

Pooled Benefits

You may be able to buy a long-term care insurance policy that covers more than just one person or more than one kind of long-term care service. The benefits provided by these policies are often called “pooled benefits.”

One type of pooled benefit covers more than one person, such as a husband and wife, or two partners, or two or more related adults. This pooled benefit usually has a total benefit that applies to all of the individuals covered by the policy. If one of the covered individuals collects benefits, that amount is subtracted from the total policy benefit. For example, if a husband and wife have a policy that provides \$150,000 in total long-term care benefits, and the husband uses \$25,000 in benefits from the policy, \$125,000 would be left to pay benefits for either the husband or the wife, or both.

Another kind of “pooled benefit” provides a total dollar amount that can be used for various long-term care services. These policies pay a daily, weekly, or monthly dollar limit for one or more covered services. You can combine benefits in ways that best meet your needs. This gives you more control over how your benefits are spent. For example, you may choose to combine the benefit for home care with the benefit for community-based care instead of using the nursing home benefit.

Some policies provide both types of pooled benefits. Other policies provide one or the other.



How Do Long-Term Care Insurance Policies Work?

Today, long-term care insurance policies are not standardized like Medicare supplement insurance. Companies sell policies that combine benefits and coverage in different ways.

How Benefits Are Paid

Insurance companies that sell long-term care insurance generally pay benefits using one of two methods: the expense-incurred method or the indemnity method. It is important to read the literature that accompanies your policy (or certificate for group policies) and to compare the benefits and premiums.

When the expense-incurred method is used, the insurance company must decide if you are eligible for benefits and if your claim is for eligible services. Benefits are paid either to you or your provider up to the limits in your policy. Your policy or certificate will pay benefits only when you receive eligible services. Most policies bought today pay benefits using the expense-incurred method.

When the indemnity method is used, the benefit is a set dollar amount. The insurance company only needs to decide if you are eligible for benefits. The specific services are not important. The insurance company will pay benefits directly to you up to the limit of the policy.

What Services Are Covered



It is important that you understand what services your long-term care insurance policy covers and how it covers the many types of long-term care services you might need to use. Policies may cover the following:

- Nursing home care
- Home health care
- Personal care in your home
- Services in assisted living facilities
- Services in adult day care centers
- Services in other community facilities

There are several ways policies may cover home health care. Some long-term care insurance policies only pay for care in your home from licensed home health agencies. Some also will pay for care from licensed health care providers not from a licensed agency. These include licensed practical nurses; occupational, speech, or physical therapists; or licensed home health care aides. Other policies may pay for services from home health care aides who may not be licensed or are not from licensed agencies. Home health care aides help with personal care. You may find a policy that pays for homemaker or chore worker services. This type of policy, though rare, would pay for someone to come to your home to cook meals and run errands. Generally, adding home care benefits to a policy also adds to the cost of the policy.

NOTE: Most policies don't pay benefits to family members who give care in the home.

Where Services Are Covered

You should know *what* types of facilities are covered by your long-term care insurance policy. If you're not in the right type of facility, the insurance company can refuse to pay for eligible services. New kinds of facilities may be developed in the future and it's important to know whether your policy will cover them.

Some policies may pay for care in *any* state-licensed facility. Others only pay for care in *some* state-licensed facilities, such as a licensed nursing facility. Still others list the types of facilities where services will not be covered, which may include state-licensed facilities. Policies often will not cover homes for the aged, rest homes, and personal care homes. Some policies may list specific points about the kinds of facilities they will cover. Some will say the facilities must care for a certain number

of patients or give a certain kind of care. When shopping for a long-term care policy, check these points carefully and compare the types of services and facilities covered in the policy. If your policy lists kinds of facilities, be sure to check if your policy requires the facility to have a license or certification from a government agency.

NOTE: If you are NOT placed in the kind of facility specified by your policy, the insurance company may not pay for the services you require.

What is Not Covered (Exclusions and Limitations)

Most long-term care insurance policies usually do not pay benefits for:

- a mental or nervous disorder or disease, other than Alzheimer's disease or other **dementia**;
- alcohol or drug addiction;
- illness or injury caused by an act of war;
- treatment the government has provided in a government facility or already paid for; or
- attempted suicide or intentionally self-inflicted injuries.

NOTE: In most states, regulations do not allow insurance companies to refuse to pay for covered services for Alzheimer's disease that may develop after a policy is issued. Ask your state insurance department if this applies in your state. Nearly all policies specifically say they will cover Alzheimer's disease. Read about Alzheimer's disease and eligibility for benefits in the section on benefit triggers on pages 16-17.

How Much Coverage You Will Have

The policy or certificate may state the amount of coverage in one of several ways. A policy may pay different amounts for different types of long-term care services. Be sure you understand how much coverage you will have and how it will cover long-term care services you receive.

Maximum Benefit Limit. Most policies limit the total benefit they will pay over the term of the policy, but a few don't. Some policies state the maximum benefit limit in years (one, two, three, or more, or even lifetime). Others write the policy maximum benefit limit as a total dollar amount. Policies often use words like "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit" to describe their maximum benefit limit. When you look at a policy or certificate be sure to check the total amount of coverage. In most states, the minimum benefit period is one year. Most nursing home stays are short, but illnesses that go on for several years could mean long nursing home stays. You will have to decide if you want protection for very long stays. Policies with longer maximum benefit periods cost more. Read your long-term care insurance policy carefully to learn what the benefit period is.

Daily/Monthly Benefit Limit. Policies normally pay benefits by the day, week, or month. For example, in an expense-incurred plan, a policy might pay a daily nursing home benefit of up to \$100 per day, and a weekly home care benefit of up to \$350 per week. Some policies will pay one time for single events, such as installing a home medical alert system.

When you buy a policy, insurance companies let you choose a benefit amount (usually \$50 to \$250 a day or \$1,500 to \$7,500 a month) for care in a nursing home. If a policy covers home care, the benefit is usually a portion of the benefit for nursing home care. It is important to know how much skilled nursing homes, assisted living facilities, and home health care agencies charge for their services BEFORE you choose the benefit amounts in your long-term care insurance policy. Check the facilities in the area where you think you may be receiving care, whether they are local, near a grown child, or in a new place where you may retire. The worksheet on page 38 can help you track these costs.

When You Are Eligible for Benefits (Benefit Triggers)

“Benefit triggers” is the term a company usually uses to describe the way it decides when to pay benefits. This is an important part of a long-term care insurance policy. Look at it carefully as you shop. The policy and the outline of coverage usually describe the benefit triggers. Look for a section called “Eligibility for the Payment of Benefits” or simply “Eligibility for Benefits.”

Different policies may have very different benefit triggers. Some policies use more than one way to decide when to pay benefits. Some states require certain benefit triggers. Check with your state insurance department to find out what your state requires.

NOTE: Companies may use different benefit triggers for home health care coverage than for nursing home care.

Types of Benefit Triggers

Activities of Daily Living. The inability to do activities of daily living, or ADLs, is the most common way insurance companies decide when you are eligible for benefits. The ADLs most companies use are bathing, continence, dressing, eating, toileting, and transferring. Typically, a policy pays benefits when you can't do a certain number of the ADLs, such as three of the six or two of the six. It will be harder for you to be eligible for benefits when a policy requires you to be unable to do more ADLs. Federally tax-qualified policies are required to use being unable to do certain ADLs as a benefit trigger. A qualified policy is allowed to require you to be unable to do at least two of a list of five ADLs to collect benefits. Or, it can require

that you be unable to do **no more** than two of six ADLs. The ADLs that trigger benefits in a tax-qualified policy must come from the list in the preceding paragraph. These triggers are specified in your policy.

If the policy you're thinking of buying pays benefits when you can't do certain ADLs, be sure you understand what that means. Some policies spell out very clearly what it means to be unable to feed or bathe oneself. Some policies say that you must have someone actually help you do the activities. That's known as hands-on assistance. Specifying hands-on assistance will make it harder to qualify for benefits than if only standby assistance is required. The more clearly a policy describes its requirements, the less confusion you or your family will have when you need to file a claim.

NOTE: The six activities of daily living (ADLs) have been developed through years of research. This research also has shown that bathing is usually the first ADL that a person can't do. Qualifying for benefits from a policy that uses five ADLs may be hard if bathing isn't one of the five.

Cognitive Impairment. Many long-term care insurance policies also pay benefits for "cognitive impairment" or mental incapacity. The policy usually pays benefits if you can't pass certain tests of mental function.

Coverage of cognitive impairment is especially important if you have been told you have Alzheimer's disease or other dementia. If being unable to do ADLs is the only benefit trigger your policy uses, it may not pay benefits if you have Alzheimer's disease but can still do most of the ADLs on your own. But if your policy also uses a test of your mental ability as a benefit trigger, it is more likely to pay benefits if you have Alzheimer's disease. Most states do not allow policies to limit benefits solely because you have Alzheimer's disease.

Doctor Certification of Medical Necessity. Some long-term care insurance policies will pay benefits if your doctor orders or certifies that the care is medically necessary. However, tax-qualified policies can't use this benefit trigger.

Prior Hospitalization. Other long-term care insurance policies sold in the past required a hospital stay of at least three days before paying benefits. Most companies no longer sell policies that require a hospital stay.



NOTE: Medicare still requires a three-day hospital stay to be eligible for Medicare payment of skilled nursing facility benefits.

When Benefits Start (Elimination Period)

With many policies, your benefits won't start the first day you go to a nursing home or start using home care. Most policies have an **elimination period** (sometimes called a deductible or a waiting period). That means benefits can start 0, 20, 30, 60, 90, or 100 days after you start using long-term care. Elimination periods for nursing home and home health care may be different. How many days you have to wait for benefits to start will depend on the elimination period you pick when you buy your policy. You might be able to choose a policy with a zero-day elimination period, but expect it to cost more.

During an elimination period, the policy will not pay the cost of long-term care services. You may owe the cost of your care during the elimination period. You may choose to pay a higher premium for a shorter elimination period. If you choose a longer elimination period, you'll pay a lower premium but must pay the cost of your care during the elimination period.

For example, if a nursing home in your area costs \$100 a day and your policy has a 30-day elimination period, you'd have to pay \$3,000 before your policy starts to pay benefits. A policy with a 60-day elimination period would mean you'd have to pay \$6,000 of your own money. You'd spend \$9,000 of your own money for nursing home care if the elimination period was 90 days.

If you only need care for a short time and your policy has a long elimination period, your policy may not pay any benefits. If, for example, your policy had a 100-day elimination period, and you received long-term care services for only 60 days, you would not receive any benefits from your policy.

On the other hand, if you can afford to pay for long-term care services for a short time, a longer elimination period might be right for you. It would protect you if you need extended care and also keep the cost of your insurance down.

You may also want to think about how the policy pays if you have a repeat stay in a nursing home. Some policies count the second stay as part of the first one as long as you leave and then go back within 30, 90, or 180 days. Find out if the insurance company requires another elimination period for a second stay.

What Happens When Long-Term Care Costs Rise (Inflation Protection)

Inflation protection can be one of the most important additions you can make to a long-term care insurance policy. Inflation protection increases the premium. However, unless your daily benefit increases over time, years from now you may find that it hasn't kept up with the rising cost of long-term care. A nursing home that costs \$110 a day will cost \$292 a day in 20 years, if inflation is 5% a year. And the cost of nursing home care has been rising at an annual rate of 8% for the past several years. Obviously, the younger you are when you buy a policy, the more important it is for you to think about adding inflation protection.

You can usually buy inflation protection in one of two ways: automatically or by special offer. The first way automatically increases your benefits each year.

Policies that increase benefits for inflation automatically may use simple or compound rates. Either way, the daily benefit increases each year by a fixed percentage, usually 5%, for the life of the policy or for a certain period, usually 10 or 20 years.

The dollar amount of the increase depends on whether the inflation adjustment is "simple" or "compound." If the inflation increase is simple, the benefit increases by the same dollar amount each year. If the increase is compounded, the dollar amount of the benefit increase goes up each year. For example, a \$100 daily benefit that increases by a simple 5% a year will go up \$5 a year and be \$200 a day in 20 years. If the increase is compounded, the annual increase will be higher each year and the \$100 daily benefit will be \$265 a day in 20 years.

Automatic inflation increases that are compounded are a good idea but not all policies offer them. Some states now require policies to compound inflation increases. Check with your state insurance department to find out if this applies in your state. All individual and some group tax-qualified policies must offer compound inflation increases as a required optional provision. Compounding can make a big difference in the size of your benefit.

The second way to buy inflation protection lets you choose to increase your benefits periodically, such as every three years. With a periodic increase option, you usually don't have to show proof of good health, *if* you regularly use the option. Your premium will increase if you increase your benefits. How much it increases depends on your age at the time. Buying more benefits every few years may help you afford the cost of the additional coverage. If you turn down the option to increase your benefit one year, you may not get the chance again. You may get the

Effect of Inflation on Daily Rates for Nursing Home Care				
Rate of Inflation	1995	2000	2005	2010
5%	\$110	\$140	\$179	\$229
6%	\$110	\$147	\$197	\$264
7%	\$110	\$154	\$216	\$303
8%	\$110	\$162	\$237	\$349

Source: *Long Term Care Planning: A Dollar and Sense Guide*. (1997). Washington, D.C.: United Seniors Health Cooperative.

chance later, but you may have to prove good health, or it may cost you more money. If you don't accept the offer, you need to check your policy to see how it will affect future offers.

NOTE: Most states have adopted regulations that require companies to offer inflation protection. It's up to you to decide whether to buy the coverage. If you decide not to take the protection, you may be asked to sign a statement saying you didn't want it. Be sure you know what you're signing.

Additional Benefits

Third Party Notice. This benefit lets you name someone who the insurance company would contact if your coverage is about to end because you forgot to pay the premium. Sometimes people with cognitive impairments forget to pay the premium and lose their coverage when they need it the most.

You can choose a relative, friend, or a professional (a lawyer or accountant, for example) as your third party. After the company contacts the person you choose, he or she would have some time to arrange for payment of the overdue premium. You can usually name a contact without paying extra. Some states now require insurance companies to give you the chance to name a contact. You may even have to sign a waiver if you choose not to name anyone to be contacted if the policy is about to **lapse**.

Other Long-Term Care Insurance Policy Options You Might Choose

You can probably choose other policy features. Each may add to the cost of your policy. Ask your insurer what features increase your policy's cost.

Waiver of Premium. This option lets you stop paying the premium once you are in a nursing home and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait 60 to 90 days. The waiver of premium may not apply if you are getting home health care.

Restoration of Benefits. This option gives you a way to keep the maximum amount of your original benefit even after your policy has paid you benefits. With this option, if you go for a stated period without getting more long-term care services, your benefit goes back to the amount you first bought. For example, assume your policy paid you \$5,000 in long-term care benefits out of a policy maximum of \$75,000. You would have \$70,000 in benefits left. With a restoration of benefits option, if you didn't use any long-term care services for a specified time, your maximum benefit would go back to the original \$75,000.

Premium Refund At Death. This benefit pays to your estate any premiums you paid minus any benefits the company paid. To get a refund at death, you must have

paid premiums for a certain number of years. Some refund premiums only if the policyholder dies before a certain age, usually 65 or 70. The premium refund option may also add to the cost of a policy.

Downgrades. While it may not always appear in the contract, most insurers let policyholders ask to change the policy if they have trouble paying the premium. When you downgrade to a less comprehensive policy, you probably will pay a lower premium. This may allow you to keep the policy in force instead of dropping it.

What Happens If You Can't Afford the Premiums Anymore?

Nonforfeiture Benefits. If, for whatever reason, you drop your coverage and you have a nonforfeiture benefit in your policy, you will receive some value for the money you've paid into the policy. Without this type of benefit, you get nothing even if you've paid premiums for 10 or 20 years before dropping the policy.



Some states may require insurance companies to offer long-term care insurance policies with a written offer of nonforfeiture benefit. In this case, you may be given benefit options with different premium costs. In one type of benefit, when you stop paying your premiums, the company gives you a paid-up policy with a shorter benefit period. That means the policy will pay the same daily benefit that you bought but for fewer years. How many years depends on how long you paid premiums. Since it's paid-up, you won't owe any more premiums.

Other insurers may offer a "return of premium" nonforfeiture benefit. They pay back to you all or part of the premiums that you paid in if you drop your policy after a certain number of years. This is generally the most expensive type of nonforfeiture benefit. A nonforfeiture benefit can add roughly 10% to 100% to a policy's cost. How much it adds depends on such things as your age at the time you bought the policy, the type of nonforfeiture benefit, and whether the policy has inflation protection.

You have the option to add a nonforfeiture benefit if you're buying a tax-qualified policy. The "return of premium" nonforfeiture benefit isn't available in tax-qualified policies, but you may be able to get a "reduced paid-up policy" if you drop the policy. You should consult a tax advisor to see if adding a nonforfeiture benefit would be good for you.

Contingent Nonforfeiture. In some states, if you don't accept the offer of a nonforfeiture benefit, a company is required to provide a "contingent benefit upon lapse." This means that when your premiums increase to a certain level (based on a table of increases), the "contingent benefit upon lapse" will take effect. For example, if you're 70 years old and have **not** accepted the insurance company's offer of a nonforfeiture benefit, when the premium rises to 40% more than the original premium

you will be offered the opportunity to accept one of the “contingent benefits upon lapse.” The benefits offered are: 1) a reduction in the benefits provided by the current policy so that premium costs stay the same; *or* 2) a conversion of the policy to paid-up status with a shorter benefit period. You may also choose to keep your policy and continue to pay the higher premium.

Will Your Health Affect Your Ability to Buy a Policy?



Companies that sell long-term care insurance “underwrite” their coverage. They look at your health and health history before they decide to issue a policy. You may be able to buy coverage through an employer or another type of group without any health underwriting.

Insurance companies’ underwriting practices affect the premiums they charge you now and in the future. Some companies do what is known as “short-form” underwriting. They ask you to answer a few questions on the insurance application about your health. For example, they may want to know if you have been in the hospital in the last 12 months or must use a wheelchair.

Sometimes companies don’t check your medical record until you file a claim. Then they may try to refuse to pay you benefits because of information found in your medical record after you file your claim. This practice is called “post-claims underwriting.” It is illegal in many states. Companies that thoroughly check your health before selling you a policy aren’t as likely to do post-claims underwriting.

Some companies do more underwriting. They may ask more questions, look at your current medical records, and ask your doctor for a statement about your health. These companies may insure fewer people with health problems. Having certain conditions that are likely to mean you’ll soon need long-term care (Parkinson’s disease, for example) probably will mean you can’t buy coverage from these companies.

No matter how the company underwrites, you must answer certain questions that the company uses to decide if it will insure you. When you fill out your application, be sure to answer all questions correctly and completely. A company depends on the information you put on your application. If the information is wrong, an insurance company may decide to void, **rescind**, or cancel your policy and return the premiums you have paid. It can usually do this within two years after you buy the policy. Most states require the insurance company to give you a copy of your application when it delivers the policy. At this time, you can review your answers again. You should keep this copy of the application with your insurance papers.

What Happens If You Have Pre-Existing Conditions?

A long-term care insurance policy usually defines a **pre-existing condition** as one for which you received medical advice or treatment or had symptoms within a certain period before you applied for the policy. Some companies look further back in time than others. That may be important to you if you have a pre-existing condition. A company that learns you didn't tell them about a pre-existing condition on your application might not pay for treatment related to that condition and might even cancel your coverage.

Many companies will sell a policy to someone with a pre-existing condition. However, the company may not pay benefits for long-term care related to that condition for a period after the policy goes into effect, usually six months. Some companies have longer pre-existing condition periods; others have none.

Can You Renew Your Long-Term Care Insurance Policy?

In most states, long-term care insurance policies sold today must be guaranteed renewable. When a policy is **guaranteed renewable**, it means that the insurance company guarantees you a chance to renew the policy. It does not mean that it guarantees you a chance to renew at the same premium. Your premium may go up over time as your company pays more and larger claims.

Insurance companies can raise the premiums on their policies but only if they increase the premiums on all policies that are the same in that state. **No individual can be singled out for a rate increase**, no matter how many claims have been filed. In some states, the premium can't increase just because you are older.

If you bought a policy in a group setting and you leave the group, you may be able to keep your group coverage or convert it to an individual policy but you may pay more. You can ask your state insurance department if your state requires this option.

What Do Long-Term Care Insurance Policies Cost?

A long-term care insurance policy can be expensive. Be sure you can pay the premium and still afford your other health insurance and other expenses. It's not unusual for a couple aged 65 to spend around \$7,500 per year for all of their health insurance coverage. The annual premium for long-term care insurance policies with inflation protection can be as much as \$2,000 or more for a person aged 65.

The premium will be lower if you're younger, higher if you're older. If you buy a policy at age 75, the premium will usually be much higher and can be more than double than if you had bought the policy at age 65.

If you buy a policy with a large daily benefit, a longer maximum benefit period, or a home health care benefit, it will also cost you more. Inflation protection can add 25% to 40% to the premium. Nonforfeiture benefits can add 10% to 100% to the premium, as noted on page 21.

When you buy a long-term care policy, think about how much your income is and how much you could afford to spend on a long-term care insurance policy now. Also try to think about what your future income and living expenses are likely to be and how much premium you can pay then. If you don't expect your income to increase, it probably isn't a good idea to buy a policy if you can barely afford the premium now.

Some states have laws that limit rate increases. Check with your insurance department to learn how your state regulates rate increases.

NOTE: Don't be misled by the term "level premium." Some agents might tell you that your long-term care insurance premium is "level" and suggest that it will never increase. Except for **whole life insurance** policies and **noncancellable policies** or riders, companies can't guarantee premiums will never increase. Many states have adopted regulations that don't let insurance companies use the word "level" to sell guaranteed renewable policies. Companies must tell consumers that premiums may go up. Look for that information on the outline of coverage and the policy's face page when you shop.

If You Already Own a Policy, Should You Switch Plans or Upgrade the Coverage You Have Now?

Before you switch to a new long-term care insurance policy, make sure it is better than the one you already have. Even if your agent now works for another company, think carefully before making any changes. First check to see if you can upgrade the coverage on your current policy. If not, you may replace your current policy with a different one that gives you more benefits, or even choose a second policy. Be sure to discuss any change in your coverage with your financial advisor.

If you decide to switch to a new long-term care insurance policy, make sure the new company has accepted your application and issued the new policy before you cancel the old one. When you cancel a policy in the middle of its term, many companies will not give back any premiums you have paid. If you switch policies, new restrictions on pre-existing conditions may apply. You may not have coverage for some conditions for a certain period.

Switching may be right for you if your old policy requires you to stay in the hospital or to receive other types of care before it pays benefits. Before you decide to change, though, make sure you are in good health and can qualify for another policy. If you bought a policy when you were younger, you might ask the insurance company if you can improve it. For example, you might add inflation protection or take off the requirement that you stay in the hospital. It might cost less to improve a policy you have now than to buy a new one.