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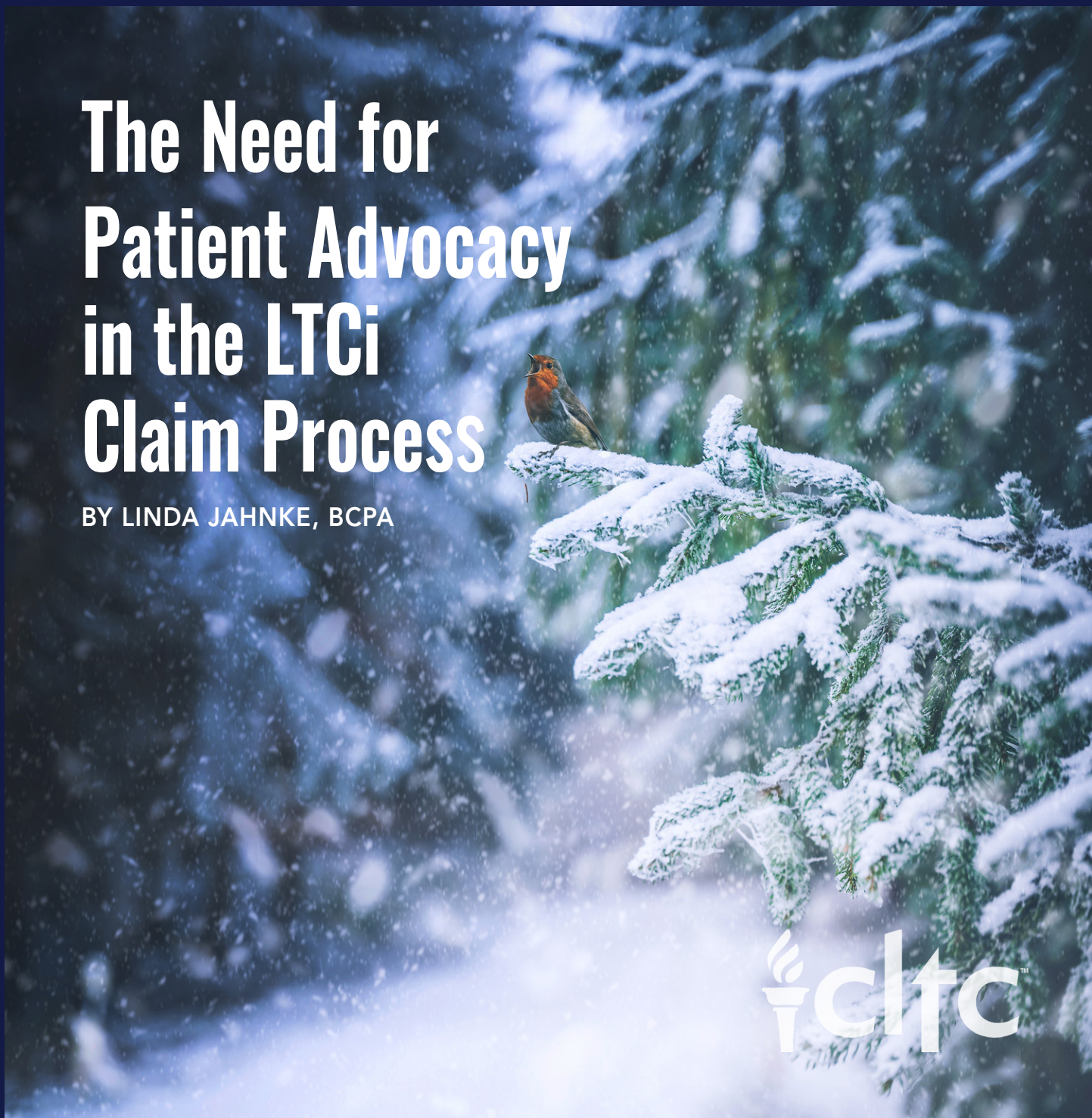

The Need for Patient Advocacy in the LTCi Claim Process

BY LINDA JAHNKE, BCPA

INSIDER'S *Note*

What is the sale of any insurance policy but a promise to pay when help is needed? Is it always that straightforward?

Three of our articles discuss the claims process—two from women with a great deal of first-hand knowledge. We know that providing long-term care is complex, that what once seemed simple can be elusive and difficult when reality strikes, particularly when it is borne from a crisis.

A long-standing member of the CLTC® family, and experienced LTCi specialist, Nancy Dykeman, CLTC, CSA, shares her claims journey with her husband. Linda Jahkne, BCPA, a LTCi agent—now claims advocate—validates Nancy's experience about the complexity of navigating LTCi claims. She also adds insights into how to ease the path for family, friends and clients. Kerry Peabody, CLU, CLTC, RICP, and LTCi veteran helps us think about the true cost of memory care.

Shawn Britt, CLU, CLTC, offers perspective on the ups and downs of the HIPAA per diem. We round out the issue with a case study from Laurie Sappern Gaugler, CLTC, who reviews her work with clients that had plenty of LTC experience and still questioned the need to plan.

As always, a big **thank you** to all our contributors for helping us produce yet another informative and impactful *Digest*.

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TABLE OF Contents

How Our Lives Changed in an Instant and the Claims Journey that Followed

By Nancy A. Dykeman, CLTC©, CSA

It has been 18 months since our family experienced a life-changing event. As said by the founder and former President of CLTC©, Harley Gordon, Esq., our household has become a care-house for my husband and our four children's father, 'Chick. This change in our lifestyle came without warning on June 29, 2022, when he went to the University Medical Center in Charleston, for an exploratory heart catheterization to determine why his breathing was uncomfortable. We had just spent an uneventful week on Sanibel Island, FL, where we walked the beaches and enjoyed time together.

FULL-TIME CARE

The medical tests found that 'Chick had six blockages, congestive heart failure, and a high heart rate. During recovery, he coded and life-saving measures, including shocking his heart, saved him. It happened again two days later. We went from thinking he was healthy, except for well-managed Type 2 Diabetes, to death in one week. Our lives changed in an instant; suddenly he needed full-time care from me and our children, three of whom live out of state. After the two cardiac arrests his diagnosis was post hypoxia myoclonus, a neurological disorder associated with quick, involuntary muscle movements; he was unable to walk without assistance. His heart needed to be controlled by a pacemaker and defibrillator implanted in his chest. Gratefully, he suffered no cognitive loss.

WE HAD PLANNED

We felt we were well prepared by having purchased long-term care insurance (LTCi) policies 24 years earlier. Never did we think we would need the benefits except for something like recovery from a car accident or a manageable illness. We always felt relief knowing we had planned ahead for major care expenses.

Once stabilized for a couple of weeks and four more emergency hospitalizations due to serious falls

leaving him too weak to walk, I was ready to contact the insurance company to file his claim for benefits. I wish I had contacted the company and filed the forms earlier. His Activities of Daily Living (ADLs) were clearly deficient, and he required 24/7 care by all of us for several months. All health professionals agreed, and the nurse visit to assess him verified, that he was benefit-eligible. This was obvious and his benefits were quickly approved in September 2022, after satisfying the 90-day service elimination period.

THE JOURNEY BEGINS

From that September approval date, the claim was extremely challenging, creating unneeded stress for me. Not only was I worried that 'Chick would not survive this devastating diagnosis, I also had to beg for someone in the claims department to listen to me. I had responded to their many requests for documentation to reimburse some or all our out-of-pocket expenses (nearly $20,000). But no one had determined exactly when his Elimination Period had been satisfied. I was persistent, but exhausted. I can't help but wonder how policyholders and their families navigate the claims process without having the years of experience I have—former Licensed Nursing Home Administrator, instructor for CLTC and CSA, Care Manager, and President of my own company, Long-Term Care Planning Consultants. Since 2014 I have been a Senior Services Advisor at LTCI Partners, LLC.

The experience was overwhelming and took a toll on my own health.

I was managing day-to-day homecare for 'Chick while working full-time helping clients and friends understand the importance of planning for the possibility of needing or providing extended care.

THE LEARNING

I have learned so much about my tolerance as a caregiver and what it takes to collect benefits from a well-designed LTC insurance policy issued by a reputable carrier. I have had weekly contact with claims department representatives for nearly a year. Benefit payments only started in April 2023. I have been told many untruths by untrained third-party claims representatives about satisfying the Elimination Period. One told me there are two 90-day periods to satisfy with proof of expenses for care. One is for facility care, which he has not needed, and a separate one for home care (which he has been receiving, five days a week, since August 2022). After nine months, the claims department apologized and acknowledged they had mistakenly omitted his Medicare hospitalization and rehab days for Elimination Period satisfaction. They have reimbursed me for the cost of the professional providers I have hired.

It has been an eye-opening experience.

Now the benefit payments are automatically deposited into our checking account, and 'Chick is receiving excellent attention and care from his home care provider. And needed modifications to our walk-in shower will be covered by the home modification benefit. I can start to breathe again!

Taking so long to resolve the qualifying requirements and arguing with claims representatives was frustrating. As professionals, we promise what the

carriers have told us—that they will pay claims as long as the Elimination Period is satisfied, and benefits are approved. Getting through those 90 days-of-service is a nightmare, and it should not be.

IT TAKES A VILLAGE

I leaned on experts in my community throughout this journey. Neurologist, Geriatric Care Manager, Elder Law Attorney, social worker, home care agency owners, palliative caregivers, cardiac therapists, and LTCi industry friends. All were willing to help us receive the benefits the policy promised.

It should not be this hard.
We can do better.

I suggest that you, as CLTC designees, establish relationships with professionals in your community. People who could help you and/or valued clients navigate the long-term care insurance claims process. I love this industry and will continue to promote the important protection we offer to save families from the devastating consequences of needing and providing care. I believe the policies available today are the best we have seen.

UPDATE: My husband still needs four hours of professional home care assistance each morning. After cardio therapy two to three days a week and physical therapy, 'Chick is finally walking with a walker. He needs help managing 19 medications while his heart heals. We feel blessed by our colleagues in the industry, as well as our friends and neighbors as our family continues to include him in the activities that give him the most joy.

NANCY A. DYKEMAN, CLTC®, CSA
President
LTC Planning Consultants LLC

Nancy Dykeman is a long-term care planning consultant, and President of Long-Term Care Planning Consultants, LLC. She provides education and solutions to individuals and business groups on developing a plan for extended care and funding that plan. Nancy has been a licensed insurance producer for over 20 years, and is a Plan Advisor with LTCI Partners, LLC.

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The Need for Patient Advocacy IN THE LTCi Claim Process

By Linda Jahnke, BCPA

My career as a long-term care insurance specialist spans more than 35 years. In my experience most brokers and agents who specialize in this market do so because they care deeply about the wellbeing of their clients and their families.

The long-term care insurance (LTCi) sale is unique. It requires education, patience, and knowledge of the care delivery systems that cater to the elderly. These delivery systems continue to evolve, adapting to changing demands and ever-increasing need. Specialists who recommend long-term care insurance do so because they know the smallest home care benefit can change lives. They want to be part of the solution for seniors and their caregivers. They want for their clients what we all desire: care with dignity without bankrupting our families. For our clients, security is achieved by a successful claim outcome.

Unfortunately, many LTCi claims can be problematic. Benefits are delayed because ineligible providers are hired, insureds report inaccurate medical histories, and appeals are very often unsuccessful.

Jahnke Consulting Inc. was founded to address the complex process insureds experience when they file a claim. LTCi claim advocacy is necessary to insure fairness.

Increased technological requirements, complex care delivery systems and fractured family support put our clients at a disadvantage. Advocacy services level the field by representing the best interests of the client. Advocacy can be provided by professionals, such as our company, or family members. Because elderly clients are at risk, they not only need support for their care, but during the entire claim process.

WHO IS TO BLAME?

It would be too easy to place the blame of denied claims on insurance companies alone. In our experience consumer miscommunication, complex technology requirements, and care provider errors are often at the root of the problem.

Insureds cannot assume their first call to file a claim is unimportant. Often, that call determines whether the claim will go forward. Questions will be asked that relate to the contract language and specifically how it defines a chronic illness. The insured will have to confidently, and clearly communicate their need for daily living support, such as bathing and dressing. Older policies may require the claimant to receive substantial support, such as one-to-one physical

contact. Some intake interviewers will drill down and inquire about the precise percentage of time the claimant needs support.

- Is care needed every day?
- Morning or nighttime?
- Is the support given fifty percent of the time or less?
- What about when the insured is alone, do they try the task themselves?

These questions cause anxiety. The insured wants to be truthful, but not knowing the questions in advance can be so unsettling the insured will forgo the claim altogether.

Most carriers use third party administrators to handle their claim process. Companies such as Helper Bees, Illuminfin, and AssuriCare manage claims. They also supply the nurses for the required-on site and virtual assessments. Claimants think they are dealing with their insurance company who they believe know them, appreciate their faithful premium payments, and are happy to make good on their promise to pay benefits. When we explain the claim is managed by a different entity, they realize the connection to their carrier was transactional and less personal.

Some carriers are no longer accepting fax or email transmissions requiring the claimant to set up an online portal to view all communications and to submit documents. This method helps the carriers, but it is difficult for elderly clients who do not have secure internet access, a tech savvy family member, or the ability to recall IDs and passwords that need to be changed regularly.

COMMON MISTAKES

One of the biggest mistakes consumers make is selecting whom to supply their care.

These errors are most often in the home, but vague language in older contracts make it exceedingly difficult for families to select alternative facility care settings that fit the contract definition of "facility care." Many contracts ***do not allow*** claimants to hire independent care providers, but this is a widespread practice as families are leery of working with home care agencies and fearful of strangers being in their home.

Conversely, when policies do allow independent caregivers, the benefits stall or are denied because care logs and proof of payment lack clarity.

When our company accepts a new claim, we are careful to evaluate the situation making sure the care needs match the unique policy language. We complete the intake interview on behalf of our clients, so they do not have to worry about communicating incorrect information. We order clinical records and physician reports to verify what our clients have told us. If a family member or POA (Power of Attorney) is not available, we represent our clients during their virtual or on-site nursing assessment. We set up portals and handle all transmissions for the client. We keep digital copies while following all HIPAA requirements. We also work with a variety of care providers who we know will be approved and who supply professional documentation showing proper proof of loss. When our client hires an independent caregiver, we secure the care logs and proof of payment, insuring proper benefit payouts.

COGNITIVE IMPAIRMENT TRIGGERS

Although consumer misunderstanding may contribute to a negative experience, a particularly difficult area for families is managing cognitive impairment claims. And we are seeing more of it than ever. Why is this? Most often, the culprit is the contract language. Some policies require a *severe impairment* resulting in a need of *constant or continual supervision*. The use of the word "severe" is problematic. It is rare to see the word severe mentioned in any clinical notations relating to cognitive decline. Words we do see describing our clients' decline are moderate, progressive, advanced or mild. These words are very subjective depending on the experience of the physician caring for the insured. If the policyholder has not had a formal neurological exam with detailed cognitive testing and recommendations for supportive services, the claim path can be an uphill battle. Some companies do require their own physician to conduct a cognitive exam if they believe there is not enough proof.

These exams are terribly difficult and stressful for the insured. When we are hired by a family to help with a loved one suffering from dementia, we collect the proof of loss that meets the policy standard. If there is no such proof, we help the family collect what is needed or we wait until that documentation is ready before we file a claim. We do not want our families to be subjected to a process that typically takes up to 12 weeks to complete, only to be denied in the end! We prefer to take our time, gather what is needed, secure a care provider who can contribute proof of need, and walk our client carefully along the way to a successful outcome.

PROVIDER ENGAGEMENT

Our clients aged 65 plus have no experience with billing, coding, claim submission or appeals. Their physician's back-office provides this important service. The physician is motivated to get it right because they are paid directly from the insurance company. This is not the case for a LTCi claim. Benefits are most often paid directly to the insured. As a result, the claimant must assume the care provider is paying attention to what is transmitted so they can be reimbursed. If the provider has already been paid for services (i.e., assisted living billing is due one month in advance) the urgency to submit missing or incorrect documentation becomes an annoyance. Often this is where the process breaks down.

Long-term care insurance claims organically unfold month over month. A claim may start in the home with a care provider who then goes to another agency. If so, the change will require updated approvals. A current approved care plan may only allow up to four hours of care per day. When more care is needed, an updated plan of care must be submitted. When an insured has an event like an injury or hospitalization, the change must be reported because claim complexity has changed. It is not unusual for a claim to be approved, only to be closed due to missing information six months later. Our company follows each claimant for a year at a time. Our support guarantees the claim will not close unless the claimant no longer needs care.

A MODEL FOR LTCI INSURANCE AND CLAIM ADVOCACY

Long-term care insurance has helped millions of insureds receive quality care while protecting financial assets. Successful claim outcomes protect primary caregivers from declining in their own health due to the strain of ongoing care requirements. To carry out the goals policyholders intend when purchasing LTCi, advocacy must be part of the process.

When I started selling LTCi insurance in 1987, I did not think through the ramifications of my client's difficulty in securing quality care while overseeing the details of their insurance claim. I learned this when a client of mine passed away in her home while waiting for her benefits to be paid. Her death was tragic and unnecessary. It was ironic that my client took the time to think through her retirement, secure an excellent policy only to be failed by both the care community and the claim process.

Advocacy makes a way for client centered solutions. Our mission at Jahnke Consulting is to bring our claim advocacy model to as many families as possible. With this support we ensure that care with dignity is secured, and promises are kept.

LINDA JAHNKE, BCPA
Founder and President
Jahnke Consulting, Inc.

Linda has been a long-term care insurance specialist for over 30 years and began her career working in a skilled nursing facility providing care for residents suffering from Alzheimer's disease. In 2013 she founded Jahnke Consulting and Long-Term Care Alliance. Their mission is to provide premier long-term care insurance options and claims advocacy. Linda and her team manage and oversee all aspects of a claim event as well as manage professional care options.

jahnkeconsultinginc.com

The Recent ROLLER COASTER with the HIPAA Per Diem

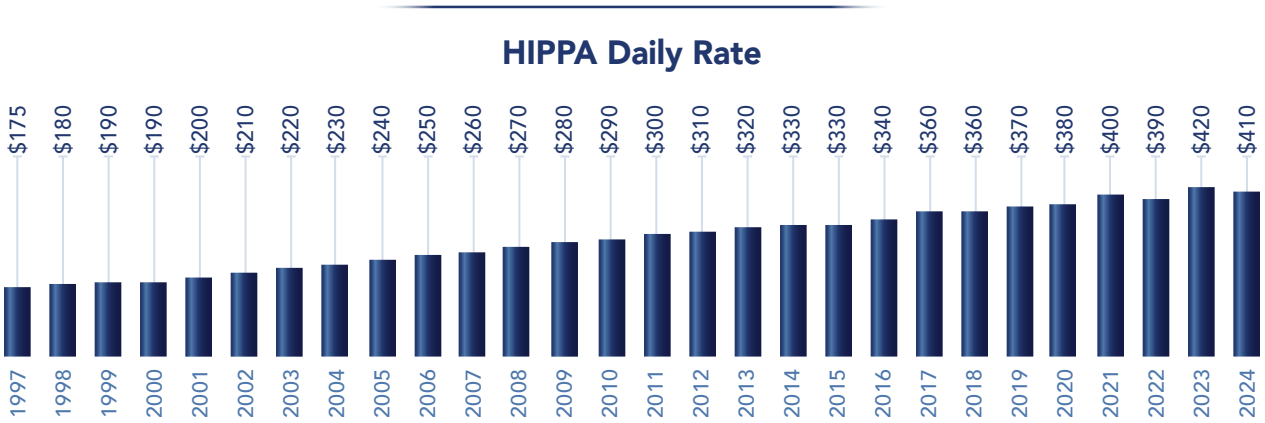
By Shawn Britt, CLU, CLTC©

Each year by early November, the IRS establishes a HIPAA per diem rate for the following year. This rate is applied to calculate the receivable tax-free benefit amount from traditional long-term care (LTC) policies, linked benefit LTC policies, LTC riders on life insurance and annuities, and chronic illness riders. The 2024 announcement, however, proved unusual, dipping down for only the second time in history. Since its inception in 1997, the HIPAA per diem rate has typically risen each year, with the exception of a few years where it remained unchanged.

What may have caused the HIPAA per diem to go down (and why may it not make any difference to most people who own cash indemnity LTC coverage)?

A CHANGE IN FORMULA BRINGS CHANGES TO THE HIPAA PER DIEM

The Tax Cuts and Jobs Act (TCJA) implemented on January 1, 2018, brought about a change to how fixed dollar amounts, such as the long-term care (LTC)



HIPAA per diem, would be indexed for inflation. Prior to 2018, the medical component of the Consumer Price Index for all Urban Consumers (U-CPI-U) was used in calculating the HIPAA per diem each year. This type of formula measures the change in price, and thus the inflation, of a fixed set of products and services.[1]

With the implementation of TCJA, the formula to index for inflation and determine the annual HIPAA per diem now incorporates the Chained Consumer Price Index (C-CPI), often referred to as "Chained CPI" or "chained weighted inflation." This formula is based on changes in consumer preferences and product substitutions made by consumers due to changes in the price of goods. C-CPI is better suited to measuring the cost of living because it focuses on the actual mix of goods and services consumers purchase, including less expensive substitutions, but it is a less accurate measure of inflation.[2] While the cost of many items were impacted by high inflation in the last year (such as fuel and food), actual dollars spent on medical care, with the exception of home health care, did not suffer the same impact. Additionally, LTC is a just a small percentage of the medical care component of the Consumer Price Index.[3]

Since the change in formula, there have been a few hiccups in the HIPAA per diem, namely $10 reductions that occurred twice. There has been talk that this effect on HIPAA could be harmful to policy owners of cash indemnity LTC coverage. But this assumption is flawed. In 2021, the HIPAA per diem increased for the first time by $20, and in 2023 the increase was $30. Over time, since HIPAA's inception, the numbers have kept up with inflation. When you consider that 3% compound inflation is the most popular inflation choice for long-term care insurance policies, the HIPAA per diem has kept up with that choice over time.

IRS GUIDELINES FOR TAX-FREE LTC BENEFITS

LTC benefits may be received tax-free, cumulative of all policies being paid for the benefit of an insured—regardless of who owns the policies—at either (1.) the greater of the HIPAA per diem in the year of claim, or (2.) actual qualifying LTC expenses incurred. Thus, any amount of LTC benefits received in the year of claim that are equal to or less than the HIPAA per diem will be tax-free with no need to justify expenses. Additionally, any amount received that exceeds the HIPAA per diem but does not exceed actual qualifying expenses, will also be tax-free.[4]

WHY VERY FEW POLICIES WILL BE AFFECTED

When you look at the breakdown of LTC benefit amounts issued, it turns out this is of little concern to most owners of indemnity or cash indemnity LTC coverage. Looking at figures of policy amounts issued from a major insurer of LTC riders on life insurance and linked benefit policies, here is the approximate breakdown:[5]

- 87% of life insurance policies with LTC riders have been issued with LTC benefits less than the 2024 HIPAA limits.
    - With time, some of the remaining 13% of policies will also fall within the HIPAA per diem in the year in which a claim is filed. How many of these LTC rider benefits will eventually fall within the HIPAA per diem is unknown as the commencement of LTC claims on these policies cannot be predicted.
- 98% of linked benefit policies with no inflation added were issued with LTC benefits below the 2024 HIPAA limit.

- 99.5% of linked benefit policies with inflation were issued below the HIPAA limit amount.
    - Since the HIPAA per diem has increased at 3.2% compound since inception in 1997, policies with 3% simple interest most likely will not exceed the HIPAA per diem in the future, and policies with 3% compound inflation have little chance of exceeding HIPAA based on historical data.
    - The few polices with 5% compound inflation issued near the HIPAA per diem at issue could eventually see LTC benefits exceed the annual per diem. Even so, that leads us to the next point to consider.

CASH INDEMNITY VS. REIMBURSEMENT

There are those who might argue that reimbursement plans are better because LTC benefits are not tied to the HIPAA per diem. But the LTC benefits available for reimbursement under such a plan are tied to what the contract says is covered. Any LTC expenses not covered under the policy will have to be paid for out-of-pocket.

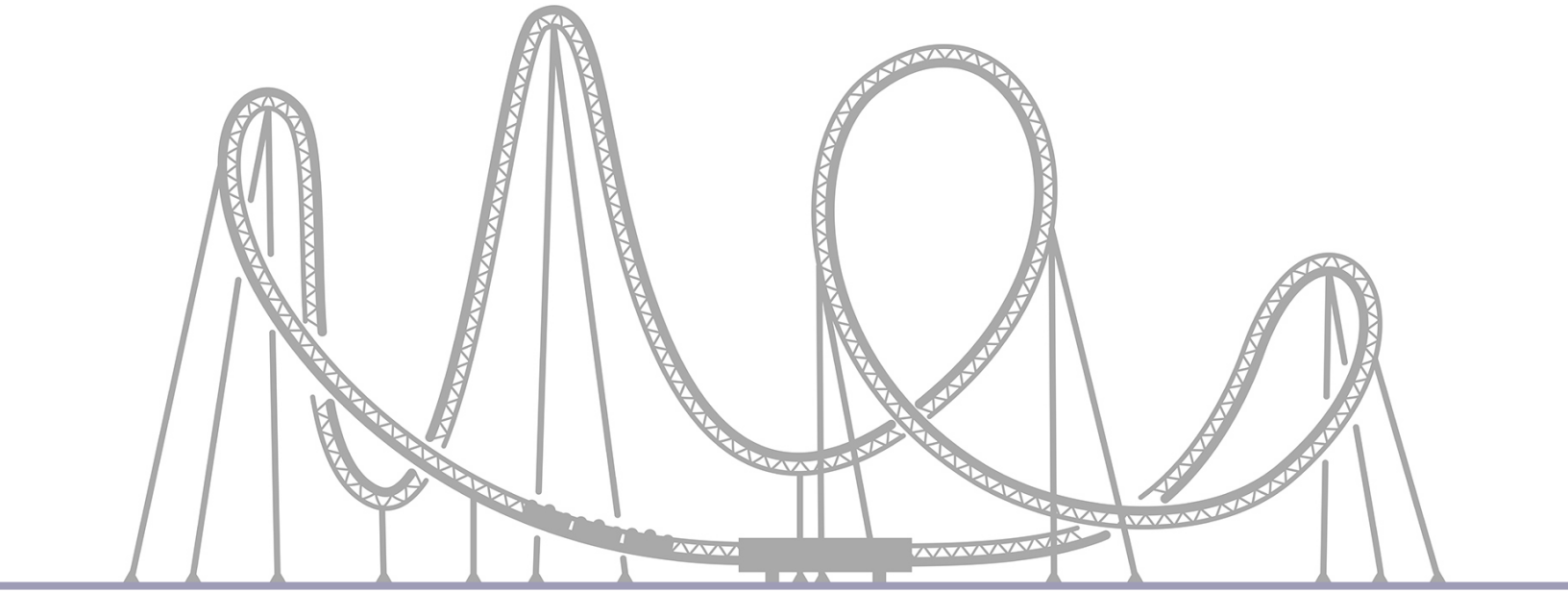
With cash indemnity benefits, the insurance company places no restrictions on how LTC benefits are used. More importantly, many of the cash indemnity carriers pay LTC benefits up to two times the HIPAA per diem, or place no HIPAA cap on their LTC benefits. This means that policy owners will still have access to LTC benefits that exceed HIPAA if such an amount is available in the policy.

After taking a closer look at the circumstances surrounding the changes in the HIPAA per diem calculations, there is really little to worry about for most owners of cash indemnity LTC coverage. For the few policy owners that have LTC benefits exceeding the HIPAA per diem at claim time, they can still receive LTC benefits tax free simply by limiting the amount of LTC benefits they take from their policy which will keep benefits received within the IRS tax free limits.[6]

SHAWN BRITT, CLU® , CLTC®
Director of LTC Initiatives for Advanced Consulting Group
Nationwide Financial

Shawn has been engaged in the life insurance and LTC industry for nearly 30 years. Shawn has been a major influence in promoting the need for long-term care and development of Nationwide's LTC product solutions.

[1] Investopedia: "Chain-Weighted CPI Definition", by Will Kenton; updated 09/02/21
[2] Investopedia: "Consumer Price Index for All Urban Consumers (CPI-U)", by Will Kenton; updated 01/15/22
[3] U.S. Bureau of Labor Statistics,"Measuring Price Change in the CPI: Medical Care," 08/22/23
[4] A tax professional should be consulted to help determine which of the insured's expenditures would be considered a qualifying long-term care expense for purposes of the IRS formula for tax-free benefits.
[5] Actuarial figures from a major insurance company
[6] Supra, Note 4



Memory Care

Is it really that expensive?

By Kerry Peabody, CLU®, CLTC®, RICP

According to the APFM (A Place for Mom) 2022 Senior Price Index, the national median cost for a memory care community is $5,430 per month. Here in my home state of Maine, it's $7,695. However, prices can range from $4,800 to upwards of $9,500. While it's clearly not an inexpensive proposition, when a loved one needs memory care, it really is a bargain.

This may seem a bold statement in a market where you can get a nice, two-bedroom apartment for $2,200 a month. A memory care community is a lot more than a place to sleep, though. For example, a list of essential amenities and services offered at local memory care communities include:

- Escorts to meals and programming
- Dressing and grooming (choosing an outfit, putting it on, brushing hair, or shaving)
- Assistance with bathing
- Medication management and reminders
- Continence care
- Housekeeping and linen service
- Scheduled transportation to appointments
- An emergency response system

What would it cost to replicate that at home? If a loved one is suffering from severe cognitive impairment, they're going to need 24/7 supervision. Using a licensed home care agency, that type of custodial care is going to cost anywhere from $25–30 per hour.

As an example, let's say the hourly cost of care is $27.50. To have a caregiver in the house 24/7 would cost you roughly $660 per day, or a mind-numbing $240,900 per year. The memory care home, for the same year, would cost $92,430—a far cry from a quarter of a million dollars. Did you ever think that would seem like a great deal?

What if you simply hire a private-duty nurse to live with your loved one? You would think it's possible to do that for a lot less than $240,000 per year.

According to Ziprecruiter.com:
The average salary for private-duty registered nurses in the U.S. in 2023 is
$74,828 per year.

Keep in mind: that number is based on a 40-hour week, and you need a live-in nurse. So, let's bump that up a bit to $100,000.

Then, of course, you're an employer, so you'll have to deal with the tax matters involved. These include social security, workers' compensation, and more. If the nurse prefers to work on a 1099 basis, you can avoid all of this, but then they're going to need a bump in the salary to cover these expenses. So, let's say $125K.

What if they get sick? Hard to call in sick when you live with your patient, isn't it? When they're unable to work, it'll be up to you to fill that gap. It might be a day, or it might be a week. They'll want a few weeks of vacation per year, of course. Regardless, there's no backup in these scenarios, so you'll have to fill in yourself or turn to that agency we talked about earlier. All the while, you're buying groceries, keeping up the home, paying property taxes, etc. You're still spending a lot more than the memory care community would cost and dealing with more stress in the process.

"Fine, then. I'll just move them in with us. We have a spare room."

A perfectly reasonable plan, and very commendable on your part. That said, your family—your spouse, kids, and maybe the dog—will need to adjust to having a live-in grandparent who needs 24/7 care. Of course, these needs are almost certainly going to increase over time. Still, while this approach will cost a lot less, you're paying a far higher price in physical and emotional commitment, stress, and lifestyle sacrifice. Like it or not, it will inevitably take a toll on the family. So, that needs to be included in the care equation.

There are several ways that you can ensure a loved one with cognitive issues gets the care they need. As with anything, each has pros and cons. If you're nearing or at this point with a family member, it's time to act. There are some excellent resources out there to help. Your local Area Agency on Aging can offer referrals to caregiver support groups and resources for education, care planning, and more. You may want to consider consulting with a geriatric care manager to get a handle on care planning.

You also certainly need to ensure that your loved one's legal documents—a will, advanced care directive, financial power of attorney, etc.—are all up to date. You'll need to consult with an elder law or estate planning attorney. Be sure to choose one that specializes in this area rather than a generalist. And, of course, visit some local memory care communities across the price spectrum.

Memory care is an expensive proposition, no matter which approach you take. However, it's one that many families are going to need to deal with. Planning for this now will make it easier in the long run and help you avoid doing this in the middle of a care crisis.

KERRY PEABODY, CLU®, CLTC®, RICP
LTC Insurance Specialist
Clark Insurance

Located in Portland, ME, Kerry has been working directly with consumers for over 20 years, helping families and small business owners protect themselves against the staggering emotional, physical, and financial impact of an extended LTC event.

clarkinsurance.com

LTC CASE STUDY

Meet Ian and Corinne

Study provided by
Laurie Sappern Gaugler, CLTC®

Ian and Corinne are 63 and 60 years old respectively and live in Connecticut. They have two employed children in their mid-20s who live in New York City. Ian and Corinne are unclear where they will live after retirement; that decision will depend on where their children settle.

Ian's father cared for his mom who had Alzheimer's. Ian's brother and sister both lived within 30 minutes of their parents and were very helpful during that time. Ian's mom died at age 75 and his dad passed away at age 95 without any cognitive deficiencies.

Corinne had watched her dad care for his second wife, who had dementia and no long-term care insurance. She ended up managing her dad's care long-distance during the last few years of his life and it was made easier by the fact he had purchased an LTCi policy. Her dad had a wonderful caregiver and he passed away at age 92. Her mom had died at age 71. Neither of her parents had any cognitive challenges.

Ian and Corinne want to make sure their children are never put into a position of having to make tough decisions about their care. Additionally, and if possible, they would like to leave the children an inheritance.

OVERCOMING HESITANCY

Ian was reticent to spend money on a long-term care insurance policy. He asked us to prepare options for Corinne alone and for the two of them together. Corinne is not a fan of the insurance industry in general.

Both Corinne and Ian are college professors; they also generate some self-employment income, allowing for a tax deduction. Ian was not comfortable sharing much about his financial situation. During a separate discussion, Corinne shared that her projected monthly retirement income will be about $10,000. She has about $300,000 in IRAs and will be selling half of her father's house to her brother, which will bring her $350,000. They own their home outright, which is worth $600,000.

Ian takes a statin, a medication for acid reflux, had successful rotator cuff surgery five years ago, and uses edibles recreationally a couple of times a week. He practices yoga and tai chi daily and volunteers as a groundskeeper at the local lawn bowling park where he plays. As groundskeeper, Ian uses a push mower and walks five and a half miles to mow the bowling greens, as needed. Corinne takes no medications and has no current or prior health conditions. Both prospects are fit and well within the acceptable height and weight limits.

We first looked at a traditional, stand-alone policy of $150/day for three years—one illustration from National Guardian Life and another from Mutual of Omaha. We showed individual plans in two scenarios, one where just Corinne would purchase a solution and the other where both spouses would be covered. We also showed shared plans. On the Life/LTC front, we looked at Lincoln for Ian and Securian for Sarah, as the edibles knocked Ian out of the running for Securian.

The benefits of applying as a couple for a stand-alone solution encouraged Ian to stay with the process, and

OPTIONS PRESENTED

	National Guardian Life	Mutual of Omaha	Lincoln (Ian Only)	Securian (Corinne Only)
Daily/Monthly Benefit (Each)	$150	$4,500	$3,500	$3,500
Benefit Period (Each)	3 Years	3 Years	5 Years	5 Years
Initial Policy Max (Total)	$164,250	$162,000	$210,000	$210,000
Elimination Period	90 Service Days	90 Calendar Days	None	90 Calendar Days
Inflation Protection	3% C	3% C	3% C	3% C
Death Benefit	None	None	$84,000 Each	$84,000 Each
Shared LTC Benefit?	Yes	Yes	No	No
Total Annual Premium	$6,577	$6,825	$13,994	
Premium Guaranteed?	No	No	Yes	Yes
LTC Benefit Per $1 Premium*	$6.33	$4.01	$4.70	$5.01

**Paid when oldest spouse is 85, assuming no rate increase.*

so the options illustrated in the above chart include coverage for both spouses.

Ian and Corinne expressed concern of being cash poor and insurance rich. For the stand-alone options, they preferred lifetime pay to minimize annual cash outlay and a "shared" policy structure for flexibility. They were not interested in single pay options for the Life/LTC plans. And so we opted to show a lower monthly benefit (than for the stand-alone options) out of concern for sticker shock and their focus on cash flow.

CONCLUSION

They preferred the National Guardian Life (NGL) shared option and decided that between income at retirement and the eventual sale of their home, they would be able to co-insure the cost of care and reduce the benefits of their policy.

We presented NGL,

- 3 years each, shared at $100/day
- 2 years each shared at $150/day, and
- 2 years each shared at $100/day

They chose to apply for two years each and $100/day, at a lifetime annual premium of $3,758 and a benefit per $1 of premium at age 85 of $4.93 (assuming there are no rate increases). This proved to be a comfortable premium and benefit amount and a compromise between the two spouses.

To our great surprise, Ian was rejected due to a diagnosis of lupus that was listed in his medical records. When I reached out to Ian to discuss this, he was off the grid camping in a remote area without cell service, campsites or bathrooms—not exactly activities you'd expect from someone suffering from lupus! After almost eight weeks and countless discussions with his doctor's office, it was determined the wrong records ended up in Ian's file. Apparently, there are three other men with the same name that live in his city. We submitted an appeal with a letter from the doctor and the decline became an approval.

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Laurie has been a LTC Insurance Specialist for over 17 years and believes strongly that planning for an extended period of care is a responsibility that shouldn't be left to others when a crisis strikes. Whether that is an insurance policy or another solution, everyone should have a plan.

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