How to Make Decisions about Long Term Care

As you approach the later stages of your life, what do you feel your biggest financial risk may be?

Sixty-nine percent of Americans are worried about how they will finance long term care for themselves and their spouses. By comparison 56% say they are worried about paying for retirement. (A 1997 survey conducted jointly on behalf of the National Council On the Aging and John Hancock).

The concern over long term care makes sense, since nursing home costs currently average $30-40,000 annually, with an upper end passing the $60,000 mark. Over the next ten years these figures are expected to more than double. While Americans are generally enjoying a longer lifespan today, living longer may turn out to be very costly.

Many people are mistakenly under the impression that the government provides a support system for long term care needs through Medicare or Medicaid. But government support is focused on a very narrow definition of long term care, for which few will qualify. Moreover Medicare programs are designed to meet the needs of aging and physical disabilities, not for the kind of custodial care most Americans are likely to need. It does not help with debilitating illnesses like Alzheimers, Parkinsons, stroke, and the multitude of problems from which people do not get better and need quality care.

The next safety net, Medicaid, was designed for those with extremely limited private means. Some people have gotten around the limitations with strategies designed to make them look impoverished by hiding or giving up assets. But the potential trade-offs, not to mention the legal and ethical implications, are severe. The Health Insurance Portability and Accountability Act of 1996 made it a crime to deliberately spend down assets to go on Medicaid, but the prospect of actually sending elderly constituents to jail led to a rewrite of the law.

If government programs don t support long term care, what is the answer? Long term care insurance coverage supports people with a prolonged illness, disability or cognitive disorder with services that help them function in spite of their physical and mental limitations. It is not designed to treat medical problems, but to provide assistance with the activities of daily living. These services are generally divided by the terms skilled care and personal care (or custodial care).

Skilled care involves skilled medical personnel, such as register nurses, and most likely involves residence in a nursing home, though not always. It is generally ordered by a physician on a 24-hour basis as part of a treatment plan. Personal care provides for daily activities such as bathing, eating, dressing, continence and the like. It can be provided in a permanent residential setting such as a nursing home or assisted living facility, or in an adult day care facility, or at home.

The risk of requiring these types of care are high. Statistically, two-fifths of Americans currently over age 65 are expected to spend some time in nursing home care. Half of these will spend an average of two-and-a-half years. Ten percent will stay five years or longer. Numbers like these make long term care coverage a high priority.

How can you determine coverage needs and analyze different long term care policies requires a further education about the variables? You need to learn the language of long term care to make your decisions. Here are some guidelines.

1. What should a policy cover for you?

Choice of coverage depends upon how you feel you would utilize long term care under different scenarios. There are policies which cover only nursing home care, those which cover home care, those that cover both. Some policies include services provided by adult day care centers and other community facilities.

Some comprehensive plans provide for lifetime home health care at the same benefit amounts as nursing home care. Others pay on a percentage basis. There are flexible plans that allow one to choose among care options once the claim begins. If the home health care feature is not part of the policy, it may be offered as a rider.

Levels of nursing home care are not usually distinguished in policies. The coverage is the same no matter which level you require. However, home health care coverage can vary from a broad range to a specific set of services.

Depending on projected needs, you can determine how relevant such care is to your circumstances, and whether the expense risk warrants coverage. It is also important to determine policy definitions of the kinds of facilities that qualify for coverage, and if possible ascertain the kind of facilities you are considering to be sure they fall into the definitions.

2. What is the optimum benefit period for you?

Lifetime coverage provides maximum protection. With many policies, the incremental premium difference between a plan limited to four to six years and one for a lifetime will not be significant. However, since the average stay in a nursing home is less than three years, you may decide that the limited coverage is sufficient.

3. What benefit amounts make sense for you?

Benefits are most often calculated on a daily cost basis. Average daily costs vary in different local areas, and the daily benefit should be analyzed in terms of real costs and estimated increases. Other benefits, such as home health care may be paid on a weekly basis. Still others represent one time events, such as the installation of a medical alert system.

The second factor that must be carefully considered is the total benefit that the policy will pay over the length of the plan. The total maximum benefit can be expressed as a time frame or as a dollar amount.

4. What triggers the benefits?

Over the years, the insurance industry and regulatory agencies have developed criteria in the form of ADLs ("activities of daily living") Most, but not all, policies use some combination of these as triggering events for benefits. Six ADLs are the most commonly used bathing, continence, dressing, eating, toileting and transferring. When the required number cannot be performed, the benefit period begins. The definitions of inability to perform are critical to understanding coverage. Also, research has shown that bathing is usually the first ADL that cannot be performed. Policies that exclude bathing may be more difficult to qualify for benefits than one that does include this activity.

A policy may have a "cognitive impairment" provision, which would provide benefits based on the inability to pass tests of mental functioning. This is particularly relevant to Alzheimer s sufferers. While most states have passed regulations prohibiting the exclusion of Alzheimer s from long term care policies, if the person is still capable of performing specified ADLs, without such a mental incapacity clause, he or she might not qualify for benefits until the ADL criteria are met. Qualification may also come if a physician orders it for a patient as a medical necessity, depending on policy definitions of that term.

5. What is the right deductible or waiting periods for you?

Deductibles are structured as waiting periods with a range between zero and 365 days. Once a person enters the nursing home, the waiting period begins. Some have a one-time waiting period, while other plans have waiting periods that must be satisfied for each stay, though repeat stays are not the norm.

There are also policies in which new waiting periods are not required if the subsequent stay occurs within six months for the same illness. Typically, the trade-off for a shorter waiting period is a higher premium, but this is not always the case. Most insurers offer options, and the cost difference between different waiting periods may not be significant.

6. What other features make sense for you?

Among the most common policy features, almost all policies are guaranteed renewable. Some are non-cancelable. Waiver of premium features vary from immediate to ninety days. With this provision, once you are in a nursing home and the benefit payments have begun, your premium payments stop.

For those purchasing coverage far in advance of the expected need, inflation protection becomes an important feature, since costs are likely to escalate as demand increases with the shifts in population already discussed. Some policies feature a simple percentage increase each year, while premium levels remain the same. Others increase on a compounded basis. Still others solve this problem by allowing coverage increases without evidence of insurability, tied to an inflation index, but premiums increase accordingly.

7. What are the underwriting requirements?

Underwriting at the time of application is clearly more favorable than underwriting at the time of claim, so this policy feature should be clearly understood. Underwriting data may require a detailed medical questionnaire, attending physician statements, or, rarely, a medical exam. Applications may be considered on an accept/reject basis or on a rated basis deductible and/or benefit periods depending on the company underwriting policies. Health questions must be answered truthfully or coverage might be rescinded just when it is needed if inconsistencies are discovered.

In summary, even though the government safety net has some big holes, a support industry has arisen to minimize the financial risk of late life problems. The biggest risk may be waiting to decide how to use it.