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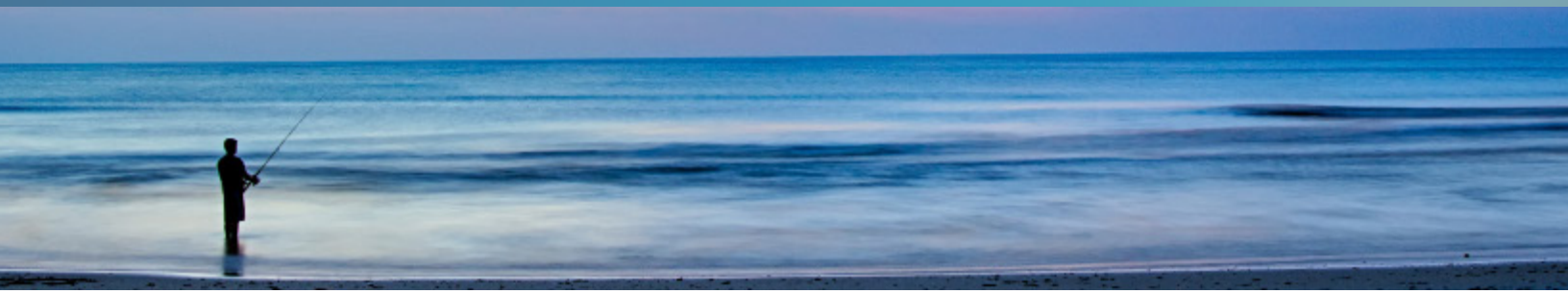

LTC vs. Chronic Illness Riders: What's The Difference?

Situation: Not that long ago, the only way to insure the risk of long-term care was through the purchase of a standalone long-term care insurance policy. While stand-alone long-term care products offered a variety of features allowing customization of a policy, many customers did not like the "use it or lose it" nature of the product. [1]

In response to customer concerns and changes in the tax law, insurers designed the "hybrid" or "linked-benefit" products as alternative solutions. Linked-benefit products combine the benefits of a life insurance policy with that of a long-term care policy. This design allows the policy-holder to accelerate death benefit to pay for qualifying long-term care expenses of the insured, but the death benefit component of the policy is paid to the beneficiary if the long-term care benefit is not used. Thus, this design overcomes the "use it or lose it" shortfall of the stand-alone products, as there is always some type of payout.

Solution: More insurers are now incorporating linked-benefit products into their portfolios as advisors and clients gravitate toward these options as a solution. However, with the mass increase in the number of linked-benefit riders, confusion abounds. While various companies appear to offer the same protection, there are a number of important differences. Those differences determine which types of claims qualify for benefits, how benefits are paid out, how riders are charged, and even the financial representative's educational requirements. Consequently, it is important to do the proper due diligence so that you understand the functionality and intricacies of the various products. This Counselor's Corner addresses some of the primary differences in linked-benefit products.

Rider Classification: Long-Term Care vs. Chronic Illness Determines Triggers Required to Pay Benefits. As a starting point, it is important for advisors to understand the two basic classifications of linked-benefit products. Specifically, linked-benefit products are classified as either providing long-term care benefits under Section 7702B of the Internal Revenue Code or providing chronic illness benefits under Section 101(g). The difference in classification is significant to both the client and advisor.

Let's start with long-term care riders that are classified as meeting the requirements of Section 7702B. Only 7702B riders can be marketed as providing long-term care benefits. This means that for a client to qualify for a claim, they must be certified as unable to perform at least two activities of daily living (ADLs) or suffer from severe cognitive impairment (also known as instrumental activities of daily living or IADLs) that is expected to last at least 90 days.

Generally, ADLs are the physical functions necessary to complete everyday tasks, including:

- **Transferring** – The insured's ability to move into or out of bed or chair.
- **Toileting** – The insured's ability to get to and from the toilet and perform associated personal hygiene.
- **Continence** – The insured's ability to maintain control of bowel or bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated person hygiene such as caring for a catheter.
- **Bathing** – The insured's ability to bath including the task of getting into or out of a tub or shower.
- **Dressing** – The insured's ability to put on or take off clothing and any necessary braces.
- **Eating** – The insured's ability to get food into the body from a receptacle such as a plate or feeding tube.

The IADLs are the cognitive functions that pertain to the mental processes of comprehension, judgment, memory, and reasoning. These activities include managing finances, managing medications, preparing meals, doing housework, shopping.

It should be noted that riders classified under Section 7702B **must provide coverage for temporary claims** (illnesses that an individual can recover from) **as well as permanent claims.** For example, conditions such as recovery from certain cancers and stroke can be covered. Thus, 7702B riders may be available to cover multiple long-term care events throughout the insured's lifetime.

In contrast to the linked-benefit riders that meet the Section 7702B requirements, the Section 101(g) riders may not be described/marketed as providing long-term care. These riders are frequently referred to as "chronic illness" riders. Like the Section 7702B rider, to qualify for benefit with a 101(g) rider the insured must be unable to perform at least two activities of daily living (ADLs) or suffer from severe cognitive impairment. However, historically with a **Section 101(g) chronic illness rider** the insured's illness had to be certified as likely to last the rest of the insured's life. In other words, **the condition had to be permanent** – temporary conditions were not eligible for claim.

However, in December 2014 **the standard for chronic illness riders was revised to include the *option* of paying temporary claims.** Note that the revised standards provide only the option to pay temporary claims and while some carriers are beginning to offer chronic illness riders that pay temporary claims, most still require the condition be permanent. To determine whether a chronic illness rider will require the claim to be permanent, you likely will need to look to the filing of claim section of the contract.

Products with 7702B riders generally **require underwriting** separate from the underwriting of the life insurance portion and **include an additional long-term care premium charge.** With this type of product, it is possible to qualify for the life insurance portion and not the long term-care. It is also possible to have a preferred rating on the long-term care portion and a rating on the life portion (or vice versa), which will result in a blended premium.

In contrast, products with Section 101(g) riders ***may not* require underwriting** separate from the underwriting of the life insurance portion. Specifically, some chronic illness products do not underwrite or charge for the chronic illness rider at the time of policy application. However, no charge does not equate to free coverage. Instead of charging for the rider, the death benefit is discounted when the rider benefits are used. Thus, the benefit is not determined until a claim is filed. The discount is based on several variables including age, sex, current interest rates and policy cash values at time of claim. So, the younger an insured is at the time of filing a claim the greater the death benefit is discounted. Other chronic illness products are underwritten and assign a cost to the rider. While this increases the premium for the overall life insurance policy, the client knows exactly what they will be entitled to, no matter when the need arises.

The classification of the rider has a couple of key implications for the licensed representative. First, to offer Section 7702B products the licensed representative must meet the state educational and licensing requirements applicable to long-term care. In contrast, since the 101(g) rider is not providing a long-term care benefit the licensed representative only needs to meet the educational/licensing requirements to sell the base life insurance policy. Second, since only 7702B riders can be marketed as providing long-term care benefits representatives must be sure their communications do not imply anything to the contrary.

Reimbursement vs. Indemnity Models: Determining How a Benefit Is Paid. Another primary differentiator among riders is whether the rider pays claims by an indemnity model or reimbursement model. Policy riders that qualify under Section 7702B are available as either an indemnity or a reimbursement plan. In contrast, Section 101(g) products are only available as an indemnity plan. Reimbursement plans are not available with Section 101(g) riders because they are not considered a long-term care product.

With a **reimbursement model**, the plan will **never pay more than the qualifying long-term care expenses** incurred up to the maximum benefit stated in the plan. Thus, with reimbursement model products it is important to understand the type of qualifying expenses

the product will cover. The benefit received in a reimbursement model is likely to vary based on the actual expenses incurred and covered by the plan. Many types of expenses associated with a long-term care event often are not covered. For example, reimbursement plans usually do not cover the costs of home modification, medical equipment, and other potential expenses that go along with long-term care needs. Some insurers will allow the provider of the long-term care service to bill them directly and the insurer will provide direct payment to the provider. However, other insurers require the policyholder to pay the service provider and submit all the bills and receipts to the insurer for reimbursement. Since the reimbursement model only pays out the amount qualifying for coverage, the long-term care coverage may be stretched for a longer period of time. Any remaining unused benefit is paid as a death benefit.

Indemnity model plans **pay the maximum benefit the policy allows without reference to the actual expenses** incurred provided certain levels of qualified services are received. Assuming qualified expenses are regularly incurred, the amount of benefit is likely to be more fixed under the indemnity model. Indemnity plans may require evidence of qualified services at a specified frequency, but receipts for the full benefit are not needed.[2] Consequently, indemnity plans permit an array of solutions because excess benefits not needed to pay for qualified care can be used for any purpose. However, benefits in indemnity plans are usually limited in some manner to the annual limitations established by HIPAA (Health Insurance Portability and Accountability Act), while reimbursement plans can exceed the dollar limitations established by HIPAA as long as the reimbursement is for a qualified claim.[3] Any remaining unused benefit is paid as a death benefit.

Summary of Rider Categories			
Section 7702B Long-Term Care Rider		**Section 101(g) Chronic Illness Rider**	
May market as providing long-term care coverage		May NOT market as providing long-term care	
Pays temporary and permanent claims		May pay temporary claims (check policy details) as well as permanent claims	
To sell, the representative must meet state licensing and education requirements for long-term care.		To sell, the representative only needs to meet state licensing and education for the base life policy.	
Policies are underwritten for life and long-term care, and charge an additional cost for the rider.		Some policies underwritten and charge for the rider at time of application, while others do not charge for the rider until claim.	
Benefit payments can be reimbursement or indemnity		All are indemnity	
Basic Differences in 7702B Riders		**Basic Differences in 101(g) Riders**	
Reimbursement	**Indemnity**	**Charge for Rider at Application**	**Discount Benefit at Claim**
Only pays the actual cost of qualifying expenses up to the policy maximum. Payments are NOT limited to HIPAA	Pays full benefit once a qualifying expense is incurred. Payments often limited to HIPAA daily limits.	Cost of rider incurred at time of application. Benefits are known at policy application.	No initial cost for rider at time of application. Total benefit pool is not known until claim.

Additional "Fine Print" Policy Differences:

Consumer Protection Requirements. Now that it's possible for a chronic illness rider to pay on a temporary claim, it is even more important to know the fine print differences in the policies. Consumer protection provisions which are required on 7702B policies are not required on chronic illness riders (including the those providing temporary benefits), so you need to read the specific terms of the policy to determine if the following important consumer protection provisions are included.

Unintentional Lapse provision. This consumer protection provision requires that the carrier provide the policy owner the opportunity to set up an authorized representative to receive notice of lapse. Both the owner and representative must receive notice within 30 days of lapse. This right must be extended to the owner every two years.

Reinstatement provision. Under the reinstatement provision, reinstatement must be available without any evidence of insurability for a period of five months of the date of policy termination. The reinstatement must include evidence that the insured either had a functional incapacity or a cognitive reason for being unable to pay the premium due that would have kept the policy in force. It should be noted that this provision is more liberal that the standard reinstatement provision on a life policy. Since chronic illness riders don't require this more liberal reinstatement provision, evidence of insurability may be required. The danger of a reinstatement provision requiring evidence of insurability is that if the policy lapses because the insured has a functional or cognitive incapacity, the insured may not be able to pass underwriting and the policy would remain lapsed.

Extension of Benefits provision. When a long-term care rider is added on a life insurance policy this provision allows the policy owner to go back on a terminated policy and capture long-term care benefits the insured would have qualified for on the policy if they had applied for the benefits while the policy was still in force. The policy is still considered terminated for purposes of the death benefit, but not the long-term care benefit.

Covered Benefits/Expenses. Both long-term care and chronic illness riders have limitations on what is considered covered or qualified care. There is no standard across the industry of what an insurer must consider qualified care, and each insurer may have varying stipulations regarding the expenses covered. For example, one insurer may cover home health care provided by a family member of the insured, while another may require that home health care be provided by a licensed health care practitioner. So, it is important for advisors to know what expenses (types of services) are covered by the particular linked-benefit product. Examples of possible covered expenses include:

- Nursing home care
- Assisted living care
- Specified home health care services
- Adult day care services
- Respite care
- Hospice services
- Alternative plan of care

Since a large percentage of the population needing assistance stay at home and a significant number have some form of dementia, it is especially important to assess whether these expenses are covered.

Waiting or Elimination Period and Recertification for Benefits. Both long-term care and chronic illness riders stipulate the amount of time an insured must wait before benefit payments can begin. Some reduce or waive the time period for home health care while requiring an elimination period for facility care. Traditional stand-alone long-term care policies typically give the insured the ability to select from a variety of elimination periods such as 30, 90, or 180 days. In contrast, most linked-benefit products define a specific period, such as 90 days. It's important to understand how the elimination period is satisfied since this ultimately determines how long an insured must wait before benefits begin. For example, does the elimination period require 90 days of consecutive qualified service or can the 90 days be satisfied with intermittent service. Insurers have varying methodology concerning claims processing. So, once it appears that an insured may qualify for a benefit, the advisor should reach out to the insurer to ascertain the necessary paperwork and other requirements.

In addition to satisfying the initial elimination period, most long-term care and chronic illness riders **require recertification.** Generally, the recertification is done annually, but the frequency differs by insurer. Recertification requirements must be received as requested by the insurer and approved, otherwise payment of benefits can be discontinued. Some insurers pay the cost of any necessary medical examination for the recertification; while in other cases the insured will need to cover the expenses. Chronic illness riders may also require claim renewal. This requires completion of forms and other requirements established by the insurer in a timely manner. Some insurers charge a fee to renew the claim.

Maximum Amount of Benefit. Insurers have varying guidelines regarding the maximum amount of benefit that is available to the client. The benefit is **either determined as a maximum monthly benefit, as a percentage of the total death benefit, or as a specific dollar amount.** Some insurers limit the maximum amount of death benefit they will permit with a policy providing a long-term care or chronic benefit rider. Some riders provide an i**nflation benefit**, while others provide benefit increases based on using death benefit option "B" (increasing based on cash value) or "C" (increasing based on cumulative premiums).

Residual Death Benefit. Both long-term care and chronic illness riders allow the insured to accelerate the life insurance policy's death benefit to pay for qualifying expenses as defined in the policy. Amounts paid out to pay for qualified expenses reduce the policy's death benefit. In many cases, the death benefit is reduced dollar for dollar while the cash value is reduced proportionately. However, **there is no single method of adjusting the death benefit or cash value.** As indicated above the death benefit is discounted in Section 101(g) riders that don't include a cost at time of application.

If the insured only utilizes a portion of the long-term care/chronic benefit, any remaining benefit is paid out as a death benefit to the beneficiaries.

Furthermore, a number of policies pay out a "residual death benefit" even if the entire long-term care benefit is paid out. In general, the residual death benefit is a predetermined percentage of the initial death benefit.

Premium Payment. Policies vary in how and when to pay premiums, ranging from single-pay, short pay for a defined number of years, and continuous pay. Furthermore, with changes in the tax law since 2010 it has been possible to do a 1035 exchange from an existing cash value life insurance policy to a linked-benefit policy. A few policies include a **return of premium feature** that permit the policy owner the right to premiums back. These policies are often describes as providing benefits whether the insured "lives, quits, or dies."

Summary. As more and more insurers incorporate long-term care and chronic illness riders into their life insurance product portfolios it's important that advisors understand the riders similarities and differences. In addition to the information provided in this Counselor's Corner, we recommend that you review the terms of the particular policy.

[1] It is estimated that 70 percent of people over age 65 will need long-term care during their lifetime. With a projected 7,000-10,000 Baby Boomers reaching 65 daily until the year 2030, the need for long-term care planning is likely to be a primary concern for many years. National Clearinghouse for Long Term Care Information. "Will You Need LTC?" www.longtermcare.gov. Linked benefit products also combine annuity and long-term care, but for purposes of this article our focus is on the life insurance based linked benefit combination.

[2] Advisors will want to know how frequently evidence of qualified services need to be submitted to the specific insurer.

[3] The per diem limit established by HIPAA for 2017 is $360 a day.