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Financing Long-Term Care for the Elderly

A Satellite Program

Chair
Peter J. Strauss

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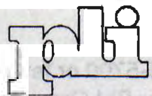

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INSURANCE COVERAGE FOR LONG TERM CARE EXPENSES

Peter J. Strauss

May 3, 1993

INSURANCE COVERAGE FOR LONG TERM CARE EXPENSES

A. The Use Of Long Term Care Insurance And Accelerated Benefits Options In Conjunction With Trusts For Health Care Planning.

1. As the elderly population continues to grow and health care costs increase dramatically, the financing of home health care for impaired clients who do not need institutionalization, and nursing home care for those who do, is an increasingly serious problem. Medicare and Medicare supplemental policies offer minimal coverage for home care.

2. Long-term care insurance for those who can afford it and for those who can meet medical underwriting criteria may offer a viable option for financing long-term home care and nursing home costs.

3. Long-term care insurance may also be used as an integral part of an overall financial plan which can protect the assets of an impaired senior citizen by financing the costs of nursing home care during the Medicaid period of ineligibility after asset transfers either outright or in trust-are made. If long-term care insurance is in place, the senior citizen need not prematurely divest himself or herself of assets, but may retain ownership of assets until it appears that institutionalization is necessary or actually occurs, at which time transfers, triggering the Medicaid period of ineligibility, can be made with the long-term care insurance paying for all or a major portion of the nursing home costs during the penalty period. If the penalty period can be shortened by using the "half-a-loaf" approach or (to the extent it is workable in a particular state) the monthly, sequential transfer approach, even greater flexibility can be achieved.

   Careful planning requires that the tools to make the transfers of assets after incapacity and/or

institutionalization be available, such as a durable power of attorney with a gift provision. If assets have been placed in trust, provisions authorizing invasion of principal can lapse at the time of institutionalization, and even if a period of ineligibility results, the LTC insurance will then be in place.

4. In an income cap state (a state that does not have a medically needy program for Medicaid eligibility purposes), the existence of monthly benefits from a long-term care insurance policy could result in an ineligibility for Medicaid.

   Query: Could a contract be written with an insurance company which provides that if the policy benefit exceeds the monthly income cap, but is not sufficient to meet the actual monthly SNF cost, payment under the policy directly to the insured will be limited to $20 less than the monthly allowable income with the balance of the monthly benefit paid to some other family members.

B. How To Evaluate Long Term Care Policies.

1. What levels of care are covered?

   - Skilled nursing care.
   - Intermediate care.
   - Custodial care.
   - Home health care.
   - Adult day programs.

2. How much will be paid for each level of care? Is the policy benefit realistic when compared to costs in your community?

3. How long will the policy pay benefits? Consider your assets, out-of-pocket costs and eligibility for public entitlements.

4. Is there a maximum policy benefit?

5. Will benefits increase with inflation? Is the inflation rider amount compounded?

6. Is there a waiting period before benefits are payable? How much can you afford?

7. Are pre-existing conditions covered? If so, what is the waiting period?

8. Does the policy impose any of the following eligibility requirements?

   - Prior hospitalization to receive nursing home benefits.

   - Need for skilled nursing care prior to payment of custodial care costs.

   - Prior coverage in custodial-care facility or hospital to receive home care benefits.

   - coverage only in a medicare-certified facility.

9. Is Alzheimers Disease specifically covered?

10. Can the insurer cancel the policy? Is it guaranteed renewable?

11. Can the premium increase over the life of the policy?

12. Does the policy contain a wavier of premium?

13. Does the insurer have an A+ or A rating from Best's Insurance Reports? Other reporting agencies?

14. Is the insurer experienced in handling health insurance claims?

15. What is the annual premium?

16. Is the policy an indemnity policy or a reimbursement policy?

17. Is a group or individual policy better?

18. What type of benefit trigger mechanism does the policy have?

   - Medical necessity.

   - Functional disability.

   - Cognitive impairment.

19. Does the company have a case management or patient advocacy component?

Are benefit payment decisions made by traditional claims personnel or by separate benefits coordinators or outside case managers?

C. Income Tax Issues.

1. There are two income tax issues for which there are no clear answers as of this date: (1) are the premiums for long-term care insurance deductible under Section 213 of the Internal Revenue Code as a medical expense deduction and (2) will payments received by an individual under a long-term care policy be treated as income to the insured?

2. The answer as to whether the premiums are deductible as a medical expense should be determined in the same way as the question as to whether payments for nursing home expenses or home care expenses are deductible. Generally, nursing home costs or home care costs are allowable as a medical expenses deduction if one of the reasons for the expense is medical necessity. Thus, if the long-term care policy is designed to assist persons who have a medical need, even though the policy will cover strictly custodial care, the premium should be deductible. However, by its very definition as a custodial care policy, it would not be surprising if the Internal Revenue Service attempts to disallow deductions for long-term care policy premiums. The argument for deductibility is strengthened if the policy benefits are triggered by a medical need certification, as most are. Even where the triggering mechanism is the inability of the insured to perform a certain number of the activities of daily living and/or loss of cognitive functioning, medical certification of such dysfunction is usually necessary.

3. The income issue is also unclear. Under Internal Revenue Code Section 61, all payments received by an individual are treated as income unless specifically excluded under another provision of the Code. Payments received by the taxpayer under a health insurance policy to reimburse the taxpayer for medical expenses is not treated as income by the specific provisions of Section 105. If a long-term care policy is treated in the same manner as a health insurance policy for the purposes of premium deductibility, the payments received by the taxpayer should also be treated as excludible from income to the same extent as payments under a health insurance policy. The position of the

Internal Revenue Service on this question is also not clear and a ruling may be necessary.

4. Several bills are now pending in Congress to clarify these issues and are expected to pass.

D. "Living Benefits" Riders To Life Insurance Policies

1. Description - face value of policy may be drawn down on a discounted basis in the event the insured is terminally ill or needs permanent institutionalization. Also known as "accelerated benefits."

2. It had been believed that accelerated benefit payments would probably be treated as income under current law. However, the Internal Revenue Service has promulgated interim regulations extending the death benefit exclussion from gross income for income tax payments to accelerated benefits payments provided certain "safe harbor" rules are met.

3. Several states have authorized accelerated benefits by statute or regulation. New York authorized these accelerated benefits by passing Chapter 428 of the Laws of 1991 on July 19, 1991, but only in cases of terminal illness as for extraordinary medical expenses, not for long term care.

E. Viatification Companies

THE PUBLIC-PRIVATE PARTNERSHIP

A. Programs in four states, Connecticut, New York, Indiana and California, originally sponsored by the Robert Wood Johnson Foundation, provide for asset protection when Medicaid is applied for if a person purchases a state approved long-term care policy. When the policy benefits are exhausted, asset protection will be given to the individual who will be eligible for Medicaid. There is, however, no income protection. Approved policies must meet state minimum benefit requirements.

B. In Connecticut, there will be asset protection equal to the total policy benefits paid out. Thus, if a person has a policy with a benefit of $50,000, that amount of the person's assets may be kept; additional assets would have to be "spent down" or properly transferred prior to eligibility.

C. The New York program is different. A policy with a minimum benefit period of three years must be purchased.

When the policy benefit is exhausted, the insured will have <u>unlimited</u> asset protection and will be Medicaid eligible regardless of assets owned. New York has new insurance regulations in place and expects to have policies approved and available by April of 1993.