



TAKING AN IN-DEPTH LOOK:

LONG-TERM CARE BENEFITS VS. CHRONIC ILLNESS BENEFITS



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Most of the baby-boom generation is on the precipice of retirement, and some people born after 1946 have already left the workforce. In 2011, the first of the baby boomers reached what used to be known as retirement age. For the next 18 years, roughly 8,000 boomers will celebrate their 65th birthdays each day.¹ This generation not only faces the challenges associated with saving money for retirement, but managing future health costs as well. Boomers may need funds for long-term care services at some point and find themselves with insufficient insurance coverage or personal savings to pay the bills.

Did you know that an average couple that retires at age 65 today should expect to spend, on average, \$220,000 for out-of-pocket medical expenses during their retirement years?²

So how can retirees protect themselves against the risk of not having enough money to pay for long-term care services at some point in their lives? Traditionally they could purchase a stand-alone long-term care policy. But before we define how that type of contract works, let's first discuss what long-term care means. LongTermCare.gov defines long-term care as a range of services and supports someone may need to meet his or her personal care needs. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called activities of daily living.

These include:

- Eating
- Toileting
- Transferring
- Bathing
- Dressing
- Continence

Other common long-term care services and supports are assistance with everyday tasks, sometimes called instrumental activities of daily living, including:

- Housework
- Managing money
- Taking medication
- Preparing and cleaning up after meals
- Shopping for groceries or clothes
- Using the telephone or other communication devices
- Caring for pets
- Responding to emergency alerts such as fire alarms

Now that we've discussed what qualifies as long-term care, let's talk about how it's provided. The U.S. Department of Health and Human Services explained that long-term care services and support typically come from:

- An unpaid caregiver, likely a family member or friend
- A nurse, home health or home care aide, and/or therapist who comes to the home
- Adult day care services in the area
- A variety of long-term care facilities



You may be wondering how these services are typically paid for. Informal care from family and friends make up the bulk of care (especially among the elderly), while Medicaid/Medicare provide the majority of funding for paid care. There are four main financing options that can be used to pay for long-term care services: self-funding, government programs, long-term care insurance and charity. Let's hone in on government programs and long-term care insurance, as self-funding and charity are self-explanatory. Long-term care expenditures are primarily paid for through government programs, which are both state and federally funded via Medicare and Medicaid. Below are some staggering numbers.

Projections of National Long-Term Care Expenditures for the Elderly
(in Billions of Inflation-Adjusted Dollars) Services Provided in Institutional Settings

YEAR	2000	2010	2020
Medicare	\$12.3	\$16.0	\$19.5
Medicaid	\$36.2	\$52.0	\$57.7
Private LTCI	*	\$11.2	\$25.9
Out of Pocket	\$34.3	\$29.3	\$35.6
Other	*	*	*
Total	\$85.8	\$108.5	\$138.7

*Less than \$5 billion.

Source: Congressional Budget Office 2014

Projections of National Long-Term Care Expenditures for the Elderly
(in Billions of Inflation-Adjusted Dollars) Services Provided in the Home

YEAR	2000	2010	2020
Medicare	\$17.1	\$23.8	\$31.0
Medicaid	\$7.1	\$14.9	\$17.1
Private LTCI	*	\$5.5	\$10.2
Out of Pocket	\$8.5	\$6.3	\$7.3
Other	*	*	*
Total	\$37.2	\$52.2	\$68.6

*Less than \$5 billion.

Source: Congressional Budget Office 2014



As you can see in the table, most of the money provided to pay for long-term care services is supplied by Medicare and Medicaid. Medicare was not specifically designed to cover long-term care needs and does not pay for any care services provided specifically for activities of daily living or instrumental activities of daily living. However, it does cover some post-acute care services, though with very limited coverage and strict eligibility requirements.

On the other side of the coin there is Medicaid, which is the largest government source for long-term care financing at \$129.3 billion a year (31 percent of the total Medicaid budget).³ Medicaid is a joint federal and state program. Therefore, the eligibility requirements and long-term care coverage may vary by state. Requirements for Medicaid include low-income and asset level tests. In order for your clients to qualify, they may have to first spend down a percentage of their assets.

If Medicare and Medicaid are not the most viable options, what are some better solutions? Let's get back to the traditional stand-alone long-term care policy. With this type of plan, clients pay a premium and receive benefits when qualified expenses occur. Long-term care contracts utilize the two of six activities of daily living or severe cognitive impairment as a benefit trigger.

This simply means that if insured persons are unable to perform two of the six activities of daily living, or if they experience a severe cognitive impairment, they will qualify for long-term care. Additionally, the condition must be expected to affect the insured for at least 90 days. With a long-term care policy, those covered by the policy are supported throughout the healing process and are able to apply for more funding at a later date. This means a long-term care contract can cover both short-term as well as long-term conditions. We will discuss short-term vs. long-term conditions a little later.

Long-term care insurance premiums have seen significant increases since 2000. In fact, many companies have restricted their offerings and pulled out of the long-term care insurance business completely. Lately there have been many factors impacting the LTC markets. Let's look at a few major influences.

- **Its use-it-or-lose-it nature.**
Consumers are more hesitant about paying for a product they may not use, especially with a budget limit.
- **Rising life expectancy and health care costs.**
Consumers are living longer and are more likely to use long-term care.



- **Long-term care costs are rising along with average medical care expenses.**

The average annualized increase of U.S. nursing home costs from 1994 to 2011 is 3.95 percent.⁴

- **Prolonged low interest rate environment.**

Insurers need a 10 to 15 percent increase in premiums to offset every 1 percent decline in long-term interest rates.

Some insurers drop benefits to keep the same premiums.

Because of the market pressures listed above, insurance companies began searching for new ways to provide long-term care protection that extends beyond a typical stand-alone LTC policy. This ushered in the development of life combination products, which are life insurance policies with either chronic illness or long-term care benefits.

However, there are no marketplace standards in place for these products. As such, they have differing design characteristics as well as naming conventions. This can make it difficult for consumers to understand the pros and cons of the various options. Before we compare and contrast the types of policies, it's important to discuss two key design components of these products: reimbursement design and indemnity design.



Reimbursement

- Reimbursement products provide a benefit if the client meets the requirements of the policy and spends money on a qualified service.
- The upside of a reimbursement product is that clients receive a benefit equal to their total cost, up to a predetermined maximum.
- The downside is that there is a delay between when expenses are incurred and when the Insured gets paid. The Insured has to incur the expense, then collect and submit the receipt, then the carrier reviews and approves the receipts and finally issues the payment.

Indemnity

- Indemnity products are those that provide clients with a benefit once they meet the requirements of their policy.
- The benefit of an indemnity rider/product is that it does not require clients to receive services in a care facility. Therefore, the client can use the benefit to pay medical or nonmedical expenses, or to enhance his or her savings.

The distinctions between these two products are very important. The indemnity design is the more adaptable of the two options and can provide the client with flexibility. Did you know that the vast majority of people – 4 in 5, or 80 percent – live in private homes where about 80 percent of the care is provided by family and friends?^{5, 6}

An indemnity plan is beneficial because funds from the policy can be accessed for ANY needs without receipt once the insured person qualifies for coverage. For example, if a family member has to stop working to take care of his or her loved one, the monthly benefit can be used to help compensate the caregiver and help cover any expense including but not limited to mortgage payments, utilities, phone bill, home repairs or modifications, housekeeping, etc.

With an indemnity design, the insured must only prove qualification for the benefit before the claim can be made, which initiates benefit payments without having to submit proof of services. With reimbursement plans, receipts must be reviewed, and often payments can only be made directly to the care provider. Additionally, with an indemnity design, the insured receives the full monthly benefit as long as he or she qualifies.



With reimbursement riders, only the expenses incurred each month are paid, meaning an insured person who does not incur expenses that total up to his or her monthly benefit may not receive the maximum monthly benefit.

Below is a table that will compare a few of the design differences between a chronic illness rider design and a long-term care rider design.

FEATURE	Chronic Illness	LTC
Diagnosis	Severe cognitive impairment or unable to perform 2+ ADLs	Severe cognitive impairment or unable to perform 2+ ADLs
Duration	Usually permanent	At least 90 days
Payment Types	Indemnity	Reimbursement or Indemnity
Benefit Types	Face amount acceleration	Face amount acceleration
Benefit Payments	Tax favored if meet IRS per diem requirements (Current maximum of \$330 per day for 2015)	Tax favored if meet IRS per diem requirements (Current maximum of \$330 per day for 2015)
Other Features	May waive policy monthly deductions while on claim	Carrier predetermined limit for reimbursement riders
Licensing Requirements	Life Licensed Agents can sell	Requires A&H License & LTC certification depending on state



One main difference that is often discussed in the industry is the permanent vs. non-permanent requirement. Some examples of short-term, non-permanent conditions include: broken bones, heart attack, fractures and minor strokes. Although these conditions require a certain degree of medical care, most of the time Medicaid will partially cover the short-term hospital care and services, while family and friends pay for the remaining short-term care until the insured person fully recovers. However, it is not these short stays that consume most of the financial resources - it is the stays that require people to remain in facilities or receive care for years. Many clients who purchase a life insurance policy have enough savings to pay for short-term expenses not covered by Medicare or Medigap.

On the other hand, there are true long-term conditions. Did you know that 9 in 10 people who go on long-term care claims do not recover?⁷ This means that only 10 percent of the market has an ultimately non-permanent condition. Some examples include Alzheimer's disease, certain types of cancer, serious stroke, brain injury and many more. These are conditions that people need to be protected against to combat the rising cost of long-term care. Such illnesses can last for many years and place a significant strain on an individual's finances. Additionally, veritable long-term conditions can greatly impact family members and friends, which is why

being able to access flexible funds, like those available through the indemnity options, is so vital. According to the AARP, "the 'average' caregiver is a 49-year-old woman who works outside the home and spends nearly 20 hours per week (which is equivalent to a half-time job) providing unpaid care to her mother for nearly five years."⁸ Advisors need to make sure that their clients have a long-term care plan, whether it is government funded, self-funded or covered under long-term care/chronic care insurance.

Now that we've described the basic differences between long-term care and chronic illness riders, let's turn our attention to the different types of chronic illness riders. From an industry standpoint, there are currently three different chronic illness rider designs: discounted death benefit method, lien method and the dollar-for-dollar acceleration method. For each design, we'll compare three questions:

- **Does the client have to pay up front?**
- **Does the client know the monthly benefit he or she can get when he or she goes on claim?**
- **Does the client know how much of the death benefit he or she will receive if he or she goes on claim?**



With this design, clients can accelerate all or part of their death benefit following diagnosis of a chronic illness.

Discounted Death Benefit

The first design we will look at is the discounted death benefit method. With this design, clients can accelerate all or part of their death benefit following diagnosis of a chronic illness. The no-cost accelerated benefit payout that results from a client's chronic illness is based primarily upon a factor related to the change in his or her insurer's expectation of his or her mortality since the time he or she acquired the coverage. If the client has a significantly shorter life expectancy, he or she will receive a larger payout. If his or her life expectancy is moderately impacted, then it will be a smaller payout. Depending on the carrier, clients may accelerate up to 100 percent of the policy death benefit up to a lifetime maximum.

Let's walk through an example - a hypothetical representation for illustrative purposes only.

Mr. Able, age 50, purchased a \$500,000 life insurance policy that offered chronic illness protection via the discounted death benefit method. Ten years later, at age 60, he experienced a stroke and was unable to perform two of the six activities of daily living. Prognosis for recovery was not good and the medical costs associated with this event were substantial. To help cover these expenses, he decided to accelerate \$100,000 of his \$500,000 policy. At the time of claim, the company determined the benefit and made an offer of \$44,888 based on the severity of the condition and revised life expectancy. He accepted the offer and received \$44,888. His policy's death benefit was reduced by the full \$100,000 acceleration to \$400,000.

Let's see how the discounted death benefit fits with the three fundamental questions.

- Does the client have to pay up front? **NO**
- Does the client know the monthly benefit he or she can get when he or she goes on claim? **NO**
- Does the client know how much of the death benefit he or she will receive if he or she goes on claim? **NO**





Lien Method

Next, let's look at the lien method design. With this chronic illness policy, the client isn't charged until he or she uses the benefit. Clients can accelerate a portion of their death benefit in the form of a lien against the policy if they're diagnosed with a chronic illness. The no-cost accelerated benefit payout is based on a formula linked to the death benefit or net amount at risk, which applies a factor that can vary based on the insured person's age at the time of claim. The lien interest rate is set when the benefit is enacted and is typically based on market rates. The policy must continue to be kept in force, although there may be a lapse in coverage if the lien plus interest exceeds the death benefit. Now we'll circle back to the three main questions:

- Does the client have to pay up front? NO
- Does the client know the monthly benefit he or she can get when he or she goes on claim? NO
- Does the client know how much of the death benefit he or she will receive if he or she goes on claim? NO



Dollar-For-Dollar Acceleration Method

The third and final design is perhaps simplest to explain and understand. With the dollar-for-dollar acceleration method, the cost of adding chronic illness coverage to an existing policy is blatant. When a client becomes chronically ill, there is a dollar-for-dollar acceleration of the death benefit. As an example, if a client had purchased a \$500,000 life insurance policy and added a dollar-for-dollar acceleration chronic illness rider, he or she would be able to accelerate his or her entire \$500,000 death benefit and be paid dollar-for-dollar if necessary. Note that depending on the carrier, there may be maximum amounts of death benefits that can be accelerated when employing this design. As you consider this payment option, let's review the core questions.

- Does the client have to pay up front? YES
- Does the client know the monthly benefit he or she can get when he or she goes on claim? YES
- Does the client know how much of the death benefit he or she will receive if he or she goes on claim? YES

It is essential that you are aware of these distinct features and benefits if you're working on a long-term care plan with clients.

Waiver of Monthly Deductions/Premiums

Understanding the differences between chronic illness rider designs along with the differences between long-term care products is crucial in providing an appropriate product for your clients. Another key aspect to review with clients is the process after a claim is filed.

Will the policy owner still be required to pay premium?

We previously discussed the fact that 9 in 10 people who go on long-term care claims do not recover. Currently, the market doesn't have chronic illness life insurance riders that allow for coverage of a non-permanent condition while waiving charges for the entire base policy.

Riders that do not waive charges (unless the policyholder continues to pay policy premiums while on claim) may owe all the missed charges assessed during the claim. This happens because policy owners

who do not pay the required premiums might have a lapsed policy following the end of the claim. Therefore, they could be faced with a very large premium to catch up on if the policy is to remain active, particularly in a GUL, where the timing of premium payments can have a significant effect on the overall cost.

It is imperative that you familiarize yourself with how the products you offer your clients deal with owed premiums. For example, did you know that there is a feature that waives all policy charges while the insured is on claim?

As you can see, there are many nuances to these different designs. It is essential that you are aware of these distinct features and benefits if you're working on a long-term care plan with clients. Understanding these products can set you apart from other financial professionals and arm you with the information needed to improve service and results. Depending on each client's goals, objectives and budget concerns, you can help determine which option is best for that individual. American General Life is here to assist you with any questions in regard to this topic. Please reach out to your American General Life representative with any further questions or concerns.

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