I. What is Long-Term Care?

Long-term care includes a vast array of services aimed at helping people when they are no longer able to function independently. The types of long-term care services depend upon the individual’s needs. Some long-term care is aimed at providing help with day-to-day activities for people with chronic illness, or cognitive impairment, such as dementia. Other long-term care services may be rehabilitative, helping someone regain function after a serious injury. It can range from helping with household chores, to assistance with activities of daily living, to highly skilled medical care.

Long-term care services may be provided in a variety of settings such as the home, the community (e.g., adult day care centers) or in assisted living facilities. The chances of needing home health care are considerably greater than the likelihood of needing nursing home care.
In fact, 87% of long-term care is provided at home or in the community, often by family members who also have full-time jobs.¹

II. The Need for Long-Term Care Insurance

Statistics show after age 65, an American has more than a 70% chance of needing some form of long-term care.² It is not surprising that lack of planning for long-term care is the number one cause of poverty among the elderly, given that the nationwide average length of a stay in a nursing home is about 2.4 years³ and that national nursing home costs for a semi-private room now average over $57,000 per year.⁴ However, the need for long-term care is not limited to the elderly. Statistics show that 40% of people receiving long-term care services are working age adults, between the ages of 18 and 64.⁵ Many more individuals may not need long-term care for themselves but will become involved as caregivers. In fact, one out of five families are now providing care to an elderly relative or loved one.⁶

Long-term care insurance is designed to help pay the cost of long-term care services if you need them. Long-term care insurance policies offer a wide range of benefits. Some policies cover only nursing home care, others cover only home health care and still others cover both home health and nursing home care. The ability to receive benefits for home care may allow the care recipient to live independently at home instead of living in a long-term care facility. The cost for these policies will depend on such factors as age, current medical condition, the amount and length of benefits, the elimination period and the types of services covered. Benefits typically begin once the insured can no longer perform a specified number of activities of daily living (ADLs), such as bathing, dressing or eating.

Benefit payment methods will vary between expense reimbursement and indemnity plans. Under the expense reimbursement plan, once an insured is eligible for benefits, those benefits will be paid as reimbursement for expenses actually incurred or up to the policy’s monetary limit, whichever is less. An indemnity plan pays the monthly benefit when the policy requirements have been met, notwithstanding actual expenses incurred.

III. Medicare’s and Medicaid’s Limited Coverage

Medicare provides only minimal coverage of nursing home care. The purpose of Medicare, the federal health care insurance for those 65 and older, is to provide for skilled or acute medical care. Medicare may pay for 20 days in a nursing home, plus an additional 80 days subject to a $110.00

¹ Family care Giving in the US: Findings from a National Survey, National Alliance for Care Giving & AARP, 2004
⁶ Supra Note 1.
(in 2005) deductible per day. The word “may” is used because Medicare will pay only after a three-day hospital stay and only if the beneficiary is receiving skilled care. After 100 days, Medicare will pay nothing for these services. Medicare supplements (also known as Medigap) may cover the daily co-pay amount. These policies, however, are not designed to cover long-term custodial expenses. If a beneficiary is receiving only custodial care in a nursing home (i.e., help with bathing, dressing, eating, etc.), then Medicare will not cover any of the costs. Unless long-term care insurance was previously purchased, the only program available to assist in financing nursing home care is Medicaid.

Older individuals with means also cannot rely on Medicaid as the Medicaid program funds health care for the poor. In general, Medicaid will not pay bills until the patient’s savings are depleted. To qualify for Medicaid coverage of nursing home care, a single individual cannot own more than $2,000 in “countable” assets. The starting point in the treatment of assets for married couples is that all assets owned by either spouse are considered available to the institutionalized spouse for purposes of Medicaid. Some assets such as the principal residence if occupied by the community spouse are not counted. After adding together all countable marital assets, the state Medicaid agency then determines what share of those assets the community spouse will be allowed to keep. This figure, which is based upon federal and state law, is called the Community Spouse Resource Allowance (CSRA). The exact rules for attributing a couple’s assets vary from state to state, some being more generous than others. There is, however, a federal minimum and maximum CSRA to which all states must adhere. Once receiving Medicaid assistance, the nursing home resident must use his or her income, after certain deductions, to pay for the nursing home. Medicaid pays the balance. The spouse at home does not have to pay any of his or her income to the nursing home.

Many people try to transfer all their assets immediately after it has been determined that they will require long-term care assistance. However, the transfer of assets to qualify for Medicaid will often result in a period of ineligibility. In determining Medicaid eligibility the states will look-back to see what disqualifying transfers were made in the 36-month period of time prior to a Medicaid application date (i.e., the look-back period). This means that transfers of certain assets for less than fair market value made during the look back period will result in a waiting period before one can start to collect Medicaid benefits. So, for example, if a client gives his house to his children in the year before he enters a nursing home, he would be ineligible for Medicaid for quite some time (the period of ineligibility is determined by dividing the value of the transferred property by the average monthly cost of nursing home care in that state). The look-back period for assets transferred for less than fair market value to a trust is 60 months.

Some states have enacted state partnership laws with respect to long-term care insurance. There are four states that currently have Partnership Programs. California, Connecticut, Indiana and New York. The Partnership Programs are joint efforts by state governments and the private long-term care insurance industry to create an option to help individuals plan to meet their future long-term care needs without depleting all of their assets to pay for care. Generally, under these state partnership programs, a person buys a long-term care insurance policy that meets certain requirements. If that person later enters a nursing home and exhausts those insurance benefits, then the individual becomes eligible for Medicaid without being required to “spend down” his or her assets. State partnership programs differ widely, so it is wise to check the specifics of the program in the state where the individual resides. If an individual moves to another state, the original
“qualified” long-term care policy may no longer afford the same protection against being forced to “spend down” assets.

IV. Long-Term Care Planning as Part of the Overall Planning Process

Long-term care planning should be considered within the context of the overall financial and estate planning process. Unfortunately, the process of purchasing long-term care insurance is often wrapped in emotion, after a family member or friend falls ill and needs extended care. The objectives of the typical client (e.g., providing sufficient lifetime income, preserving assets for the children, creating an orderly transition in the event of death or disability) can be achieved more effectively when long-term care planning and estate planning are integrated. For example, a properly established and funded IRA distribution plan that is designed to make payments over more than one generation can be essentially destroyed if the client needs to access the IRA funds to pay for long-term care expenses. By providing funds to meet these expenses, long-term care planning can help assure that the benefits of continued income tax deferral are realized.

A common theme pervading both long-term care planning and estate planning is the need for liquidity. Clients require cash to meet expenses, whether to pay for long-term care expenses or to pay for estate settlement costs. The essential problem in both situations is how to create the right amount of liquid assets just at the right time in the most economical way. Establishing a plan that creates sufficient cash at the time it is needed avoids the costs and complexities of having to later restructure the plan in an effort to pay those expenses. Clients want the comfort of knowing that a plan is in place, which will avoid uncertainty and provide for anticipated budget breaking expenses. Just as life insurance can create at the appropriate time the liquidity needed to pay estate taxes, long-term care insurance can similarly provide the cash to pay long-term care expenses.

Even large estates can experience a cash crunch and the benefits provided under a long-term care insurance policy can help assure that the estate plan will be carried out as planned. For example, if the surviving spouse’s health should fail and he or she enters a nursing home, the long-term care insurance benefits can cover the nursing home expenses. This could enable the client’s investment portfolio to remain intact so as to continue to pay the premiums on a second-to-die life insurance policy, better assuring that the insurance policy will not lapse. Since this financial disaster can occur without warning, both spouses may need long-term care insurance protection.

A second theme running through both estate and long-term care planning is the need to minimize the shrinkage that can occur in intergenerational transfers. Just as minimizing federal and state death taxes is a large part of the estate planning process, minimizing the financial risk of incapacity is key to the long-term care plan. While life insurance is often recommended to offset the shrinkage due to estate settlement costs, long-term care insurance can similarly be used to prevent erosion of assets. The objective is to minimize this shrinkage. In this light, long-term care can be seen as just another cost item such as estate taxes or probate fees. Even wealthy clients who may appear to have the financial wherewithal to absorb the expense may need to consider long-term care insurance. The expenses associated with maintaining a household for one spouse while concurrently paying long-term care expenses for the other spouse can be financially devastating.
Long-term care insurance can also help give clients the requisite peace of mind to begin an aggressive gifting program. There is a common fear among clients who are contemplating a gifting program that they will transfer too many assets, and that in the future the expenses of failing health may overwhelm them financially. Clients who possess this fear often fail to begin making gifts, or if they begin a gifting program, they may abruptly cancel it, often resulting in the payment of unnecessary estate settlement costs upon their death.

For smaller estates, long-term care insurance can also be an important component of an effective plan. Long-term care insurance can help clients retain control of their assets and help prevent the dissipation of their entire estate if they should at some future time need long-term care. It can also help provide clients with some of the many benefits of retaining ownership of their assets (e.g., preserving the client's autonomy to make his or her own financial decisions, retaining control over the ultimate disposition of the assets, permitting assets to receive a step-up in basis to market value at death).

V. Income Tax Treatment of Long-Term Care Insurance

• Tax-Qualified Long-Term Care Policies

A qualified long-term care insurance contract is defined as any insurance contract that provides coverage only for qualified long-term care services and meets certain other requirements as set forth in the Health Insurance Portability and Accountability Act, commonly known as "HIPAA". Qualified long-term care services are benefits paid to a “chronically ill” individual. To qualify as “chronically ill” the insured must be certified by a licensed healthcare practitioner that:

a. They are unable to perform, without substantial assistance, at least 2 out of 6 Activities of Daily Living (ADLs) due to loss of functional activity that will last at least 90 days; or

b. They require substantial supervision to protect the individual from threats to health and safety due to a severe cognitive impairment.

A federally tax-qualified long-term care insurance policy provides certain federal income tax advantages. Individuals can deduct the portion of their medical expenses that exceed 7.5% of their adjusted gross income\(^7\) (AGI) where the taxpayer itemizes his or her deductions. If an individual has a tax-qualified long-term care insurance policy, he may be able to include, as medical expenses, his eligible long-term care premiums. In addition, individuals can generally also deduct as a medical expense their unreimbursed expenses for long-term care services. As is the case with other medical care expenses, a deduction is generally available for a taxpayer paying such expenses, if the medical care is for the taxpayer, the taxpayer's spouse or the taxpayer's dependent.

Amounts paid for eligible long-term care insurance premiums are treated as medical expenses to the extent that the amounts do not exceed certain annual limitations. These limitations are based upon the individual's attained age before the close of the tax year and are adjusted annually based

\(^7\) IRC § 213(a).
on increases in the medical care component of the Consumer Price Index. These limitations for the 2005 (and 2006) calendar year are as follows:

<table>
<thead>
<tr>
<th>Age Before Close of Tax Year</th>
<th>2005 Limitations (2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or Younger</td>
<td>$270 ($280)</td>
</tr>
<tr>
<td>41 to 50</td>
<td>$510 ($530)</td>
</tr>
<tr>
<td>51 to 60</td>
<td>$1,020 ($1,060)</td>
</tr>
<tr>
<td>61 to 70</td>
<td>$2,720 ($2,830)</td>
</tr>
<tr>
<td>71 or older</td>
<td>$3,400 ($3,530)</td>
</tr>
</tbody>
</table>

Amounts paid for qualified long-term care services provided by a relative are not treated as medical care, and thus are not deductible, unless the relative is a licensed professional with respect to the service. The term “relative” includes stepparents, stepchildren, in-laws and children of a sibling.

The following hypothetical example illustrates the tax consequences for an individual taxpayer:

Assume that Karen, a 58 year-old individual, has adjusted gross income of $50,000 and itemizes deductions on her federal income tax return. She elects to purchase a qualified long-term care policy with an annual premium of $2,500. Karen also has $4,000 in unreimbursed medical expenses. In tax year 2005, a 58 year-old individual can deduct up to $1,020 in qualified long-term care insurance premiums. Therefore, Karen’s total medical expenses equal $5,020 ($4,000 plus $1,020). Her medical expenses can be deducted to the extent that they exceed 7.5% of her adjusted gross income, which in this example is $3,750. Therefore $1,270 ($5,020 less $3,750) is the total medical expense deduction Karen can take on the Schedule A of her tax return.

In addition to the deductibility of the premium (subject to the 7.5% of AGI floor), a second advantage of a qualified long-term care policy is that benefits paid by a qualified long-term care insurance policy are generally not taxable as income. Because a qualified policy is considered an accident and health insurance contract, amounts received under a long-term care contract are excluded from income as amounts received for personal injuries and sickness. (It is currently not clear whether benefits paid by a non-qualified plan might be taxable as income.) There is a tax-free cap of $240 per day for tax year 2005 ($250 for 2006) on benefits received under a per diem plan unless the taxpayer can show that long-term care expenses exceed the cap. In such cases, the actual long-term care expenses would be excludible. This tax-free cap is adjusted for inflation and may be reduced to the extent that the long-term care expenses are reimbursed from other sources, such as another long-term care policy or Medicare.

• Tax-Qualified or Non-Qualified?

It is not always more advantageous for an individual to choose a federally tax-qualified policy over one that is not federally tax-qualified. To qualify for benefits under a federally tax-qualified policy, the insured may need to be more incapacitated than for a non-qualified policy. Tax-qualified
policies require stricter, more specific language concerning ADLs and benefit triggers. Furthermore, the tax deduction is limited to “eligible” premiums and then only available to the 5% of taxpayers who spend 7.5% or more of their adjusted gross income on medical expenses. Policies issued as tax-qualified must meet certain federal standards. They must be guaranteed renewable, have no surrender value other than a possible return of premium feature, provide no benefit to the extent expenses are covered by Medicare, include a number of consumer protection provisions, and cover only “qualified long-term care services.” On the other hand, HIPAA clarified that benefits paid by a qualified long-term care insurance policy generally are not taxable as income. This is a significant area of concern for non-qualified policies. Since HIPAA was so specific about not taxing any benefits received from a tax-qualified policy, it is not clear how benefits received from a non-qualified policy will be treated. Finally, unlike the payment on a tax-qualified policy, the insured will not be able to deduct the premium on a non-qualified policy as a medical expense. In addition to federal tax incentives, almost half of all states offer tax incentives for long-term care insurance premiums.

- **Grandfathered Long-Term Care Policies**

Under HIPAA, any long-term care insurance contract issued before January 1, 1997, which met the applicable state long-term care insurance requirements, is considered as a qualified long-term care contract and receives favorable federal income tax treatment. However, a significant or material change to a grandfathered contract could cause it to be considered a newly issued policy jeopardizing its tax-qualified status. For instance, changing the amount or the timing of benefits or premiums would generally result in a loss of the policy’s tax-qualification. On the other hand, IRS regulations provide that the exercise of an option or right granted to one party under the contract will not constitute a material change. For example, a change in the mode of premium payments is the exercise of policyholder’s rights under the original contract, and thus, will not affect the tax-qualified long-term care contract. Likewise, if a contract is guaranteed renewable so that premiums may be changed only on a class basis, the insurer’s exercise of its right to change premiums on this basis is not a material change.

- **Self-Employed Individuals**

HIPAA also clarified that the health insurance deduction for self-employed individuals is available for qualified long-term care insurance premiums. Self-employed individuals, including sole proprietors, members of a limited liability company, partners and more than 2% shareholders of a Subchapter S corporation, can generally deduct 100% of the eligible premiums paid for qualified long-term care plans as a business expense. The eligible premiums are the same age-based limits established for individual taxpayers.

This deduction for self-employed individuals is an “above the line” deduction, so it is not necessary to itemize and meet the 7.5% of AGI floor in order to obtain any tax benefit. Just as for individuals, the deduction is available only for premiums on long-term care insurance policies for the taxpayer, the taxpayer’s spouse and dependents. Benefits paid to self-employed individuals under tax-qualified policies are treated the same as those paid to individual taxpayers. For 2005, the tax-free 

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8 IRC § 162(l), HIPPA § 322(b)(2)(B).
cap allows the employee to exclude up to $240 of the daily benefit from taxable income ($250 for 2006). The following hypothetical example illustrates these tax benefits:

Assume that Linda, a 65-year old self-employed individual, has AGI of $100,000 and $5,000 of medical expenses. Her business purchases a qualified long-term care policy for her with an annual premium of $3,000. In 2005 the business can deduct as a business expense 100% of the eligible premium paid. Since the eligible premium for a 65-year-old is $2,720, this amount can be deducted as a business expense.

- Employer-Provided Long-Term Care Insurance

HIPAA treats a qualified long-term care insurance contract as an accident and health insurance contract. Thus, an employer can generally deduct as a business expense both the cost of setting up a long-term care insurance plan for employees as well as all qualified long-term care premiums paid for employees, their spouses, and dependents. The premiums are deductible by the employer without regard to the limitations applicable to individual taxpayers or self-employed individuals. In addition, the employer's contributions toward the cost of the long-term care premiums are not included in the employee's taxable income, provided the employee is not a partner, a member in a limited liability company or holds a 2% or more interest in an “S” corporation. Benefits under a tax-qualified policy paid to an employee are treated the same as those paid to individual taxpayers. For 2005, the tax-free cap allows the employee to exclude $240 of the daily benefit from taxable income ($250 for 2006). This deduction and exclusion from income is also available for retired former employees and for employees who were laid off.

In order to exclude the contributions from income, there needs to be an employer-employee relationship. Thus, premiums paid on behalf of an independent contractor or for members of the company’s Board of Directors would not appear to qualify for the exclusion. The general nondiscrimination rules applicable to health insurance are followed. Thus, long-term care coverage can be provided to a select group of employees without jeopardizing the employer deduction or the employee exclusion from income. A plan may cover one or more employees and there may be different plans for different employees or classes of employees. Almost any reasonable classification can be used. Thus, while the plan must be for the sole benefit of employees, the employer can generally pick and choose the employees to whom it will offer this benefit as long as it meets the general non-discrimination rules applicable to health insurance. Note, however, that premiums paid by an employer for long-term care insurance for stockholder-employees, without regard to their employment classification, might be taxable to the insured stockholder-employee. In fact, the premium payments could be characterized as dividends.

In addition to having the ability to carve out certain groups of employees for coverage, the employer can also vary the amount of benefits provided to the employees in different groups, as long as the arrangement meets the applicable health insurance nondiscrimination rules. Furthermore, there may be advantages to purchasing a limited payment plan (e.g., 5 pay, or 10

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9 IRC § 7702(B)
10 IRC § 106(a)
pay plan). A limited payment plan may enable the business to increase its current tax deduction. However, the rules for deductibility can be complex and depend on the taxpayer’s particular circumstances. A second advantage of a limited payment plan is that it may also limit the insurer’s ability to later adjust the premium based upon claims experience. This premium guarantee does not come into effect until the end of the number of years selected for the limited pay period. For instance, an employer who opts for a 5-pay plan for its key executive has made its lifetime payments for that policy after paying the five premiums. Again, the benefit received by the employee would be excludible from gross income. The following hypothetical example helps to illustrate the tax benefits of employer-provided long-term care insurance:

Assume that a “C” corporation purchases a qualified long-term care policy on its 62-year old President and majority shareholder. If the annual premium is $5,000, the company can deduct the entire premium as a business expense and the executive does not have to include the $5,000 in income. The benefits paid to the President would be treated the same as those paid to an individual taxpayer.

HIPAA also limits the availability of the exclusion for employer-provided long-term care insurance. Long-term care benefits cannot be purchased with pre-tax dollars under a “cafeteria” plan. (A cafeteria plan gives participants a choice among one or more nontaxable benefits and one or more taxable benefits.) Similarly, expenses for long-term care cannot be reimbursed tax-free under a flexible spending account.

- Contributory Arrangement

The plan could be designed as an employer-funded base plan, with employees given the option to purchase additional coverage and/or benefits. Where the employer and employee split the cost of the long-term care premiums, the company may generally deduct its share of the premiums for qualified long-term care plans as a business expense. The employee’s portion of the premium is treated as if paid by an individual and is deductible subject to the age-based limits and the 7.5% of AGI floor. Benefits paid to employees in a contributory arrangement are treated the same as those paid to individual taxpayers.

VI. Gift Tax Benefits of Long-Term Care Insurance

In addition to the income tax benefits provided by long-term care insurance, wealthy individuals can expand their available gift tax exclusions by purchasing a qualified long-term care insurance policy for family members and friends. Under the Code, a donor has an unlimited gift tax exclusion for payment of “medical care” expenses on behalf of an individual.\(^{11}\) Qualified long-term care insurance premiums qualify as a “medical care expense” as long as the payment is made directly to an insurance company and not to the insured. Only eligible long-term care premiums, as defined previously, qualify for the exclusion.\(^{12}\) For example, assume that an 82-year-old widow with a $5 million estate wishes to reduce her projected estate settlement costs by purchasing a long-term

\(^{11}\) IRC §§ 2503(e)(2)(B), 213(d), 7702(B)(b)
\(^{12}\) IRC § 213(d)(f)
care policy for her daughter. To maximize her gift tax exclusions, she could purchase a long-term care insurance policy for her 61 year-old daughter by paying the $5,000 premium directly to the insurance company. The eligible premium amount (i.e., $2,720) would qualify for the annual gift tax exclusion for payment of “medical care” expenses and the balance of the premium, $2,280, would use up a portion of her annual exclusion.

VII. Suitability for Long-Term Care Insurance

Long-term care insurance might not be appropriate for individuals whose income and assets are fairly modest because they may qualify for Medicaid if they become disabled and needed care. The National Association of Insurance Commissioners (NAIC) established “Suitability Rules” which state that a consumer should have at least $30,000 in assets besides his or her house and should spend no more than 7 percent of his or her income on long-term care insurance. While this $30,000 figure may be appropriate for areas where the cost for long-term care is lower, people residing in more expensive areas should generally have a greater amount of assets, before considering long-term care insurance.

The 7 percent of income rule is a good rule of thumb. When considering the purchase of a long-term care policy, individuals should reflect upon how one’s income might change in retirement. It would be a terrible financial decision for someone to pay for a long-term care policy for ten years and then have to cancel the policy because it became unaffordable during retirement.

Some commentators have stated that persons whose financial assets exceed $1 million do not need long-term care insurance. While individuals with a certain level of wealth may be able to afford to pay long-term care expenses, it may make more sense for some to pass the financial risk of paying hundreds of thousands of dollars for long-term care to an insurance company.

VIII. Conclusion

Long-term care insurance policies have improved considerably over the past decade. Better benefits and lower costs mean that many individuals should seriously consider purchasing a long-term care policy as part of their overall financial and estate plans. The long-term care policy can help ensure that individuals will be able to pay for the long-term care they need while at the same time preserve assets for their families.
Legal & Tax Trends is provided to you by a coordinated effort between the advanced markets attorneys in both the Advanced Markets Organization and the Law Department. The following individuals contribute to this publication: From the Advanced Markets Organization; Thomas Barrett, Kenneth Cymbal, John Donlon, Lori Epstein, Jeffrey Hollander, Jeffrey Jenei and Barry Rabinovich; From the law department, Stephen Chiumenti, and Stacy Wolfe.

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