or exceeding the minimum levels mandated by Colorado:

Less than age 61	5% automatic compound Consumer Price Index (CPI) automatic compound
Ages 61 to 75	3% automatic compound 5% simple Consumer Price Index (CPI) automatic compound 5% automatic compound until benefits double
76 and above	No inflation is required

States like Colorado that have begun to market Partnership Plans under authority of the Deficit Reduction Act of 2005 are known as DRA Partnership States. Should a Colorado resident move to another DRA Partnership State, the asset disregard from Medicaid spend-down follows the policyowner to the other state. This recognition of another state's Partnership program is referred to as reciprocity. Colorado and the other DRA Partnership states reserve the right to opt out of reciprocity in the future, although the author knows of no state that has opted out as of this writing.

Colorado's State Plan Amendment (SPA), which is Colorado's agreement with the federal government as to how the state will spend Medicaid dollars, was approved by the federal government with an effective date of October 1, 2006. Policies sold in Colorado prior to October 1, 2006, cannot be granted Partnership status. This fact does not mean that non-Partnership Policies written in the past are of lesser value. In fact, policies written more than a few years ago are, in most cases, already much lower in premium than policies being marketed today.

An insurance carrier has the discretion to allow a policyowner to exchange a non-Partnership Policy for a Partnership Policy if the effective date of the coverage was after October 1, 2006, and before January 1, 2008, assuming the policyowner included one of the age-based inflation riders listed above. Many carriers have chosen to only allow policies written on or after January 1, 2008, to be Partnership eligible. Contact your insurance agent and/or insurance company to find out the status of your coverage.

To date, the author knows of no life/LTCi or annuity/LTCi combination policy that qualifies as a Partnership Plan. Also at this time, 21 insurance companies are marketing Partnership Plans in Colorado.

7-14. When Should One Purchase Long-Term Care Insurance?

The best time to purchase any form of insurance is before it is needed, as it is usually too late to obtain coverage once an insurable claim event occurs or becomes likely. LTC insurance is no different. The average age of people purchasing LTC insurance has been dropping steadily for years. Once a product sought after by retirees, LTC insurance is being considered a must-have by an increasing number of baby boomers. According to the American Association for Long-Term Care Insurance, 50 percent of purchasers in 2007 were between the ages of 55 and 64, 33 percent were under 55, and only 17 percent were over 65. More than 62 percent of group LTC insurance purchasers were under age 55, taking advantage of programs offered by more than 10,000 employers nationwide.

Factors impacting the premiums go beyond age. Insurance carriers often sell a policy series for several years before introducing a new generation of coverage, often times pricing the new plan significantly higher than the premiums enjoyed by those who started earlier. A 50-year old considering a daily benefit today of $200 with the 5 percent automatic compound inflation rider would have to buy a $255 daily benefit at age 55 or $326 per day at age 60 in order to match the growth due to the automatic inflation adjustment inside the policy. Insurance companies frequently offer 10 to 15 percent discounts for those in excellent health, and a 30 to 40 percent discount for couples both applying and approved. Should the applicant lose one or both of these discounts in the future by waiting, the premiums will be significantly higher.

7-15. Is Long-Term Care Insurance Right for Me?

To answer this question, begin with two basic questions:

1) Can I pass the health underwriting required by the insurance company to qualify for a policy?
2) Can I afford the premiums for a policy that meets my needs and expectations?

If the answer to one of these questions is "no," then LTC insurance may not be available or appropriate. If the answer to both questions is "yes," continue to become educated about this important topic. Talk with an insurance agent with expertise in LTC insurance. You may wish to work with an insurance broker who can help you consider more than one insurance carrier. The agent or broker may help you consider ways to pay the premiums, design a policy to fit your budget, compare and contrast the different types of LTC insurance, and more.

7-16. Tax Incentives

Colorado offers a state income tax credit equal to the lesser of 25 percent of premiums paid for a tax-qualified LTC insurance policy or $150 per policy. Individuals who qualify for the credit are those with federal taxable income less than $50,000. Joint filers claiming a credit for two policies must have federal taxable income less than $100,000 (see Colorado Department of Revenue FYI tax publication #37).

Generally, unreimbursed medical expenses and premiums for tax-qualified LTC insurance are deductible from federal income tax if qualified medical expenses exceed 7.5 percent of adjusted gross income. Deductible premiums for LTC insurance are limited to the following table (deductible amounts increase each year):

Attained Age in 2009	Limitation of Premiums
Age 40 or less	$320
Age 41 to 50	$600
Age 51 to 60	$1,190
Age 61 to 70	$3,180
Age 71 and above	$3,980

(Rev. Proc. 2008-66)

C corporations may be able to deduct 100 percent of premiums paid on behalf of employees and spouses. The self-employed may also enjoy some tax deductibility. Group plans may have the added benefit of discounted premiums and limited health underwriting.

Finally, the benefits received from a tax-qualified, reimbursement LTC insurance policy are not subject to income tax. Daily benefits received from a cash or indemnity policy are income-tax-free up to $280 per day in 2009. Benefits received above $280 are taxable as income unless used for qualified medical expenses.

7-17. Choosing the Right Carrier

Know that there is no such thing as "the best company" or "the best policy," as different people have different needs. Clearly, the lowest premium does not necessarily mean the best value. Choose a carrier with high financial ratings from A.M. Best, Moody's, Standard & Poor's, and others. Look for a carrier that has written LTC insurance for more than just a few years. Consider whether your needs are best met by a reimbursement, indemnity, or cash plan, or a combination LTCi policy.

7-18. Resources

A Shopper's Guide to Long-Term Care Insurance

Published by the National Association of Insurance Commissioners and available from an insurance carrier or agent, or www.naic.org

Colorado's website dedicated to Partnership Plans

www.coloradoltcpartnership.org

National Clearinghouse for Long-Term Care Information

www.longtermcare.gov

The Centers for Medicare and Medicaid Services

www.cms.hhs.gov

Colorado Division of Insurance

(303) 894-7499
www.dora.state.co.us/insurance

Colorado State Health Insurance Assistance Program (SHIP)

(800) 544-9181

Colorado Division of Aging and Adult Services

(303) 866-2800
www.cdhs.state.co.us/aas

Veterans' benefits

www.va.gov