

Understanding long-term care insurance

As anyone with an elderly relative or friend who is unable to provide for his or her own care can tell you, the cost of that care—whether at home or in a facility—is a major expense. The financial outlay for such care, because of advanced age or chronic illness or injury, may not be an issue for the very rich, with significant personal resources, or the very poor (who qualify for government assistance).

But, for the vast majority of people, whether to purchase a long-term care insurance (LTCI) policy is a worthy topic for discussion. Below we provide a few questions and answers that may assist in determining whether you want LTCI coverage.

1. How likely is it that you will need long-term care?

According to the National Council of Insurance Commissioners, one person in three who turned 65 in 1990 will stay in a nursing home, with one in ten staying five years or more. On the other hand, according to recent statistics, over 25 million people in the U.S. between age 65 and age 84 are living independently. Other statistics suggest that those who do spend time in a nursing home usually remain there under a year.

But what about the chances that you will need long-term care? Perhaps one of the best steps that you can take is to evaluate your family's medical history. You are more likely to need LTCI if there have been instances of early onset of dementia, heart disease or stroke in your family. Longevity may be a factor, too. If your parents, grandparents or their siblings have lived into their 90s or later, it's not an unrealistic assumption that you will, too—thereby increasing the chances that you will need some

kind of professional care or assistance.

2. What does LTCI cover?

Terms differ from policy to policy. Generally, LTCI covers care in a qualified nursing home, in an assisted living facility or in your home. But, often, policies will pay less for care given in the home than in a facility.

As is the case with most insurance, coverage offers protection from catastrophic loss of your assets and income should you require assistance. Coverage varies, but the ability to perform a certain number of “activities of daily life” (ADLs) is a common measure of when benefits will be paid. The most common ADLs are: eating, dressing, bathing, transferring in and out of bed, toileting and continence.

3. What kind of LTCI coverage do you need?

LTCI policies offer a wide variety of options. The good news is that you should be able to fashion a policy that closely suits your needs. The not-so-good news is that you are going to have to spend a significant amount of time reviewing different policy options.

Some examples: Based upon your financial circumstances, you may be able to pay for home care and thus need coverage only if you enter a facility. Do you have a relative or a friend who might provide care? Then you'll want a policy that permits payments to unlicensed caregivers. Again, based upon your resources, you may want to lengthen or shorten the waiting period before coverage begins. You might consider inflation protection, as well.

The new Medicare legislation, enacted in December 2003, provides for a prescription drug benefit that won't exist until 2006. But also part of the new law is a provision that went into effect on January 1, 2004—the creation of the Health Savings Account (HSA). By opening an HSA, you may be allowed to deduct your contributions to the account, avoid tax on the earnings and even make withdrawals from the account tax free (when they are used to pay qualified medical expenses).

As is the case with almost every tax-favored savings program, you are going to have to understand the rules, carefully dotting the i's and crossing the t's, in order to gain the benefit. Shortly after the passage of the new Medicare law, the Internal Revenue Service issued some substantial guidance for those individuals and business owners who seek to take advantage of these new accounts.

The guidance comes in the form of questions and answers. Below we highlight some of the main points raised in the IRS discussion.

What is an HSA and who can establish one?

An HSA is an account established to help individuals and families save for certain current and future qualified medical expenses. Generally, anyone who is (1) covered by a high-deductible health plan, (2) not covered by any other health care plans, (3) not entitled to Medicare benefits and (4) may not be claimed as a dependent on another person's tax return may establish an HSA.

The IRS defines a "high-deductible health plan" as self-only health insurance coverage with an annual deductible of at least \$1,000 and annual out-of-pocket expenses (deductibles, copayments and other amounts, but not premiums) to be paid of no more than \$5,000. For family coverage the annual deduc-

tion must be at least \$2,000 and annual out-of-pocket expenses no more than \$10,000. These amounts are indexed for inflation. However, a health plan may offer preventive care without a deductible (or with only a small deductible) and still qualify as "high-deductible."

What are the rules regarding contributions to an HSA?

For an HSA established under an employer's plan, the employer, the employee or both may contribute to an employee HSA. For an HSA established by a self-employed or unemployed individual, the individual contributes. Family members also may make contributions to an HSA on behalf of another family member (presuming, of course, that the other family member is otherwise eligible to have an HSA).

The formula for determining the annual amount that may be contributed to an HSA is somewhat complicated. As a general rule of thumb, however, for the year 2004 the maximum annual contribution for self-only coverage is the lesser of 100% of the annual deductible amount, but not more than \$2,600. For family coverage it's the lesser of 100% of the annual deductible, but not more than \$5,150. In 2004, for those between ages 55 and 65, the contribution limit is \$500 higher. This "catch-up" amount grows in \$100 increments annually, until it reaches \$1,000 in 2009. All contributions must be made in cash.

Contributions to an HSA are deductible, whether or not deductions are itemized on an individual's federal tax return. Contributions made by a family member on behalf of an individual are deductible by the individual. When an employer makes contributions to an employee's HSA, they are treated as employer-provided coverage for medical expenses and are not included in the employee's income.



HSAs are “portable.” An account owner is not dependent on a particular employer to enjoy the advantages of having an HSA. Similar to owning an IRA, if the account owner changes jobs, the HSA goes with the individual.

In addition, the interest and investment return generated by the contributions to an HSA are not taxable.

How are distributions from HSAs treated?

An individual may receive distributions from an HSA at any time. When the distributions are used exclusively to pay for qualified medical expenses of the account owner, his or her spouse or dependents, they are not taxable. Any amount withdrawn that is not used for qualified medical expenses is taxable and subject to an additional 10% tax. There are exceptions: Distributions made after the account owner’s death, for disability or upon reaching age 65 won’t be taxable. If an account owner is no longer eligible to make HSA contributions (for example, he or she becomes eligible for Medicare), distributions used to pay qualified medical expenses will continue to escape taxation.

Generally, qualified medical expenses are the expenses that are considered deductible for income tax purposes, but only to the extent that they are not covered by other insurance. Health insurance premiums are not considered qualified medical expenses. But premiums for long-term care insurance, COBRA health care continuation coverage and health care coverage while an individual is receiving unemployment compensation are considered qualified medical expenses.

What happens when an account owner dies?

Upon death any remaining balance in an HSA becomes the property of the designated beneficiary. When a surviving spouse is the beneficiary, the account becomes the spouse’s. The spouse is subject to income tax only to the extent that distributions from the HSA are not used for qualified medical expenses.

If the HSA passes to someone other than a surviving spouse, the HSA ceases to exist as of the date of the account owner’s death. The named beneficiary is required to include in his or her income the fair market value of the HSA’s assets at the time of the account owner’s death. Any amount included in income may be reduced by distributions from the HSA that are used to pay the account owner’s qualified medical expenses (unless the beneficiary is the account owner’s estate), as long as the expenses are paid within one year after the account owner’s death.

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Any developments occurring after January 15, 2007, are not reflected in this article.