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The Advisor's Insurance Partner

Living Benefits Riders

A Comprehensive Guide to Life Insurance with Long-Term Care and Chronic Illness Riders

Understanding the Options

Life insurance products with long-term care and chronic illness riders present an incredible opportunity for advisors to provide extended value to their clients and their families, addressing the many financial planning needs they must account for as life expectancies continues to increase. However, among those products which offer living benefits, features and options are markedly different. This guide clarifies and explains the differences between these riders. In turn, advisors will be better equipped to address the unique economic and emotional reality each family faces.

Linked Benefit Products

Linked benefit products (hybrid products) are primarily built around long-term care protection but include a death benefit, as well. They are structured much differently than traditional life insurance products with living benefits riders. Hybrid products feature significant to full return of premium and built-in protections against inflation. All products are limited to short-pay structures; several allow single-pays only. Benefit pools start small, but long-term care benefits can balloon to two or three times the death benefit amount. Extension of benefits riders are designed to protect families when long-term care is required for more than a couple of years.

Clients predominantly seeking long-term care coverage should opt for a hybrid product, while clients desiring a more substantial and precisely defined benefit pool are better served by adding a living benefits rider to a life insurance product.

Riders with Life Insurance Products: Up-front Cost, Known Benefits

Long-Term Care (LTC) Riders

LTC riders exhibit similar tax criteria and benefit payout methodology to stand-alone long-term care products. The vast majority of policies are filed under Section 7702B of the Internal Revenue Code [IRC §7702B]. This tax code governs the limits of long-term care coverage's tax favorability because most benefits are paid out as monthly income. Other policies simply reimburse qualified long-term care expenses; these costs should be tax-favored as well.

Insureds must be receiving qualified care for at least 90 days in order to begin receiving benefits. Additionally, most carriers want annual confirmation that a doctor's plan of treatment continues to be followed, or they will go off claim. If benefits exceed the tax shelter limit, the IRS will begin to scrutinize whether benefits are being used for qualified long-term care expenses.

In order to sell hybrid products or long-term care riders with life insurance, most states require advisors have a health license and some continuing education related to long-term care.

Clients should be aware that any accelerations above the IRS's annual tax favorability limitations are treated as taxable income.

Chronic Illness Riders

Chronic illness riders have begun to more closely align with their long-term care counterparts, but very important distinctions still exist. In fact, producers and carriers are forbidden from ever referring to chronic illness benefits as long-term care coverage in any sales pitch or material.

Governed by Section 101(g) of the Internal Revenue Code [IRC §101(g)], chronic illness benefits are technically paid out as an acceleration (or advance) of the death benefit, not as long-term care benefits. Depending on the carrier, this acceleration can be paid in one lump sum or spread out as frequently as monthly payments. However, clients should be aware that any accelerations above the IRS's annual tax favorability limitations are treated as taxable income. Chronic illness riders were originally intended to only assist with permanent conditions, but as of 2014, carriers may also award these benefits for temporary conditions.

Benefits are triggered by the same conditions as long-term care benefits, but claimants do not have to follow a doctor's plan of treatment. Insureds also only need to be exhibiting qualifying symptoms for 90 days instead of receiving care for 90 days before benefits can be triggered.

Because these riders are not, strictly speaking, long-term care riders, neither a health license nor long-term care continuing education are required for producers selling these riders.

That said, important consumer protections are required with long-term care policies that are not necessarily provided in chronic illness riders. These mandatory protections are designed to ensure that policies do not unintentionally lapse or otherwise see a loss of benefits simply because a policyholder is too impaired to be able to pay premiums or file claims. These protections may exist to some degree with chronic illness riders but are not required.

Advising Clients

Where living benefit riders can really shine is with guaranteed policies. After having enough money for a comfortable retirement, most clients will be concerned with a few financial needs: investment value, long-term care needs, and avoid burdening dependents with a premature death. Guaranteed life insurance products with living benefits riders address each of these concerns with resounding authority.

Where living benefit riders can really shine is with guaranteed policies.

When selling life insurance with a long-term care or chronic illness rider, advisors should not deviate from the narrative they follow when selling only the base product. Non-guaranteed indexed (IUL) and variable universal life (VUL) policies should be sold as just that—non-guaranteed life insurance that mirrors the risk and reward of other investment vehicles on the market. When selling IUL or VUL products with living benefit riders, producers would be wise to present a conservative illustration of the policy's projected future performance.

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Relative to standalone LTC products, clients do not face the risk of buying insurance they may never use. In fact, a safe, reasonable return on investment is guaranteed. Even those who plan on self-funding their family's future needs can look forward to a return between 2% and 7%, depending on when a policy is purchased and when benefits are triggered. The client can be confident that their family will be protected, regardless of the circumstances.

Accelerated Death Benefit Riders

Delayed Cost, Unknown Benefits

Accelerated death benefit riders compensate one or more of chronic, terminal, and critical illness. Beyond chronic illness riders that are paid for with additional premium, most carriers automatically include an accelerated death benefit rider with the base life insurance product.

Clearly, if clients want chronic illness protection with their life insurance policy, they should expect to pay for it at some point. However, many accelerated death benefit riders are marketed "at no charge" or "with no additional premium."

"Free" riders will usually cost the client a significant, ambiguous portion of their benefit pool that was not determined at policy issue.

If triggered, these so-called "free" riders will usually cost the client a significant, ambiguous portion of their benefit pool that was not determined at policy issue. Thus, producers should know and advise that these delayed-cost riders are ultimately paid for in one of two ways, either charging the acceleration of the death benefit at time of claim, or charging the death benefit at time of death.

Deducted Acceleration

By far, the most common way to charge this type of chronic illness rider is to subtract from the death benefit the amount designated for acceleration. At time of claim, separate underwriting will determine how much of the elected acceleration will be charged. This charge can be quite drastic, sometimes approaching 40%, depending on when the claim is made. Women are charged more for this acceleration.

Deducted Death Benefit

The less common charge for these riders is to treat the acceleration as a policy loan and the remaining death benefit as a lien. This lien is charged with interest for the remainder of the insured's life; so, the longer the client lives, the more costly the rider becomes. The interest may not exceed the policy's loan rate at contract.

Advising Clients

Nearly every carrier provides some sort of inherent accelerated death benefit rider with their products, which demonstrates how much these "free" riders favor the carriers. By leaving the ultimate benefit pool unknown, clients risk undermining their original investment.

These riders should not be compared with LTC or chronic illness riders that have a known cost, since they do not offer the same protection. That being said, these riders may prove helpful for families in a pinch.

Terminal and Critical Illness Riders

Terminal illness rider benefits are triggered when a client is deemed to have 24 months or less to live, as indicated by the carrier. Critical illness rider benefits are generally triggered by cancer, heart attack, stroke or another seriously devastating physical event.

The most reasonable payment method for inherent accelerated death benefits is likely the lien method applied to terminal illness benefits. Since a licensed health professional will have deemed the insured to have a short amount of time left to live, individuals will have a better idea as to how long their remaining death benefit will be charged interest.

For tax purposes, terminal illness benefits are treated in the same manner as a death benefit. Critical illness benefits are not covered by the IRS in specific detail, but past rulings indicate that those benefits are treated in the same manner as accident or health insurance benefits.

How Much Do These Riders Cost?

Benefits and features with terminal and critical illness riders differ significantly between carriers, which makes it quite difficult to compare premiums and benefits. The comparison is first made between products with their maximum monthly benefits applied, as this allows the comparison of premium costs to be a meaningful one.

Also, producers are able to adjust each product's benefits in order to balance the client's current and future needs (cost and benefits).

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Findings

First and foremost, relative to other products featuring similar riders, a product's competitive positioning remains largely constant when applying a long-term care or chronic illness rider.

However, products that offer a lower premium without the rider tend to experience a higher percentage increase in premium when adding the rider. Despite this, rarely will competitive positioning significantly change, relative to other products with a similar rider. In other words, companies that start with a lower premium without the rider have more room to then charge for that rider.

This does not mean that, given a specific client, one product won't end up passing up or falling behind a competitor once riders are added. Usually, even within the same carrier, the rider price between products varies widely. On the whole, though, wild competitive swings are not seen when applying these riders.

Advisors should also be aware that almost all carriers charge more for women's LTC riders than for men. This is due to women's longer average life expectancy and therefore consistently higher usage of benefits.

Questions Advisors Can Answer

When advising long-term care or chronic illness protection to their clients, producers should be ready to answer the following four questions:

What types of services do the benefits cover?

What would have to happen for my client to claim coverage?

How much benefit will my client receive, and how often?

What happens once my client goes on claim?

What Types of Services Do the Benefits Cover?

Long-term care insurance is designed to cover custodial services, which are services that assist with Activities of Daily Living (explained below), but does not cover skilled services such as emergency room care. Adult day care, home health, hospice care, assisted living facilities, nursing homes, and even personal caregivers may all be qualified expenses. Long-term care services extend beyond venues and include many types of services that provide substantial assistance to any of the six Activities of Daily Living. Home modifications, meal preparation, transportation, and medical equipment are just a few examples of costs that may be deemed a qualified long-term care expense.

How Much Benefit Does an Individual Need?

Any discussion of long-term care or chronic illness coverage should be informed by some awareness of potential future costs. A great reference in this regard can be found at www.genworth.com/cost-of-care/landing.html. Costs vary widely between different types of long-term care, as well as location. This interactive site allows anyone to view various costs by state and estimates future costs as well.

What Would Have to Happen for My Client to Claim Coverage?

Underwriting

With living benefits riders that are paid for up front, underwriting for long-term care or chronic illness coverage takes place before policy issue and is distinct from the underwriting of the life insurance policy itself. One reason for advisors to be knowledgeable about the full range of combination products is this additional underwriting process. Because these two underwriting processes may produce different results, this may affect original plans of a producer and their client.

Activities of Daily Living

The IRS outlines six vital Activities of Daily Living, known as ADLs. If a licensed health practitioner deems an insured unable to perform at least two of these without substantial help, benefits will be triggered. The six ADLs are:

1. Transferring
2. Eating
3. Dressing
4. Bathing
5. Continence
6. Toileting

Also, severe cognitive impairments such as Alzheimer's disease or non-recoverable dementia are qualifying conditions when the lack of supervision poses a health and safety threat to the insured.

Long-term care riders require claimants to submit and follow a licensed health practitioner's plan of treatment.

Elimination Period

This requirement is referred to as the "elimination period" and functions as the rider's deductible. The elimination period varies by company, but the standard, minimum length is 90 days. With a chronic illness rider, an insured must be experiencing qualifying symptoms for 90 days. For LTC riders, the insured must also be receiving care for at least 90 days before receiving benefits.

How Much Benefit Will My Client Receive?

Some carriers make the full death benefit available for acceleration, while others limit the acceleration to a significant portion of the death benefit. With many riders, clients may elect to make a smaller portion of the death benefit available in exchange for a lower rider cost.

Residual Death Benefits

Products with LTC riders offer a residual death benefit above and beyond the original face amount if claims exhaust the policy's full benefits. With these policies, an additional residual death benefit will be available to beneficiaries if the full original benefit has been used by long-term care benefits. Residual death benefits range from a flat $10,000 to 10% of the original death benefit.

Tax Shelter

Untaxed regular income is one of the strong selling points of living benefits. Section 7702B of the Internal Revenue Code governs the limits of tax favorability for long-term care and chronic illness benefits. In 2016, the per diem limit for tax favorability is $340 per day. This limit usually rises annually relative to inflation. Benefits are determined by the IRS per diem limitations when benefits are issued, not at the time of contract.

These per diem limits can be used to determine a policy's maximum monthly benefit. In 2016, a 30-day month allows for a $10,200 benefit, while a client's total annual tax shelter is $124,440.

Untaxed regular income is one of the strong selling points of living benefits.

Carriers go to great lengths in their policy language to avoid legal liability if a policy pays out excess benefits, which are then treated as taxable income by the IRS. While this should be a rare occurrence, producers and clients seeking clarity should consult a tax advisor.

How Much Benefit Will My Client Receive, and How Often?

Carriers follow one of two payout methods when it comes to awarding an insured's long-term care claim each month: indemnity or reimbursement. This is an extremely practical consideration clients must understand when choosing an LTC rider, as it determines how much benefit the insured receives each month, how long the benefit pool lasts, what the coverage can be used for, and how much record-keeping must be done by the insured's family when receiving benefits. It is important for advisors to remember that each client will weigh these factors differently.

Carriers follow one of two payout methods when it comes to awarding an insured's long-term care claim each month: indemnity or reimbursement.

Indemnity

Indemnity plans simply pay the client a set amount each month, regardless of actual expenses. These benefits can rightly be seen as income. The money not used for long-term care expenses may be saved, reinvested, or used for any other purpose, yet still receive significant tax shelter. Because these benefits pay a fixed amount each month and do not award benefits based on the insured's long-term care costs, record-keeping is likely to be a much lesser burden than with a reimbursement plan.

Some carriers do allow policyholders to take an indemnity benefit that exceeds the IRS's tax shelter, in which case claimants would be required to pay regular tax income on any indemnity above the limit that is not used for qualified long-term care services. Because of this, some clients may choose to cap their indemnity at the IRS per diem limitation. This eliminates any additional record-keeping and taxes on benefits.

Long-term care riders require that a doctor's plan of treatment be followed, and it may also require documentation of such. While indemnity plans do tend to significantly reduce families' record-keeping burdens, some regular paperwork is still likely to be involved.

Most indemnity carriers offer a smaller maximum monthly benefit than their reimbursement counterparts. With indemnities, policyholders will elect their maximum monthly benefit at policy issue. The greater the maximum monthly benefit, the more the policy is charged.

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Reimbursement

Reimbursement is a payment equal to the specific expenses associated with the insured's long-term care. With most reimbursement plans, clients must track all of their long-term care costs each month and submit these to the carrier. The insured's benefit will equal the amount of qualifying expenses each month, and the entire reimbursement should be tax-favored. Currently, only two major carriers offer reimbursement plans.

Reimbursement policies usually offer a higher maximum monthly benefit than indemnity plans. As a result, clients may be more equipped to handle sudden expenses. On the other hand, if expenses are low, the benefit period will extend over a longer period of time.

Thorough record-keeping is required of the insured's family, as all expenses must be tracked in order to be reimbursed. Furthermore, services must be approved by the carrier to receive reimbursement. Carriers interpret qualifying expenses differently. Some may reimburse important costs like medical equipment, but others may not. For tax purposes, the IRS also has an opinion on what constitutes a qualified expense that may differ from the opinions of a carrier. Advisors should carefully read policies and carrier material to grasp the exact nature of coverage their clients will receive.

IRS per diem limitations still apply to chronic illness riders, which means that less frequent payouts could result in benefits being taxed as income.

Chronic Illness Riders

The IRS makes it abundantly clear that chronic illness benefits are an acceleration of the death benefit, not long-term care coverage. As a result, no chronic illness riders offer reimbursement-style payouts, since benefits are unrelated to actual expenses. Claimants may receive benefits in disbursements ranging from monthly frequency to a one-time lump sum, depending on the carrier.

IRS per diem limitations still apply to chronic illness riders, which means that less frequent payouts could result in benefits being taxed as income. When available, an advantageous route could be to cap yearly lump sums at the IRS per diem limitations for that calendar year.

What Is the Policy's Maximum Monthly Benefit?

Carriers use up to three methods to determine the maximum monthly benefit a claimant will receive: a percentage of the death benefit, a factor of the IRS per diem limit, and the death benefit divided by a chosen benefit duration.

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Percentage of the Death Benefit

The most common means of determining a maximum monthly benefit is a set percentage of the death benefit. This percentage usually is between 2% and 4%. For example, if a client had a $1,000,000 death benefit and their maximum monthly benefit is 2%, they could receive up to $20,000 each month, in which case his benefits would last at least 50 months. Clients may elect to receive less than their

full benefit to stay within IRS tax shelter limitations. Indemnity carriers cap the monthly benefit at either the IRS per diem limit or twice the per diem limit.

Factor of the IRS Per Diem Limit
Advisors should note that policies sold with a death benefit of $250,000 or less will likely never conflict with IRS per diem monthly limitations. No long-term care combination product, either reimbursement or indemnity, currently features a maximum monthly benefit greater than 4%, which is $10,000 under a $250,000 death benefit and therefore less than the cap of the 2016 limit.

Advisors should note that policies sold with a death benefit of $250,000 or less will likely never conflict with IRS per diem monthly limitations.

Death Benefit Divided by Chosen Duration of LTC Benefits
The least common method is for policyholders to specify a period of time for their benefits to last, such as two to four years. If a client had a $1,000,000 death benefit and chose to spread out the benefit over four years, they would receive up to $20,833 each month. Reimbursement policies' benefits could last much longer than the elected period, since costs may fall well below the maximum monthly benefit in a given month.

What Happens Once My Client Goes on Claim?

Recertification
With long-term care riders and chronic illness riders paid for with additional premium, a licensed health practitioner must annually recertify that a claimant still exhibits qualifying symptoms. With long-term care policies, the insured also must show that the doctor's plan of treatment is being followed.

Effects on Policy
Once an insured begins receiving long-term care or chronic illness benefits, the following aspects of the policy may change:

- Premiums: The insured may continue to be charged premiums for life insurance while charges for living benefits coverage may be dropped.
- Death Benefit: The benefit received is subtracted from the policy's death benefit, dollar for dollar.
- Cash Value: Carriers may deduct the same percentage from the policy's cash value that was taken from the policy's remaining benefit pool (pro rata). Some carriers choose not to reduce the policy's cash value at all.

Could My Client's Policy Lapse at Any Point for Any Reason?
Some carriers provide permanent lapse protection for the insured once benefits are triggered or if a policyholder stays on claim for a certain length of time. Other carriers will expect clients to continue paying for life insurance and maybe long-term care coverage again if a policyholder goes off claim. Ongoing premiums and charges, though, will be reduced to reflect the remaining benefits, not the original face amount.

Triggering long-term care or chronic illness benefits may ultimately preclude claimants from eligibility for Medicare, Social Security, and the like.

A Final Word

Ultimately, each protection-oriented client should be made aware of the great opportunity presented by long-term care and chronic illness riders. Life insurance with living benefits provides a reliable, tax-sheltered method for consumers to grow their money while providing significant security for their family once they are no longer able to provide.

Even more so than with selling the base life insurance policies, clients' priorities can vary widely. A producer who understands the practical planning required by those seeking long-term care protection will be much more equipped to understand the whole range of products available to them.

