Developing Financial Planner Recommendations for Long-Term Care Insurance Policies

Although long-term care insurance has been around in some form since the 1980s, its popularity only began to significantly rise after Congress established so-called "tax-qualified" long-term care insurance policies as a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This act, which was responsible for a broad range of reforms in the health care industry, also established IRC Section 7702B. In this newly created section of the Internal Revenue Code, Congress set forth most of the tax-code-mandated provisions with respect to so-called "tax-qualified" long-term care insurance policies. Since then, both the evolution of the long-term care insurance market, and a growing awareness of the significant potential cost of long-term care needs, have led to a tremendous increase in the utilization of long-term care insurance policies as a financial planning tool.

However, the myriad number of options and choices available when purchasing and recommending long-term care insurance makes it difficult for many planners to develop recommendations regarding the exact design for a policy. There is frequent debate amongst financial planners about many key points to be considered in the recommendation of any particular long-term care insurance policy.

The purpose of this month's newsletter is to set forth a series of guiding principles to aid in the process of developing long-term care insurance recommendations for clients. We will first explore the background and basics of long-term care insurance. Next, we will consider many of the common options and trade-offs that must be considered in the design of a long-term care insurance policy recommendation. Finally, we will apply this framework for developing policy recommendations for clients at varying levels of wealth, considering whether, how, and why long-term care insurance is (or is not) relevant for clients as their level of wealth increases.

Long-Term Care Insurance Design

About the Author

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Background and Basics of Long-Term Care Insurance

Under IRC Section 7702B, in order for a long-term care insurance policy to be tax-qualified, the policy is required to utilize certain rules to determine when an insured individual is eligible for long-term care insurance benefits – in other words, when the benefits are "triggered." The two standard benefit triggers for qualified policies, defined as being "chronically ill," are that for a period of 90 days, and pursuant to a doctor's plan of care, an individual inured must require care for/because he/she:

1) cannot perform at least 2 out of the 6 activities of daily living (bathing, continence, dressing, eating, transferring in/out of bed, and toileting) without substantial assistance; or

2) needs substantial supervision to protect the individual from threats to health and safety due to a severe cognitive impairment

Notably, some policies require that the individual require "hands-on" substantial assistance or supervision under the above terms; other policies may only require that the individual need a "standby" caregiver.

For all tax-qualified policies that provide benefits based on the triggers above, the basics of long-term care policy design are relatively straight-forward. The individual typically has six primary decision points to consider:

1) Amount of daily benefit
2) Duration of benefit period
3) Elimination period
4) Type of inflation rider (e.g., none, simple inflation, compound inflation)
5) Types of care covered (e.g., nursing home only, home health care, both)
6) Various additional riders (e.g., spousal joint policies, non-forfeiture benefits, etc.)

Items #1 and #2 (the amount of the daily benefit and the duration of the benefit period) ultimately combine to create a total benefit pool of dollars that are available for the insured to utilize and spend down to receive care. For example, if the daily benefit is $200/day, and the benefit period is 5 years, the total benefit pool would be $200/day x 5 years x 365 days/year = $365,000. This pool of money is anticipated to last for exactly 5 years if the individual actually draws the maximum $200/day for the full time period; if the insured makes claims for less than $200/day, then the benefit pool would last longer as it is depleted more slowly. The benefit pool, and the daily benefit amount, will typically inflate based on the terms of the inflation rider. (If the insured selects a lifetime benefit period, the benefit pool is not entirely applicable, since there is no benefit pool to be depleted when benefits are to extend indefinitely as long as the insured is still alive.)

Elimination periods (item #3 above) commonly have a limited number of discrete options available, such as 0, 30, 60, 90, 180, or 365 days. The elimination period is usually satisfied once the insured has been eligible for and receiving care for the specified number of days. However, long-term care insurance policies have varying terms to determine whether or *how* the specified number of days in the elimination period is actually satisfied. For some policies, the days of care have to be part of one continuous care event; for others, they may be accumulated through intermittent periods over a span of years. In some cases, the elimination period is only satisfied for each day of actual care received; in others, one week of the elimination period is satisfied as long as any care is received during that week. In addition, policies vary as to whether only nursing home care qualifies for satisfying the elimination period, or if home health care benefits also qualify, and the elimination period may be different for each type of care.

Inflation riders (item #4 above) typically come in only two varieties – simple or compound inflation (or the policy owner may choose no inflation rider). The riders virtually always provide for a set percentage rate of increase, most commonly 5% (as opposed to an inflation adjustment based on a standard measure of inflation such as CPI). A simple inflation rider increases benefits (the daily benefit amount, and the available benefit pool) by a fixed 5% of the original benefit. A compound inflation rider increases benefits on a 5% compounding basis over time. Notably, policies may vary as to how the compound inflation rider is applied after claims have begun; some policies will calculate the compounding based on remaining benefits, while others apply compounding based on the originally projected benefits.

The table below shows the difference between simple and compound inflation riders over time, assuming an initial 3-year benefit period and a daily benefit amount of $200/day:

	Daily benefit amount			Benefit pool		
Year	None	Simple	Cmpd.	None	Simple	Cmpd.
1	$200	$200	$200	$219,000	$219,000	$219,000
2	$200	$210	$210	$219,000	$229,950	$229,950
3	$200	$220	$221	$219,000	$240,900	$241,448
4	$200	$230	$232	$219,000	$251,850	$253,520
5	$200	$240	$243	$219,000	$262,800	$266,196
6	$200	$250	$255	$219,000	$273,750	$279,506
7	$200	$260	$268	$219,000	$284,700	$293,481
8	$200	$270	$281	$219,000	$295,650	$308,155
9	$200	$280	$295	$219,000	$306,600	$323,563
10	$200	$290	$310	$219,000	$317,550	$339,741
11	$200	$300	$326	$219,000	$328,500	$356,728
12	$200	$310	$342	$219,000	$339,450	$374,564
13	$200	$320	$359	$219,000	$350,400	$393,293
14	$200	$330	$377	$219,000	$361,350	$412,957
15	$200	$340	$396	$219,000	$372,300	$433,605
16	$200	$350	$416	$219,000	$383,250	$455,285
17	$200	$360	$437	$219,000	$394,200	$478,050
18	$200	$370	$458	$219,000	$405,150	$501,952
19	$200	$380	$481	$219,000	$416,100	$527,050
20	$200	$390	$505	$219,000	$427,050	$553,402

Policies may also vary as to the type of care provided (item #5). The insured may be eligible for benefits for care received at a nursing home, for home health care, or for both. However, given the strong trend in recent years for individuals expressing a desire to receive care in the home to the extent possible, it is extremely common in today's marketplace to be considering only policies which all provide full benefits for both nursing and home health care situations. Nonetheless, some policies may provide care only for one or the other, while others may only provide "full" daily benefits for nursing home care and only make a percentage of those benefits available for home health care (e.g., the home health care daily benefit amount may be set to 75% of the nursing home daily benefit amount).

Beyond the basic benefits described above, policies typically offer a number of additional rider options, including so-called "joint" or "spousal" policies where both spouses can take withdrawals from a single combined benefit pool, and non-forfeiture benefits that provide a certain amount of minimum benefits even if a policy is cancelled after several years of premium payments.

LTCi Policy Design

Financial planners often need to recommend a long-term care insurance policy as a result of reviewing a client situation. However, given a limited cash flow budget, in most cases the client can't exactly just buy an unlimited policy with all the bells and whistles. So, how does the planner evaluate the trade-off considerations necessary to provide a cogent insurance recommendation, balancing amongst daily benefit amounts, benefit periods, elimination periods, inflation riders, and more?

Although every client situation is ultimately unique, some guiding principles to consider in the design of long-term care insurance recommendations can aid tremendously in weighing these critical trade-offs. Below, we will explore several key principles that can help facilitate the policy design process for complex insurance recommendation, all oriented around a general guiding philosophy – to maximize the potential to extract value from the policy, and to apply the overall principles of insurance and what constitutes a risk that should be insured.

Daily Benefits vs. Benefit Period

One of the first key trade-offs to consider is the amount of the daily benefit versus the duration of the benefit period. Classically, this comparison is often something to the effect of: Should I purchase a $200/day benefit for 3 years, or a $100/day benefit for 6 years? In both cases, the starting "pool" of money is the same: $200/day x 3 years x 365 days = $100/day x 6 years x 365 = $219,000. Although this comparison isn't always quite identical in price (but it's often close), it helps to illustrate the underlying question – how do you weigh the trade-off between a longer benefit period with smaller daily benefits, versus a shorter benefit period with a larger daily benefit?

Some experts in the industry call this a comparison between "short-fat" and "long-thin" policies – in essence, is the policy short or long (i.e., short benefit duration period or a longer one), and is the policy daily benefit amount fat (large daily benefit) or thin (small daily benefit). So given the choice between the short-fat policy ($200/day for 3 years) or a long-thin policy ($100/day for 6 years), which direction should you go?

To the extent that the cost between the two is about the same, the short-fat policy should win the day virtually every time. The reasons for this are numerous, but typically include the following:

1) If your claims on a short-fat policy simply aren't high enough to extract the full daily benefit amount, you can always make claims more slowly and in effect treat it like a $100/day policy that will last for 6 years. In other words, if you purchase a $200/day policy with a 3 year benefit period, but only make claims of $100/day, the benefit pool will still last for 6 years. Thus, a short-fat policy can always be used as though it were a long-thin policy. However, if you purchase it the other way around (i.e., buy

Out and About

- Michael will be speaking at the FPA Illinois Financial Forum about "Key Issues for the Next Generation of Financial Planners" on June 16th.

- Michael will be speaking on "Tactical Asset Allocation using ETFs" for the Financial Research Associates' 2008 Investment Advisors ETF Summit on June 24th.

- Michael will also be presenting at the FPA NexGen 2008 conference on July 26th on "Advanced Concepts in Long-Term Care Insurance Planning."

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a long-thin policy), you have no such flexibility to accelerate the payments and treat it like a short-fat policy – once you reach the daily maximum of a long-thin policy, you are capped and cannot receive any more benefits for that day. Thus, a short-fat policy allows you to maximize benefits with a higher cost of care, and still receive the equivalent of a long-thin policy with a lower cost of care, while a long-thin policy simply restricts the ability to make claims in the case of more expensive care needs.

2) Although we often fear the ultra-long-term insurance claim (or the costs of a very extended period of long-term care needs if coverage is insufficient or non-existent), the reality is that the average need for care is only about 2-3 years (depending on which statistics you cite). So while it's nice to be insured for a longer claim – if it happens – you may be giving up a lot of benefits for the much-more-common, shorter-term claim where coverage can provide an immediate positive financial impact.

3) For those of limited means, where a significant long-term care event may ultimately cause them to rely on Medicaid anyway, having a short-fat policy can at least provide substantive care and significant benefits for a limited period of time. If the individual outlives the time period and exhausts both their policy benefits and their assets, they may ultimately end out receiving support from Medicaid. However, with a long-thin policy, the individual may in fact require Medicaid sooner, because the long-thin policy cannot sustain private long-term care facilities *at all* if other assets are unavailable. At least with a short-fat policy, a full claim on the policy may fully cover the costs of care for a limited period of time before ultimately reverting back to Medicaid support (depending on the amount of the daily benefit, of course).

4) A related benefit of short-fat policies is the increased flexibility in choosing a facility. With a short-fat policy, the individual will have the buying power, for a limited number of years at least, to choose from a broader range of facilities given the size of the daily amount available to pay for care (and when including any other available assets to pay for care). On the other hand, the long-thin policy – combined with the individual's other assets – may be insufficient to afford a higher level of care at any point or for any reasonable amount of time. The short-fat policyholder in essence is buying additional flexibility with respect to care facilities – at least until the policy benefits are exhausted. But if the individual was ultimately going to require Medicaid because both assets and benefits would eventually be insufficient to pay for care, it will likely apply whether the policy is long-thin or short-fat. Thus, given limited benefits to utilize before applying Medicaid, the short-fat policyholder receives full flexibility using the full daily benefit, then relies on depleting assets, and finally applies for Medicaid. The long-thin policyholder, on the other hand, begins utilizing assets immediately in conjunction with the thin policy benefits to receive some care, and may ultimately deplete the assets even while still drawing claims on the policy. If after several years other assets are depleted, the long-thin policy insured may be forced to apply for Medicaid, even while continuing to receive the remainder of a $100/day benefit – however, whether that remaining claim is available or not, the individual will likely still be fully subjected to the rules of Medicaid at that point, which brings the value of those "extra" years of long-thin claims into some doubt.

In short (no pun intended), the short-fat policy gives the individual an "opportunity" to at least attempt to extract significant value from a long-term care insurance policy, and have more flexibility with respect to decisions about where and how care is received, even if the claim is only for a limited period of time. However, with a long-thin policy, the individual typically *only* has the opportunity to harvest significant value from the policy if the claims really *do* last for an extended (and somewhat less likely) period of time. And in the meantime, the long-thin policyholder may not have as much control over his/her choice of facilities for as long, especially if the other remaining assets available for care are quite limited.

The reality, though, is that the above trade-off has one other factor to consider – that companies do tend to price a short-fat policy slightly higher than a long-thin policy that produces an equivalent-sized benefit pool. This is true for the exact reasons stated above – that a short-fat policy gives the insured a better chance, "on average," to extract a significant claim on the benefit pool, compared to the long-thin policy insured that will only draw significant claims if the health event does in fact extend for a much longer (and unlikely) period of time. The company will generally price the policy accordingly.

Nonetheless, when considering the trade-offs in short-fat versus long-thin policies, the short-fat policy virtually always prevails, because of its superior opportunity to harvest value, and the insured's often-significantly-improved flexibility with respect to their decisions about where/how to receive care for a limited time period. As will be discussed later, the only occasional exception to this general rule for short-fat policies is in the case of long-thin policies specifically with *lifetime* benefits, where the potential opportunity for claims may be significantly higher, over the long run, than even a well-designed short-fat policy.

How Much Should I Buy?

Once you make a decision about recommending a short-fat versus a long-thin policy, you still need to choose how much of a long-term care daily benefit amount to purchase – or at least, what the "full" anticipated daily cost is that you may be partially insuring.

The starting point is typically based on national statistics for the cost of care, such as $209/day for a private room in a nursing home in 2008. However, one needs to be cautious about national average cost of care statistics for several reasons.

First of all, the national average amount is just that – a *national* average. The reality is that the costs of care in any particular geographical location can deviate significantly from this national average cost of care. So as a starting point, it is crucial to at least narrow down the evaluation of the average cost of care to an analysis that takes into account the insured's geographical location. Some resources to receive a quick analysis of the cost of care by state (with additional detailed information for some metropolitan areas) include:
www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx
www.ltcfeds.com/ltcWeb/do/assessing_your_needs/costofcare?action=costofcare

Once you've narrowed down the cost of care to your state or metropolitan area, are you done with your evaluation of the cost of care? At this point, opinions seem to vary more amongst financial planners. Many will stop here, and use the resources like the ones above to determine a target level for the cost of care to insure. However, others may go even deeper into the analysis, visiting specific facilities in their area (or in the area where many/most of their clients currently live) to determine the cost of care for the *actual* facilities that their clients would likely inhabit. Not surprisingly, in many cases the facility's costs will likely be close to the average, but in some cases the particular facility the client would likely choose may be more or less expensive.

The specific facilities a client might select are not always simply a matter of what's near the client's current residence. In some cases, a facility across town, across state, or even across the country may be more relevant, since in many cases an individual needing care is relocated by the family to be near other family members, particularly if the individual does not currently have a spouse that may help as a caretaker. So the facilities available near the client's children (or one child in particular) may be more relevant than the facilities in the client's own neighborhood.

Beyond the location issue for the sake of geography with respect to family members, visiting specific facilities in the area may also reveal which care providers appear to be "nicer" and more desirable, versus those that provide a lesser apparent experience or quality of service. In some cases, planners may also try to meet with a geriatric care manager in the area, to gain more insight about particular facilities.

Visiting facilities in the area, and examining their costs, may also provide further insight about what is realistic to assume as a *total* cost of care for the facility. In many cases, the base daily rate for a nursing facility provides a very bare-bones care experience. For individuals that need further assistance, additional visits from the nurse, extra care or therapy, or simply more amenities like a more private room or a television, may find a series of additional charges that add to the base daily rate. Thus, the full experience in a facility may be at a much higher cost than the daily base rate alone implies.

In addition, it's important to remember that in general, clients accustomed to a certain standard of living will likely have expectations of a commensurate care experience and service level when living in a facility. In other words, those accustomed to an above-average standard of living in their personal lives are significantly more likely to select an above-average-cost facility in which to receive their care. Thus, simply relying on the averages for the cost of care may also be misleading, particularly for more affluent clients, because the reality is that the cost of care for a facility that a particular affluent client might select may be quite a bit higher than the overall average for the state or metropolitan area. Visiting specific facilities, and considering the cost of care in facilities that cater to more affluent clients,

can help to better evaluate and anchor expectations about the cost of care for such clients.

Finally, it's also notable that for many (most?) clients, there is a strong preference to receive care in the home to the extent possible. Depending upon the extent of care required, the total cost for care in the home may in some cases be significantly higher than the cost for a nursing home. At the point where an individual needs round-the-clock medical care, the cost of paid professional care (which may easily be in the range of $20 to $40/hour, depending on the level of care and the geographical location), can rapidly spiral care costs upwards of $400, $600, or even $1,000/day when paid for a full 24 hours per day. Obviously, many clients cannot afford this level of care. Nonetheless, thought should be given to whether the daily or monthly costs for a client's care may ultimately rise significantly above the geographical averages for the cost of care, for those who are particularly insistent, or who are simply likely given their affluence and personal preferences, to receive extensive care in the home. A conversation with a geriatric care manager in the area may provide additional insight about the typical costs of extensive in-home care for clients that may be likely to choose such a path. (For more information about geriatric care managers, and how to find one, see www.caremanager.org).

Shared vs. Individual Policies

After a decision has been made about the target daily benefit for the associated cost of care, and whether to purchase a short-fat or a long-thin policy, most long-term care insurance companies provide another choice to consider: individual versus shared policies. So what's the difference?

An individual policy is the 'standard' form of long-term care insurance with which most of us are familiar. Under this type of policy, there is one insured individual, that individual can make claims, and in the event of extended claims that individual can exhaust the available benefits under his/her policy. If the individual happens to be half of a married couple where both spouses bought policies, that individual's policy may be exhausted, while the other spouse's policy continues to have full benefits available for the remaining spouse. If the individual dies with the policy before exhausting benefits, those remaining benefits are lost (at least for almost all policies on the market), but the surviving spouse's policy may still remain, with full benefits available, for that surviving spouse.

A shared policy, on the other hand, typically provides some form of combined, or "pooled," benefits that are available for *both* spouses to use. Under this structure, either spouse can potentially utilize and exhaust the available benefit pool, but to the extent that one spouse does not use all (or any) of the policy benefits, the full amount remains for use by the surviving spouse.

For example, a husband and wife considering the purchase of a $200/day policy with a 6-year benefit period for each, would ultimately have 6 years of benefits available (at the full $200/day rate) for the husband, and a separate 6 years of benefits that the wife could utilize. On the other hand, the couple might alternatively consider a $200/day policy with a 10-year shared benefit period (yes, given the pricing of shared policies, this is not an uncommon trade-off equivalent). Typically, each spouse is subject to the daily maximum amount, but both spouses could make claims separately or simultaneously from the benefit pool (such that it is possible for both spouses together to claim a total of $400/day from the policy, at a daily maximum amount of $200/day per person). If both spouses had simultaneous maximum claims, the policy would pay out to each for 5 years. Thus, in the latter case of a shared policy, it is notable that the aggregate amount of benefits has decreased, from a combined total of 12 years of benefits (6 years each) to only 10 years of benefits (as the stated shared policy benefit period). However, the trade-off is the flexibility that if one spouse has a claim that lasts shorter than 4 years (bearing in mind that the average is typically only cited to be 2-3 years), the surviving spouse will have a policy with a remaining benefit of more than 6 years (out of the original 10-year total), in excess of what he/she would have had by simply purchasing separate policies. Notably, joint/shared policies only provide a choice of limited benefit duration periods; if a policy provides lifetime benefits, sharing would be a moot point (how do you share "unlimited" lifetime benefits!).

A common criticism of the shared policy is that there is a "risk" that the first spouse to need care could have a significant claim, and thereby deplete most or all of the entire joint policy, leaving the surviving spouse with no

available coverage. However, it is important to note that in such a situation, where the first spouse's care depletes all 10 years of benefits, that if separate policies had been purchased the spouse would have already *spent down assets* for 4 years (having exhausted the otherwise assumed 6-year individual policy). So while it's bad news that 10 years of claims have been exhausted, the good news is that 4 years of "extra" claims have already been made that would have otherwise been spent down from assets. If this means the assets also receive additional time to grow, the time value of deferring claims by drawing on an extra 4 years of benefits for the first spouse can increase the value of the strategy (and enhance the amount of assets available for the surviving spouse or heirs of the estate) even further. In the end, it requires that the surviving spouse have a multi-year claim, even after the first spouse's 10-year claim, to end out with an economically inferior result of any significance compared to simply purchasing two 6-year policies. And the reality is that such a series of claims is somewhat unlikely, to say the least, given the average period of care is usually only 2-3 years. If a married couple truly has a very high concern of upwards of 10-12 years of combined claims, perhaps a policy with lifetime benefits should be considered as an alternative.

In essence, the approach of utilizing a shared policy for couples is not unlike the philosophy of the short-fat policy in the first place – the goal is to maximize the likelihood of receiving benefits for a limited period of time, and/or if only one spouse has a significant claim. If both spouses fear a series of very significant long-term care events, then, as mentioned above, they might consider a policy with lifetime benefits (which makes a joint policy a moot point), or accept that significant claims beyond the coverage of a joint policy will be self-insured and/or will force them to rely on Medicaid if they deplete assets entirely (which is, of course, the situation for which Medicaid was originally intended to provide).

It is also notable that some carriers are expanding the definition of what "couples" may purchase joint policies. Early on, joint policies were designed primarily for spouses. However, some companies will now consider offering joint policies for unmarried couples that live together, same-sex domestic partners, and in some cases even co-habitating siblings.

Elimination Periods

The elimination period – the long-term care insurance policy's equivalent of a "deductible" – is another point of debate in the design of long-term care insurance recommendations. Elimination periods are typically available in set increments from most policy providers, and may include options like 0, 30, 60, 90, 180, and 365 days.

Many financial planners advocate a short elimination period, pointing to the fact that the cost of care is so high that virtually any level of claim will fully recover the incremental cost of the lower deductible, with a significant return as well. For instance, the difference in cost to go from a 90 day elimination period to a 30 day elimination period may be around $200 to $600/year in cost, depending on the other policy benefits. On the other hand, the extra 60 days of coverage, potentially at a cost of $200/day or more for care, can far outweigh the extra cost of the elimination period. As proponents of the short elimination period point out, why wouldn't you pay an extra $200-$600/year in premiums, for a potential additional benefit of 60 days x $200/day = $12,000 in the available pool for claims (assuming an underlying policy with $200/day as a daily benefit amount; when accounting for an inflation rider, the total value for claims during this period would be even higher!). And the best news is that if you have *any* claim, these "extra" benefits are the *first* benefits you get to extract out of the policy to recover your additional elimination period costs! Furthermore, given the high probability that most individuals will have at least *some* claim, shouldn't this be great protection for everyone?

On the other hand, when considering elimination periods, financial planners should bear in mind the principles of why insurance protection is important in the first place. The purpose of insurance is to protect against large risks, typically that the individual otherwise cannot afford to self-insure (or at least would not wish to self-insure). From this perspective, while it's interesting to observe that reducing an elimination period from 90 days to 30 days might provide an extra $12,000 potential benefits at a "relatively" modest cost, is this really a risk that the individual needs to insure? Of course, $12,000 is not a trivial amount of money, but for nearly all individuals who actually make a decision to purchase long-term care insurance, a $12,000 cost for 2 months of care is not exactly a catastrophic loss, especially if an insurance policy will begin paying claims shortly thereafter.

This logic could actually be extended to suggest that not only is it unnecessary in many cases to purchase shorter elimination periods, but that it might be advisable to consider significantly *longer* elimination periods than the industry's most-commonly-selected 90-day option. For an affluent individual, 6 months may be a very

reasonably affordable "deductible" for a long-term care event. In some cases, a 1 or even 2 year elimination period could be feasible if it helped to significantly reduce the cost to allow for the purchase of more extensive overall coverage. For example, the affluent individual who is trying to insure against truly catastrophic risks might be far better served to purchase a lifetime benefits policy with a 2-year elimination period, than "only" a 4-year policy with a 90-day elimination period.

However, the reality is that thus far, the long-term care insurance market has not evolved very much in this area. Often, the premium savings for adopting significantly longer elimination periods is surprisingly modest, and in any event almost no insurance carriers will write a long-term care insurance policy with an elimination period longer than a 1 year period. And even in those cases, the premium savings to increase this deductible from 180 days to 1 year may not feel like a very significant cost reduction, relative to the amount of benefits that the insured gives up.

So in the end, it appears that purchasing significantly longer elimination periods may have to wait until the pricing trade-off appears to be more desirable. But at the least, financial planners should seriously reconsider the higher premiums of ultra-short elimination periods (e.g., 30 days or 0 days), unless the client truly needs to retain such a small deductible before making claims to provide for their care.

Non-Forfeiture Benefits

After the primary policy benefits have been selected, most insurance carriers offer various riders, and one of the most common is some type of non-forfeiture benefit. In essence, a non-forfeiture benefit is something that the policy holder will receive back, if the policy is cancelled without being utilized. The cash value that a policyowner might receive upon the surrender of a permanent life insurance policy is an example of a non-forfeiture benefit from the life insurance world. Without a non-forfeiture benefit, a policyholder that surrendered a policy, even after paying premiums for many years or decades, would receive absolutely nothing – the equivalent of a term life insurance policy.

While long-term care insurance policies do not provide for a cash value upon surrender, insurance companies providing tax-qualified policies do offer the opportunity to purchase at least some kind of non-forfeiture benefit – in fact, it's required under IRC Section 7702B(g)(4) that the company at least *offer* some type of non-forfeiture benefit for a long-term care insurance policy. Some states may also have state laws that require additional rules or provisions with respect to non-forfeiture benefits for long-term care insurance. The most commonly seen types of non-forfeiture benefit riders include: a reduced paid-up benefit; a shortened benefit period; or, a return of premium rider.

With a reduced paid-up benefit, a surrender of the policy will typically provide the insured with a significantly reduced daily benefit amount, but one that will automatically be payable with lifetime benefits in the event that the insured has a long-term care insurance claim. For instance, if the individual surrenders a $200/day policy with a 5-year benefit period after paying premiums for 12 years, the insured may receive a reduced paid-up policy that provides for $30/day of benefits with a lifetime benefit period.

A shortened benefit period, on the other hand, will typically retain the original daily benefit amount (usually with the subsequent inflation adjustments as well), and will simply shorten the benefit period dramatically. In most cases, the benefit period is shortened to the point that the individual would simply be able to recover their aggregate premiums paid, which would be received in the form of long-term care insurance claims. For example, if the individual had purchased a $200/day benefit amount and had paid premiums of $3,500/year for 10 years, then upon surrender the individual would receive a shortened policy with a $200/day daily amount (likely adjusted upwards for inflation) but with a total benefit pool of only $35,000 (which would return the premiums of $3,500/year x 10 years). Thus, it may only take a few months of claims to fully exhaust the modest non-forfeiture benefit pool, but nonetheless it does provide some value for a policy that is surrendered after several years of premium payments.

In the case of both the reduced paid-up benefit and the shortened benefit period, no further premiums are due to receive the non-forfeiture benefit after the policy is surrendered. However, in both cases, no actual benefit is ultimately received until/unless the individual actually has a long-term care insurance claim. In addition, with both types of non-forfeiture benefits, an insurance company may require that the policy remain in force for a certain number of years before it is surrendered, in order for the non-forfeiture benefit to apply.

The return-of-premium rider differs from the other non-forfeiture benefit types above in that it typically allows for a return of premiums *in cash* at the time of surrender (or sometimes at death), rather than simply making the

non-forfeiture benefits available *in the form of long-term care insurance claims*. Such riders usually will require a significant period of time where the policy is in force and receiving premium payments (e.g., 10 years) before the policyowner would be eligible to receive premiums back under the terms of the rider. In addition, it is commonly required that during the in-force period the policy premiums must all be paid on time and there must be no actual long-term care insurance claims. In some cases, the rider may only apply in the event that the insured *dies* without making a claim, while in other cases the rider applies in the event of surrender or death. Under a few policies, the return of premium rider may still apply if claims have occurred, but the claims will reduce the amount that would otherwise be returned (which typically means even a modest claim will wipe out any actual return of premium benefits). The essential core of the return-of-premium rider, though, is that the individual has some assurance that as an insured, he/she *will* either receive benefits under the policy, or will receive a return of the premiums paid (either to the individual, or to the individual's estate/heirs at death). Thus, many view this as an almost "free" way to obtain coverage, since they are guaranteed to receive either a return of premiums or a claim on the policy. Of course, even when the return of premium rider applies, the individual does still give up the right to receive income on those premiums – it is the time value of money that the insured company receives, which gives them the financial ability to provide such coverage.

Return of premium riders tend to be quite expensive. Depending on the overall policy design and the age of the insured, the riders discussed above could increase the base cost of the policy anywhere from 20% to 100% (i.e., in some cases a return of premium rider can literally double the cost of the policy). However, it is true that to the extent the cost of the policy is higher due to the rider, those increased premiums are included as a part of the non-forfeiture benefit. For example, if a policy with a cost of $3,000/year has a return of premium rider that increases the cost to $5,500/year, the full $5,500/year premium will be eligible for the terms of the return of premium rider.

So are non-forfeiture riders a good idea? In most cases, the answer should be "no," because an approach of paying extra for non-forfeiture riders in essence violates the underlying principles of large loss risk insurance. For most individuals, the risk that should be insured is the potential need for long-term care, not the risk that they pay premiums but turn out not to need long-term care. Even worse, for some non-forfeiture benefit riders, the individual still receives nothing in the event of *dying* with a long-term care insurance policy – the provision really only provides benefits in the event that the individual surrenders the policy before death and before receiving claims, yet after paying premiums for enough years to have the rider apply to the surrender. Thus, in essence, the individual often is really only insuring against his/her own future decisions, and can theoretically avoid ever having this particular risk occur by simply committing to actually maintain the insurance policy in the first place! Notwithstanding all of the above, though, the most significant adverse impact of a non-forfeiture rider is that if the individual insured really *does* have a claim, *the non-forfeiture provision simply means that the individual paid a significantly higher premium to receive the exact same benefit for a long-term care claim*! In other words, why pay $5,500/year for a long-term care insurance policy with a return of premium rider, when you could choose to only pay $3,000/year for the exact same amount of coverage if you actually *need* care by simply declining to purchase the non-forfeiture rider? With most non-forfeiture riders, it is not only a failure to insure a large loss (because, at the end of the day, losing the premiums paid over the years is not a catastrophic financial loss), but it may actually represent a significant overpayment to insure against the same primary risk loss in the first place!

Should non-forfeiture riders even be used then? Why did Congress require insurance companies to offer non-forfeiture provisions as a consumer protection if they're such a bad approach? Because there are some situations in which such riders can still be appropriate. The primary purpose of non-forfeiture provisions, and when they *should* still be considered for clients, are situations where there really is a *financial* risk for the insured that he/she may not be *capable* of continuing premium payments, where the loss of the policy after several years due to external factors could represent a significant additional financial loss. For example, if the insured is already depleting assets, and there is a risk that assets available to make premium payments may ultimately be exhausted, a non-forfeiture provision may be desirable to manage this risk. In addition, for policyowners who may be unable to afford the policy in the event that the company needs to apply a premium rate increase, a non-forfeiture provision may be desirable to ensure that he/she is not priced out of the affordability of policy benefits in the future. Of course, for such individuals, the additional cost of an optional non-forfeiture provision itself can exacerbate the problem of a policy that was already difficult to afford, but nonetheless this is the primary group that would potentially benefit from such a rider. On the other hand,

for those who are affluent enough to be capable of reasonably affording the cost of coverage, can continue to make payments for life, and for whom making years of premium payments without a claim may be an insurance expense but not itself a catastrophic loss, the value of non-forfeiture riders is highly suspect.

To the extent that an individual *is* going to consider a non-forfeiture rider because of the financial limitations discussed above, the shortened benefit period (where the full daily amount is payable, but simply for a limited period of time as premiums are recovered through long-term care claims) is generally the most desirable. It tends to be significantly more favorably priced than a return of premium rider, and furthermore is more consistent with the philosophy of purchasing a short-fat policy (whereas a reduced paid-up non-forfeiture rider is more analogous to buying a long-thin policy). Thus, for those where the non-forfeiture rider is most relevant – those with limited financial wherewithal to pay for coverage and care who need to harvest whatever they can from a policy in a limited time period – the lower price and short-fat nature of a shortened benefit period non-forfeiture rider yields the best fit.

Indemnity vs. Reimbursement

Given all of the discussion above about how to structure policy benefits and riders, an underlying question remains: What overall type of policy payment structure do you want to have for your long-term care insurance? The two basic types are reimbursement, and indemnity (also called per-diem), and each have their own unique traits and advantages/disadvantages.

The basic approach of a reimbursement policy is that you will receive a reimbursement of eligible expenses under the policy, once the triggers for benefits apply and the elimination period has been satisfied. Administratively, this typically involves submitting a series of receipts to the insurance company on a regular basis; the insurance company in turn will review the receipts, apply them against the daily benefit amount, and determine the amount of eligible claims to be paid. Payments of claims will reduce the remaining pool of available benefits, until the pool has been exhausted by reimbursement payments.

An indemnity policy, on the other hand, will typically simply pay the stated daily benefit amount, regardless of the amount of actual expenses on any particular day. In some cases, the policy will only pay a benefit on any day for which you actually received care (although the full benefit is paid regardless of whether the expenses were $2 or $200); with other policies, the indemnity benefit may be paid for every day on which you were eligible for benefits, regardless of whether any costs were incurred or care was received on that particular day. In other words, for many indemnity policies, the mere fact that the individual has triggered benefits due to an inability to perform 2 out of 6 activities of daily living or as a result of cognitive impairment is sufficient to be eligible for receiving payments of the daily benefit.

From one perspective, indemnity policies are viewed as a significant advantage because, in essence, it is easier for the insured to maximize benefits received under the policy. For example, if an insured was eligible for long-term care benefits for the week, and had actually incurred costs of $140 on Monday, $200 on Tuesday, $60 on Wednesday, $140 on Thursday, $200 on Friday, $120 on Saturday, and $120 on Sunday (for a total cost for the week of $980), the policyowner would receive a payment of $980 from a reimbursement policy with a $200/day daily benefit amount. On the other hand, the indemnity policy would simply pay out $1,400 (equivalent to $200/day x 7 days), which the policyowner could use in any manner desired.

The flexibility of the indemnity policy can be very broad in some situations. For instance, in the above example, the total payments of $1,400 from the indemnity policy could be spent on a broad range of long-term care services and needs on behalf of the insured, or even for other ancillary purposes not directly related to the long-term care needs at all. By contrast, the reimbursement policy only allowed payments of $980, which by definition were provided *only* to reimburse for the exact costs listed that were eligible for reimbursement under the policy in the first place. Thus, the indemnity policy payments might be used for extra services such as delivery of groceries to the home, or payment to a family member for care or services, or something else, which otherwise would likely be declined as a claim under a reimbursement policy.

On the other hand, indemnity policies have also been criticized for their "excess" flexibility, most significantly because it puts a high burden on the insured (or the financial guardian of the insured) to make prudent financial decisions at a time that is typically very stressful for the family. For instance, it is technically possible under an indemnity policy that payments over and above the actual cost of care for the day/week/month (or even in lieu of paying for care!) could be spent for purely frivolous or unrelated

purposes, diminishing the amount of benefits available for more important future care-related needs. This doesn't have to be the case – the indemnity policyowner could simply take any "extra" indemnity payments for the day/week/month and depositing them into a bank account for future use when expenses rise – the reality is that this often does not occur. Instead, many individuals and families make less prudent decisions in the short term, and ultimately impact the continuity of care and the financial ability to pay for such care in the future. After all, if the indemnity policy will pay the full daily benefit every day that the individual is eligible for care, then the reality is that a $200/day policy with a 4-year benefit period *will* be exhausted at the end of 4 years, so the insured had better be making prudent financial decisions. At least with a reimbursement policy, if eligible expenses aren't at the full $200/day maximum throughout, a portion of the reimbursement benefit pool will not have been distributed, and thus the insured will actually still have at least some level of benefits remaining beyond year 4 to provide for ongoing care.

Thus, for most clients the decision between recommending an indemnity versus reimbursement policy should be weighed in no small part by the likely fiscal responsibility of the insured and his/her family. Will the flexibility of the funds be an advantage for this particular family, or simply a risky temptation? While in an ideal world such a consideration would be unnecessary, from a practical perspective it is a factor that should be evaluated.

Beyond the flexibility from the insured's perspective, though, another point to consider with respect to indemnity policies is the fact that the low threshold for receiving payments (i.e., just be eligible for benefits, or in some cases just be eligible for benefits and receiving any level of care) reduces the risk of disputes with insurance companies. Although we would all hope that insurance companies do all of their underwriting and risk management upfront by making careful decisions about who will be allowed to purchase a policy, there are certainly industry critics who complain that companies sometimes try to manage their costs too aggressively at the time of claim. In other words, some companies try to recover for bad underwriting decisions or poor policy pricing by being very restrictive at the time of claim, and trying to reduce the amount of benefits paid to manage the company's profitability. With a reimbursement policy, the company has ample opportunity to scrutinize every expense, and determine whether it fits within the definitions under the policy to be eligible for reimbursement, before any payments are made. By contrast, the indemnity policy has far fewer points in the claims process where a dispute can arise between the insured and the insurer and/or where there may be a disagreement about how to interpret certain provisions of the policy. In addition, the associated paperwork burden is generally much less with an indemnity policy, because there is far less depth required (if any) in the process of receipt reimbursement tracking.

All else being equal, clients who will be comfortable managing the cash flows of an indemnity policy should probably lean towards this type of policy, given its flexibility, capacity to maximize benefits, and reduced risk of claims dispute. On the other hand, clients who will be less likely to prudently manage their claims cash flows (and/or who may have another family member who would be responsible but may not make the most prudent financial decisions), may be more inclined towards a proactive decision to select a reimbursement policy.

In today's marketplace, though, not all else is typically equal. As you might suspect, many insurance companies will charge more for an indemnity policy than a reimbursement policy because of the flexibility of payments (although this is mitigated to some extent by the reduced insurance company expenses due to the lesser paperwork burden on the claims department in managing receipts for reimbursement). In some cases, an indemnity/cash-based structure may actually be an available rider (at an extra cost) to change the otherwise applicable reimbursement approach of the policy to an indemnity-style policy. The extent of the additional expense for an indemnity rider on a reimbursement policy will depend on how broad the flexibility is for the indemnity rider (e.g., payments any day the insured has satisfied the overall benefit triggers, or only days when care is actually received). Although some carriers will write an indemnity-style policy as the "base" version of the policy at a comparable expense to many reimbursement carriers (instead of requiring it as an extra-cost rider), other differences in the contract's fine print may still make a direct apples-to-apples cost-benefit comparison difficult. Thus, from a practical perspective, the consideration of an indemnity policy over a reimbursement policy for a fiscally responsible client will have to be weighed as a trade-off of costs, other contract features, or both, in selecting the ultimate policy recommendation for the client.

A final cautionary note with respect to indemnity policies: as a part of the enactment of IRC Section 7702B (defining tax-qualified long-term care insurance policies), Congress included IRC Section 7702B(d)(2),

which applies certain limits for indemnity/per-diem policies. Specifically, the rules state that payments from an indemnity policy may be taxable, if they exceed the greater of $270/day (in 2008, adjusted annually for inflation) or the actual cost of care for the day. For example, if an individual has a $300/day indemnity policy and only incurs $250 of costs, then $30/day of the benefits will be taxable (because $300 is $30 greater than the $270 daily maximum under the tax code). On the other hand, if an individual has a $300/day indemnity policy but actually incurs $350 of costs, then none of the indemnity payments will be taxable because they do not exceed the actual long-term care insurance costs for the day. Thus, policy benefits are only taxable when they exceed the *greater* of $270/day *or* the actual cost of care for the day – but in that case, the amount of benefits paid that exceeds this threshold may be taxable income to the insured.

Who Needs Long-Term Care Insurance? And Why?

Bringing together all of the decision rules and strategies discussed above, and the overall applicability of long-term care insurance for clients depending on their situation, it should become clear that this type of insurance is truly not a one-size-fits-all type of recommendation. Instead, different clients will have varying needs depending on their situation (both financial and health-wise), which in turn may affect the decisions about whether to buy, what type of coverage to buy, and how to select from the various features and trade-offs discussed above.

Nonetheless, clients at certain levels of wealth do tend to exhibit certain trends and have particular common concerns that need to be addressed, that aren't necessarily as relevant for clients at other levels of wealth. Thus, by separating clients into different wealth classifications, we can begin to explore how to apply the rules discussed earlier and other long-term care insurance strategies to develop proper long-term care insurance recommendations. For the purposes of this discussion, clients will be tiered into the following five wealth levels based on net worth:

- Less than $200,000 in net worth
- $200,000 to $750,000 in net worth
- $750,000 to $2,000,000 in net worth
- $2,000,000 to $4,000,000 in net worth
- $4,000,000+ in net worth

Of course, financial planners may ultimately wish to adjust these thresholds slightly, based on the standards of living and costs of care in their particular areas, as well as the overall composition of client assets (e.g., $1,000,000 of wealth held solely in a primary residence has different planning issues than $1,000,000 of wealth held solely in a brokerage account, which in turn is different if the client also has a $60,000/year pension). Nonetheless, the thresholds above can be applied to begin exploring how to craft long-term care insurance recommendations for clients and to weigh in the proper factors.

Less than $200,000 in Net Worth

For clients with less than $200,000 in net worth, the decision to purchase long-term care insurance is typically not focused on asset protection issues. Relative to the thresholds for Medicaid and the available spousal allowances, along with the assets that are exempted, long-term care insurance is simply not very cost-effective in protecting assets for this group.

Thus, consideration of long-term care insurance for this group should primarily focus on providing for access to care itself. In other words, the most effective way for individuals at this wealth level to have the flexibility to select the facility in which they wish to receive care is to have long-term care insurance to be able to afford it. This is particularly true for those facilities that place restrictions on the number of available beds for Medicaid patients. Individuals at this wealth level that wish to purchase long-term care insurance often have a specific facility that they wish to receive care in at some point in the future, and are simply trying to purchase the necessary coverage to ensure they can afford to receive care in the desired facility.

To the extent that long-term care insurance is being considered, this group should especially focus on purchasing short-fat policies, and it should be a joint policy if there is a married couple, to maximize flexibility and the ability to utilize the policy for the limited number of years that the buyer can afford. Elimination periods will likely need to be moderate – typically 60 or 90 days – because a period that is too short makes the policy too expensive, but a period that's too long may leave the insured unable to afford care during the full elimination period. Daily benefit amounts are often targeted to afford care for a specific facility, and should be at a level to afford virtually the entire daily cost of that facility (since assets to supplement care are so limited). The benefit period duration of the policy is usually the longest possible given a very limited budget for the purchase; typically the benefit duration will only be 3 years. In many cases, clients in this group may consider a nursing-home-only

policy, without home care benefits, simply to make the coverage more affordable.

Since long-term care insurance for this group will be paid directly from income and limited assets, it often represents a very direct trade-off in current standard of living just to afford the policy. As a result, in practice long-term care insurance is rarely purchased amongst this group, but should be considered for those who wish to make such a trade-off between current lifestyle and future care.

$200,000 to $750,000 in Net Worth

For clients at this wealth level, long-term care insurance is typically first and foremost an asset protection decision. In some cases, the coverage may also simply help make a certain level of care affordable, but overall this is the wealth level where the financial impact of a long-term care event can result in the most significant adverse impact for beneficiaries. Receiving care for even just a few years can destroy an individual's or couple's net worth, imposing a significant reduction in the standard of living for a surviving spouse or the size of a legacy for heirs. This is also the group which benefits most significantly from the new long-term care insurance partnership programs emerging in many states (see sidebar to the right).

This group should still focus on purchasing short-fat policies and to try to leverage the value of joint policies. At the upper end of the wealth range, this group might choose a moderate daily benefit amount and effectively self-insure a portion of their care, but in most cases the daily benefit will be targeted to cover 100% of the cost of facilities in the area. Elimination periods will typically still be either 60 days or 90 days, because shorter elimination periods make premiums too expense and longer periods are too expensive to self-insure the initial care, but for those at the upper end of the wealth range a 180-day elimination period might be considered to manage the cost of premiums. If state partnership programs are available for the client, the financial planner should also be certain that the policy conforms to any applicable state requirements.

The long-term care insurance purchasing decision typically will still represent a lifestyle trade-off for clients with this level of wealth, because the premiums will be paid either from current income sources, or from assets that were being used to directly generate current cash flows.

What are Long-Term Care Partnership Programs?

Long-term care partnership programs first originated in the 1980s, and were designed to encourage individuals to provide for at least part of their own costs if they needed long-term care. In essence, the rules stated that if an individual exhausted his/her long-term care insurance benefits and then had to apply for Medicaid, the individual would be able to keep a specified amount of assets protected from Medicaid. On a proactive basis, the idea was to encourage people to purchase long-term care insurance in advance, to protect more of their assets than Medicaid would protect alone, but thereby also pay for more of their own care. For example, an individual might be able to shelter an extra $200,000 of assets from Medicaid eligibility, if he/she first had purchased, utilized, and exhausted a 3-year long-term care policy. Unfortunately, after only four states (California, Connecticut, Indiana, and New York) adopted long-term care partnership programs almost 20 years ago when they were first established, the program was shut down. But thanks to the Deficit Reduction Act of 2005, the ability for states to create their own programs has been reinstated. As a result, numerous states have begun to implement their own plans over the past 3 years. For a quick summary of what states have adopted programs and currently have long-term care insurance partnership policies for sale, go to: www.dehpg.nent/ltcpartnership/map.aspx. Note that different states have different details about how the rules will apply, so you should ultimately get more information about the rules in your particular state before moving forward, if the partnership program would be relevant for your client.

$750,000 to $2,000,000 in Net Worth

At this level of wealth, long-term care insurance is rarely about being able to afford access to care, and instead is almost entirely about protecting assets for a surviving spouse or heirs. The goal for this group is typically to manage the cost of care for a number of years, either to facilitate Medicaid planning strategies, or simply to directly utilize insurance to pay for a significant amount of care and manage the risk of a catastrophic event. In some cases, , the policy can provide comfort for an individual or surviving spouse to

know that is it "safe" to continue to maintain a certain standard of living knowing that a policy is available to provide for a desired level of care in the future. Long-term care insurance partnership programs are typically less relevant for this group, although they may still be applicable for an extreme health event, particularly for clients at the lowest end of this wealth range.

Policies for this group should typically still be of the short-fat type, and joint policies are still appropriate. In most cases, policies will have a daily benefit amount to cover the entire cost of care for a number of years, but clients in the middle-to-upper end of the range may consider lower daily benefits and partially self-insuring. Those at the highest end of the range may begin to consider lifetime benefits policies in lieu of a joint policy, particularly if the insured is younger such that the premiums are more affordable; however, 4 to 6 year benefit periods (or 8 to 12 year joint policies) are more common. Planners should evaluate whether any policy purchased is in compliance with state LTC partnership programs if applicable, although in reality many clients at this wealth level will have too many assets for partnership programs to ever be beneficial. Clients at this wealth level may consider a broader range of elimination periods due to their ability to both afford more self-insurance and/or higher premiums, so elimination periods may range from 30 days to 180 days depending on the trade-offs the client wishes to make.

At this level of wealth, long-term care insurance premiums are often a little more affordable, and are typically drawn from assets and not necessarily as a direct trade-off to the current standard of living. However, premium affordability can still be an issue, particularly at the lower end of the wealth range, and must still be managed to avoid having the cost impinge too directly on the current lifestyle unless the client is fully willing to make such a trade-off.

$2,000,000 to $4,000,000 in Net Worth

For clients with more than $2,000,000 of assets, the nature of long-term care insurance purchasing decisions begins to shift. At this level, the decision to purchase is rarely about the direct financial impact of long-term care costs on the ability to maintain a lifestyle (although certainly in some catastrophic cases, a very extended long-term care event could at least partially impact a surviving spouse's capacity to maintain the current standard of living). Instead, long-term care insurance is more often about an overall focus on maintaining net worth, with a broader goal of maintaining a higher standard of living and/or a certain legacy for children. This group faces little risk of financial destitution or Medicaid support needs even if there is a long-term care event, but an extended period of care may still have a significant financial impact that impairs goals.

Because of the financial flexibility, and the fact that the greatest risk is an extremely long term period of care, lifetime benefits are far more common at this wealth level, in lieu of joint policies. For those that are comfortable at least partially self-insuring, some may consider long-thin policies instead of the short-fat variety utilized at lower levels of wealth. This can be particularly desirable to manage catastrophic risk, where an ultra-long-term long-thin policy (e.g., $100/day but a claim that lasts 15+ years) could actually yield more in benefits than even a well-designed short-fat policy. In other cases, individuals may choose to purchase a policy that is both rich in daily benefits and with a lifetime benefit period, on the grounds that even a policy at that level is an affordable premium (at least relative to this client's total net worth), and represents a very modest commitment to ensure that there is no significant future damage to the family balance sheet due to a long-term care event. Likewise, a broad range of elimination periods can be considered, depending on how aggressively the client wishes to protect the overall asset base; elimination periods as short as 30 or even 0 days are affordable for this group, although some will go the other direction and manage the premiums by selecting 180 or 365 day elimination periods since the cost to self-insure for as long as a full year is still quite manageable. Notably, some clients at this wealth level may also consider even higher-than-average levels of daily benefits, because their expectations for care and the quality of facility are likely to be higher than the overall average. State long-term care insurance partnership programs are typically not relevant for this group at all, unless extremely aggressive Medicaid planning is anticipated.

With this wealth group, long-term care insurance is typically funded directly from assets, and does not represent a trade-off in current lifestyle. Instead, the payment of premiums is often viewed as coming from a larger asset base, for the purpose of helping to protect that asset base.

$4,000,000+ in Net Worth

Certainly, long-term care insurance is far less common for clients with more than $4,000,000 of net worth. However, long-term care insurance is still purchased in

some cases for clients at this wealth level. The purpose is typically almost entirely oriented around the protection of an overall legacy of assets, and often involves a focus on preserving family assets for the next generation as well as a surviving spouse.

Policies for this group tend towards one of two extremes – either they are viewed as catastrophic-only coverage, with very long elimination periods, an average or slightly higher daily benefit, and a lifetime benefit duration; or they are viewed as fully paid coverage of future long-term care costs overall, and include a moderate elimination period, an above-average daily benefit, and lifetime benefits. For the latter approach in particular, a daily benefit could easily be 25%, 50%, or even 100% above the average cost in the area, due to a higher expectation about levels and quality of care and overall standard of living, and also an increased likelihood that extensive and continuous care may be received in the home at some point in the future. Long-term care partnership programs are no longer relevant for this group.

At this level of wealth, long-term care insurance is typically funded entirely from assets, and is viewed as a cost extracted from the assets in order to protect the remainder of the assets. In essence, the viewpoint is often expressed as an acknowledgement that the annual premium of coverage will never have an appreciable impact on the family balance sheet, but an extended long-term care event might, so why take the risk?

A Final Word on Inflation Riders

Some readers may have noted that the selection of inflation riders was not discussed at all in the review of typical policies purchased at varying wealth levels. This is primarily because the decision about an inflation rider – none, simple, or compound – should really be predicated primarily on the client's *age*, and not the client's wealth level. Certainly, the cost of a compound inflation rider may be difficult for some clients at lower wealth levels, but in reality such riders may still be necessary to accomplish the client's goals, even if it represents other trade-offs in a policy. For example, a less affluent client who is only 58 might consider a 2-year benefit period with a compound inflation rider, in lieu of a 3-year benefit period with only a simple inflation rider. If the policy is held for many decades, the former may still provide more benefits than the latter, and in any event can help the daily benefit amount keep up with the current cost of care, to ensure that the policy can accomplish what it was intended to accomplish (i.e., manage the full cost of care to provide access to a desired facility for some period of time).

Although the exact thresholds are of some debate in the industry, typically at least a simple inflation rider is recommended for all but the oldest of clients. A minimum of a simple inflation rider is usually desirable for almost any client purchasing in their 70s, and even in their early 80s, given today's advances in longevity and the "risk" that even an 82 year old client could live 10-15 years before needing care. Most clients begin to consider compound inflation riders when they are younger than age 75, and they are quite common for clients purchasing anywhere in their 60s. Compound inflation riders are virtually the only selection to consider for clients who are younger than age 60.

Summary

Long-term care insurance represents an important but highly complex area of risk management for most retired or nearly retired clients. The significant number of choices available in the design of long-term care insurance policies can make it difficult to find a balance when selecting benefits to provide a recommendation for clients. Nonetheless, by focusing on the guiding principles of the purpose of insurance, and how it fits into client needs, with differing goals depending on the client situation and the client's overall wealth level, appropriate solutions can be matched to client needs in the process of developing overall recommendations for implementation.