



AN ABI GUIDE TO LONG-TERM CARE INSURANCE

Things you should know about Long-Term Care Insurance

If you are thinking about buying long-term care insurance, there are a number of things you need to understand. This information sheet has been produced by the Association of British Insurers on behalf of its members to assist you as an individual purchaser with general information about the points you need to consider before you make a purchase. It will make it easier for you to choose a particular policy that suits your needs.

The answers to some of the questions below will vary depending on your circumstances and on the insurance company's policy you are considering. The financial adviser and insurer with whom you are dealing will be able to answer any further questions you may have. You should discuss possible future care needs, and how to fund them, with family or friends before you make a decision to approach a professional adviser or to buy a policy direct from an insurance company.

What is Long-Term Care Insurance?

Long-term care insurance provides a planned way of paying for some or all of the cost of any long-term care you may need now or in the future. Through a lump sum payment in advance, or regular premiums, you can buy insurance to cover the cost of care in your own home (domiciliary care) or in a residential or nursing home.

The expression "long-term care" does not apply to care needed to recover from short illnesses, or convalescence following such illness. It refers to care that is needed for the foreseeable future, perhaps as a result of permanent conditions such as arthritis, stroke or dementia. Care needs caused by these long-term conditions are not always met by the NHS and are not supported indefinitely by private medical insurance policies.

The term "care" is used to cover a wide variety of care services, from someone to do domestic work in your home, through to respite care which offers a break for your carer, and a place in a residential or nursing home. Some policies will also meet the cost of installing gadgets and machines and other physical aids such as stair lifts, handles and grab bars to help mobility in the home, or the provision of medical services such as chiropody, physiotherapy and speech or occupational therapy. Most policies also offer a helpline service which gives you medical advice and general information about services in your area.

How does Long-Term Care Insurance fit in with State benefits?

The State recognises that disability and the need for care means you may need extra income, and many people needing care will be eligible for disability benefits including Disability Living Allowance or Attendance Allowance ¹. However, these benefits are not intended to cover the full costs of all the care that you might choose to have in your own home or in a residential or nursing home.

After assessing your needs your local authority is responsible for providing you with care services from the State. It may be entitled to ask you to contribute to the cost of the services provided to you. It is not obliged to provide every service which might be needed, and a determining factor in what services are provided is the amount of money available for those services. The services provided and what you have to pay for vary from one local authority to another - check with your local authority for details on what is provided in your area and at what cost.

Currently, the state (via the local authority) will only contribute totally to care costs if your assets are £11,500 or less. These assets include cash, bank and building society accounts, national savings, investments, stocks and shares, assets held overseas and any property you may own other than your own home. In addition, if you move into permanent residential care and your own home is unoccupied, the value of your home will then count as part of your capital for these purposes. Remember, the Government has put into place measures

¹ Disability Living Allowance is available if you are under 65, have an illness or disability and need assistance or supervision with either walking or personal care or have both care and mobility needs.

Attendance Allowance is available if you are aged over 65 and require assistance or supervision with personal care, due to a physical or mental illness or disability.

(Source - Social Security Benefits Agency leaflet guide. Please refer to this guide for more information on eligibility).

to limit asset avoidance, for example transferring your assets to relatives before a need for care arises.

However, from April 2001, the value of your home will be disregarded from the means testing rule for the first three months after you have been admitted to a residential or nursing home. Your home will also not count as an asset if you have any of the following still living there: your partner or spouse, a relative aged 60 or over, an incapacitated relative aged under 60 or dependant child under 16.

If your assets are between £11,500 and £18,500 some help may be available but only after a stringent means test. If your assets exceed £18,500, you must normally fund the full costs of residential or nursing home care.

The rules surrounding entitlement to means tested benefits are complicated. You should check your entitlement with your local Social Services Department or DSS office if you think you may qualify for help. But they can only tell you about the present rules. These may change in the future, perhaps before you make a claim on your policy.

How will this type of insurance help me?

Many people take out insurance policies so they have a choice over the type, quality and funding of the care they would receive should they need it. The following sections describe how insurance can help you.

Before you take out an insurance policy you should look at the number and measurement of the "Activities of Daily Living" (ADLs) which the insurance company uses to assess the need for care as policies vary (see "When Can I Claim?"). When reviewing the different types of policy available you should consider whether you need care now or if you are planning ahead for care you may need later. Do you intend to pay for your policy with a cash lump sum, regular premiums paid out of income, or wait until you need care and pay for it out of your assets? Do you want to be able to claim if you need care in your home, care in a nursing or residential home or in either location? You also need to consider the level of weekly or monthly payment you need the policy to provide: this may or may not equal the cost of the care that you need.

There are different ways in which you can buy long-term care insurance:

- Through a lump sum purchase to pay for care immediately ("immediate need" plans).
- Through regular premiums, or a lump sum, in case you need to pay for future care ("pre-funded" policies).
- Through exchanging some of the value of your house to pay for long-term care premiums ("equity release" plans).

Immediate Need Plans

These type of policies, which are simply impaired life annuities, are designed to help fund care for those who need it immediately. If you are in poor health and already need care, or you are about to go into a nursing home, it is possible to pay a single premium to buy a policy which will begin paying for your care immediately. These policies guarantee future payments towards the cost of nursing or residential home fees for as long as necessary.

Pre-funded Policies

There are two main types of "pre-funded" policies. First, there is traditional insurance - paying a single or regular premium into a "common pool" to insure against a possible future event. You can take out a policy at any age to cover the cost of long-term care in the future. The insurance is usually underwritten, which means that your state of health will be taken into account. These policies allow you to choose the type of care you wish to receive and can cater for deteriorating health. For example, you might start by receiving care in your home, but in time residential care may become the only practical option.

As with other types of traditional insurance that are not investments, there is generally no refund of premium in the event of cancellation and future claims will not normally be possible if the policy has been cancelled. However, future claims can be made if the chosen long-term care policy permits you to stop paying premiums after a set period and retain limited cover. In this case the insurer will make a related reduction in the cover provided.

An alternative to traditional pre-funded plan is a combination single premium investment

bond and regular premium long-term care policy. These type of plans ensure that should the need for long-term care arise there will be some benefits available to the policyholder and after death, his/her heirs. The premium needed to pay for the long-term care insurance is withdrawn by the company each month from the value of the bond. If care is never needed the value of the bond is returned to your estate. This residual value will be the investment plus any growth minus the insurance premiums. If a claim is made on the insurance policy any remaining balance of the residual value of the bond can be returned to you at any subsequent time.

While these bonds can be cashed in at any time, you should be clear about the impact this would have on your long-term care insurance. In some cases it may be possible to continue paying premiums, but this is not always the case.

Equity Release Plans

Equity release is a way of exchanging some of the equity in a house in order to pay for long-term care premiums. It is therefore generally most appropriate for individuals without a mortgage who want to raise capital on the equity in their home without selling it. These types of products can be helpful if you have a high level of assets but have a low level of income; the home can therefore be used to finance long-term care insurance.

Remember: it is wise to discuss your plans for funding possible future care needs with your family and a professional adviser before buying insurance.

When can I claim?

Immediate Need Plans

With immediate need plans the payment of the claim will usually begin straight away without reference to Activities of Daily Living or the need for additional medical information.

Pre-funded Policies

For pre-funded policies, if you are unable to perform an agreed number of Activities of Daily Living (the precise definitions and number will be given in your policy) the payment of a claim will start. These activities are likely to include mobility, bathing, dressing, ability to

feed yourself and toileting. Exact definitions may vary with different insurers. A claim will also be paid if you are suffering from certain mental conditions, such as dementia. All policies will cover Alzheimer's disease.

In most cases you will need to send a completed claim form to your insurance company, who may then ask your doctor for a report. They may also want independent medical advice and information about your condition, which they will pay for.

The payment of a claim will begin after a "waiting" period during which time you will be responsible for your own care costs. This is typically 13 weeks, but shorter or longer waiting periods are available subject to appropriate adjustment to the premium, which will reduce for longer waiting periods.

Some insurance companies offer a service where they, or a company acting on their behalf, can advise you on local care services and discuss with you the type of care you need. Some policies pay the care provider direct, and some insurance companies may be tied to certain care providers.

Remember, local authorities use different criteria for assessing care needs, and if you qualify for help this does not necessarily mean you can claim on your policy, and vice versa. Some steps have been taken to establish greater continuity between local authorities. In December 2000, the Government announced the creation of the National Care Standards Commission to regulate care providers and outlined proposals to bring into force new statutory guidance to reduce the scale of variation in the cost of paying for care.²

What is not covered?

There are some instances when a long-term care policy may not provide you with payment for the care that you need. For example this might be when the need for long-term care arises from:

- Certain non-organic mental or nervous disorders eg depression, schizophrenia. However, as previously mentioned, dementia such as Alzheimer's is covered.

² (Source - The NHS Plan July 2000)

- Alcohol and drug abuse.
- Self-inflicted injuries and attempted suicide.
- HIV/AIDS.
- War risks.

These exclusions and limitations do not usually apply to policies covering immediate care needs. **Have a look at the exclusions of any long-term care policy being considered. Exclusions will differ from Company to Company.**

How much will Long-Term Care Insurance cost?

The cost of most policies depends on your age, sex and state of health when you buy long-term care insurance. Clearly there are advantages in starting early because the premiums are lower and your medical history is likely to be better. Other factors which will have an impact on the cost of your plan are the amount of money to be paid should you claim and the number of Activities of Daily Living that you are unable to perform before you can claim on your policy. The waiting period before a claim is paid will also affect the premium - see "When Can I Claim".

You must also decide whether you want the policy to provide for care in your own home, in a residential or nursing care, or both.

Once you have bought a policy individual premiums do not automatically increase with age, though they may if you choose to increase your benefits. However, the insurance company may review their overall premium rates in the future in the light of the number and type of claims they receive. This could lead to an increase or a reduction in premiums generally without any change to benefits. Some policies are available which guarantee that premiums will not change, but you might pay a higher premium for these.

What about the effects of inflation?

Most policies offer indexation, which is designed to protect your benefits against inflation up

to and during your claim. On each policy anniversary your premium and amount of cover will be increased by the value of an index - usually the Retail Prices Index. This is important as often a long time can elapse between taking out a policy and making a claim. Premiums for index-linked policies can still be subject to review of overall rates, as described above. It is also important to review the cover regularly to ensure it still meets your needs, whether or not the benefits are index-linked.

What are the Tax and State Benefit implications?

Currently insurance premiums do not qualify for any form of tax relief but claims paid under the policy are paid free of income tax, whether claims are paid direct to the care provider or to you. Being in receipt of insurance claim money or care could also affect your ability to claim state benefits but the tax and benefit position can be varied in the future by the Government.

Who sells Long-Term Care Insurance?

Insurance companies deal direct with potential customers either by telephone or through their sales persons but it is also possible to buy through Independent Financial Advisers or Insurance Brokers. You can obtain a list of Association of British Insurers' members selling long-term care insurance from the Association, as well as a copy of the Statement of Best Practice for Long-term Care Insurance. This Statement outlines good selling and marketing principles which it strongly encourages its member companies offering long-term care insurance policies to abide by.

Are there controls over those selling cover?

Currently, all sales are subject to some control - most are governed by guidance issued under Association of British Insurers' Codes of Practice which all members must comply with as a condition of membership.

At present the sale of long-term insurance is not regulated. However, the Government is considering the feasibility of introducing some form of tighter control over its sale and marketing and is currently considering the industry's response to recommendations put forward in a report by a Treasury-led committee.

What if I change my mind?

All these policies have a "cooling off" period (usually two weeks). During this time you can tell the insurer you do not want the policy and receive a refund of any initial premiums you have already paid.

What should I do if I want to complain?

You should in the first instance take your complaint up with either the salesperson or the insurer. Your policy document will provide details of the insurer's complaint arrangements. The aim will be to ensure that your complaint will be thoroughly investigated at the right level.

If, however, you are unable to resolve your dispute with the insurer satisfactorily, in most cases your complaint can be considered by an independent disputes settlement body. Members of the Association of British Insurers are strongly encouraged to belong to the Insurance Ombudsman, the Personal Insurance Arbitration Service or the Financial Services Ombudsman. Their services are free to consumers. Their decisions bind the insurer, but do not affect your right to take legal action should you wish to do so. If your complaint cannot be resolved by your insurer, they will tell you the right organisation to approach if you wish to take the matter further.

Their addresses are:

The Insurance Ombudsman
South Quay Plaza
183 Marsh Wall
London E14 9SR

Tel: 020 7964 1000
Fax: 020 7964 1001

The Personal Insurance Arbitration Service
International Arbitration Centre
24 Angel Gate
City Road
London EC1V 2RS

Tel: 020 7837 4483
Fax: 020 7837 4185

Financial Services Ombudsman
Ombudsman Bureau
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