

LTC 4 Hour Refresher

**Written by Thomas H. Ripperda, CLU, ChFC, LUTCF**

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Library of Congress Catalogue Number Pending

Version 1.4 (reprinted August 25, 2015)

Acknowledgement

I would like to take this opportunity to thank Barbara Payne, Sandy Stirnaman and my son, Chad, for all of their hard work in turning my ideas and notes into a more readable text. Without their help, this book would not have happened.

Long term care is needed when a person is no longer able to meet all of their needs for daily living. The understanding of this problem became much clearer to me when I started helping Catherine with her finances, then getting her home health care, and finally finding her a nursing home. Home based care can only go so far. In Catherine’s case the quality of life can improve by placing her in a nursing home. The process became easier because of the professional, friendly staff at her nursing home, Aviston Countryside Manor. They took us through all the steps and made suggestions. In the past years, we have attended several meetings each year with the staff going over Catherine’s progress, physically, emotionally and mentally. Catherine improved because the attention she receives from the nursing home staff. These are helping, care people working while watching their patients decline over many years. Thanks to Catherine and the nursing home staff for opening my eyes to this process. Catherine passed away at age 93 after spending 12 years in this safe place.

Long Term Care 4 Hour Refresher

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# Chapter 1Introduction

## Challenges in Our Aging Population

As you will learn through this course, Long Term Care is becoming an important part of American life. The American population is getting older, and the older population is becoming a larger percentage of our total population. The advances in medicine and public health allow people to overcome conditions that would have been fatal in past generations. But as we get older, we also find that our ability to remain living independently decreases. This is where Long Term Care becomes extremely important to our ability to grow older with dignity.

Additionally, there is always the chance that a sudden illness or disability will occur at any point during a person’s life. A fall from a ladder or other accident could be a life changing event. A healthy person awakes and finds themselves in position of needing help with the most basic daily activities. Costs for these types of physical problems can be great and can increase as time goes on. Long Term Care is often necessary in these situations.

## Need for Long Term Care

Unless a person dies extremely suddenly, they will experience some form of Long Term Care. In years past, the phrase Long Term Care made people think of depressing “nursing homes” or care by a family member in a private home.

The term, Long Term Care, describes various services that help people with chronic medical conditions. These conditions require assistance to overcome physical or mental limitations that keep them dependent on others. People suffering from physical or cognitive disabilities may use a vary Long Term Care services. The need for those services could be a result of a prolonged illness or from typical end-of-life situations.

Services range from Home Health Care to Skilled Nursing Care. Home Health Care covers a person’s needs for help with activities of daily living (ADL), including assistance with bathing, dressing, mobility, eating, and using the bathroom. Other areas of support would include management of medicines, monitoring health condition, cooking, and cleaning at the person’s home. Custodial Care typically covers activities of daily living in a structured facility setting. The most intensive form of care is Skilled Nursing Care which provides full medical care on a full time basis. A person receives this type of care until they can be moved to a more independent stage of care, or to Hospice, which is an end of life care system.

While Medicare, Medicaid and Veteran Benefits provide some financial assistance, effective Long Term Care can be financially daunting to a person facing the prospect of beginning to use these services. In most cases, the person in need of Long Term Care is not the person making the decisions. Instead it is a family member or family friend who is typically an adult child with financial priorities of their own. Decisions would include the type of services needed, and the type of facility the person in need of care will be placed. In many cases, the type and level of care provided is dictated by the financial abilities of the older individual.

A person who has developed a well thought out financial plan to provide for Long Term Care services ensures they have the most options available to them at one of the most vulnerable times of their lives. 

## Family Choices

If a person or their spouse needed Long Term Care services, they are faced one of five likely scenarios:

* Family members or friends could care for you
* If they were indigent, with assets of less than $2,000, they would qualify for Medicaid
* They could spend down your assets to qualify for Medicaid.
* They could pay for care from life savings with the hope they would not be exhausted
* Or they could purchase Long Term Care insurance at only a fraction of the actual cost of care, preserving their assets for loved ones or other uses.

# Chapter 2Aging of America

People are living longer than ever before. This means Long Term Care is an issue that affects almost every person. The population projection from 2010 to 2050 is in the chart below.

There were 44.7 million people age 65 and older in the United States on July 1, 2013. This group accounted for 14.1 percent of the total population.[[1]](#footnote-1) This fact will have a major effect all aspects of society including Medicare financing.

However, the number of Americans aged 45-64, also known as the "baby boomers", who will reach 65 in the next 20 years increased by 34% during this period. The older population will burgeon between now and 2030 when "baby boomers" reach 65. By 2030, it is expected there will be 72 million older persons, more than twice their number in 1999.

Since 1900, the percentage of Americans 65+ has more than tripled (4.1% in 1900 to 14.1% in 2013), and the number has increased more than twelve times (from 3.1 million to 44 million). Additionally, the older population itself is getting older. From now until 2050, those over age 100+ will grow by 8 times larger than their size in 2010.

## Life Expectancy

In 2015, persons reaching age 65 could be expected to live an additional 22 years (23.8 years for females and 21.6 years for males). If an individual makes it to age 65, their chances of living to age 80 are 68%[[2]](#footnote-2).

A child born in 2010 could expect to live 76.9 years, about 29 years longer than a child born in 1900. Much of this increase occurred because of reduced death rates for children and young adults. However, the past two decades have also seen reduced death rates for the population aged 65-84, especially for men – by 19% for men aged 65-74 and by 16% for men aged 75-84. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 3.7 years since 1960.

Starting January 1, 2011, about 8,000 per day will celebrated their 65th birthday. In 2005, about 1.8 million persons 65 or older died, resulting in an annual net increase of approximately 238,000 people.

There were 50,545 persons aged 100 or more in 2000 (0.02% of the total population) and that is expected to grow to 135,000 in 2020. This is four times from the 1990 figure of 37,306.

### Income[[3]](#footnote-3)

The median income of older persons in 2007 was $24,323 for males and $14,021 for females. Median money income (after adjusting for inflation) of all households headed by older people did not change in a statistically different amount from 2006 to 2007. Households containing families headed by persons 65+ reported a median income in 2007 of $41,851 ($43,654 for non-Hispanic Whites, $31,544 for Hispanics, $32,025 for African-Americans, and $47,135 for Asians). About one of every fourteen (7.4%) family households with an elderly householder had incomes less than $15,000 and 59.5% had incomes of $35,000 or more

### Figure 2: Percent of Poverty by age 2012[[4]](#footnote-4)

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***$41,851 median for 12.5 million family households 65+***

### Figure 7B: Percent Distribution by Income: 2012 (Person 65+ Reporting Income)

***$17,424 median for 35.5 million persons 65+ reporting income***

For all older persons reporting income in 2007 (35.5 million), 22.3% reported less than $10,000 and 34.4% reported $25,000 or more. The median income reported was $17,424.

The major sources of income as reported by older persons in 2012 were Social Security (reported by 89% of older persons), income from assets (reported by 55%), private pensions (reported by 29%), government employee pensions (reported by 14%), and earnings (reported by 25%). In 2012, Social Security benefits accounted for 37% of the aggregate income of the older population. The bulk of the remainder consisted of earnings (28%), asset income (15%), and pensions (18%). Social Security constituted 90% or more of the income received by 32% of beneficiaries (20% of married couples and 41% of non-married beneficiaries).

## Poverty[[5]](#footnote-5)

About 3.6 million elderly persons (9.1%) were below the poverty level in 2012. This poverty rate is a statistically significant decreasee from the poverty rate in 2006 (9.4%). Another 2.4 million or 6.4% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level).

One of every fourteen (7.4%) elderly Whites\*\* was poor in 2012, compared to 23.2% of elderly African-Americans, 11.3% of Asians, and 17.1% of elderly Hispanics. Higher than average poverty rates were found in 2006 for older persons were found among those who lived in principal cities (12.2%), outside metropolitan areas (i.e. rural areas and small towns) (10.8%), and in the South (10.8%).

Older women had a higher poverty rate (12.0%) than older men (6.6%) in 2012. Older persons living alone were much more likely to be poor (17.8%) than were older persons living with families (5.6%). The highest poverty rates were experienced among Hispanic women (39.5%) who lived alone and also by older Black women (39.0%) who lived alone.

## Marital Status

In 2012, older men were much more likely to be married than older women--73% of men, 42% of women (Figure 2). Widows accounted for 42% of all older women in 2007. There were over four times as many widows (8.7 million) as widowers (2.0 million).

Divorced and separated (including married/spouse absent) older persons represented only 11.1% of all older persons in 2012. However, this percentage has increased since 1980, when approximately 5.3% of the older population were divorced or separated/spouse absent.

### Figure 2: Marital Status of Persons 65+, 2012

(Based on Internet releases of data from the 2012 Current Population Survey, Annual Social and Economic Supplement of the U.S. Bureau of the Census)

### Health and Health Care[[6]](#footnote-6)

In 2012, 39.0% of non-institutionalized older persons assessed their heath as excellent or very good (compared to 64.8% for persons aged 18-64). There was little difference between the sexes on this measure, but African-Americans\*\* (23.7%), older American Indians/Alaska Natives (24.3%) and older Hispanics (28.9%) were less likely to rate their health as excellent or very good than were older Whites\*\* (40.4%) or older Asians (34.1%) based on 2004-06 data. Most older persons have at least one chronic condition and many have multiple conditions. Among the most frequently occurring conditions older persons in 2004-2005 were: hypertension (48%), diagnosed arthritis (47%), all types of heart disease (32%), any cancer (20%), diabetes (16%), and sinusitis (14%).

Almost 67% reported in 2012 that they received an influenza vaccination during the past 12 months and 58% reported that they had ever received a pneumococcal vaccination. About 25% (of persons 60+) report height/weight combinations that place them among the obese. Almost 25% of persons aged 65-74 and 18% of persons 75+ report that they engage in regular leisure-time physical activity. Only 8% reported that they are current smokers and only 5% reported excessive alcohol consumption. Only 2% reported that they had experienced psychological distress during the past 30 days.

In 2012, over 13.1 million persons aged 65 and older were discharged from short stay hospitals. This is a rate of 3,508 for every 10,000 persons aged 65+ which is over three times the comparable rate for persons of all ages (which was 1,169 per 10,000). The average length of stay for persons aged 65+ was 5.5 days; the comparable rate for persons of all ages was 4.8 days. The average length of stay for older people has decreased by 5 days since 1980. Older persons averaged more office visits with doctors in 2005: 6.5 office visits for those aged 65-74 and 7.7 office visits for persons over 75 while persons aged 45-65 averaged only 3.9 office visits during that year. In 2012, over 96% of older persons reported that they did have a usual place to go for medical care and only 2.5% said that they failed to obtain needed medical care during the previous 12 months due to financial barriers.

In 2006 older consumers averaged out-of-pocket health care expenditures of $4,631, an increase of 62% since 1996. In contrast, the total population spent considerably less, averaging $2,853 in out-of-pocket costs. Older Americans spent 12.7% of their total expenditures on health, more than twice the proportion spent by all consumers (5.7%). Health costs incurred on average by older consumers in 2006 consisted of $2,770 (60%) for insurance, $859 (18%) for drugs, $844 (18.5%) for medical services, and $159 (3%) for medical supplies.

## Future Growth[[7]](#footnote-7)

The older population will continue to grow significantly in the future (see Figure 1). This growth slowed somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. But the older population will burgeon between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

Improved health is a key reason for the rapid growth of the older population, particularly the old­est old. Reduced mortality has increased the number of cente­narians, those living to age 100 or beyond. About 50,500 cente­narians were counted in Census 2000. In 2010, that number was over 53,400, about 6 percent higher. The growth of centenarians between the two censuses was relatively modest compared with the other age groups among the older population. This may reflect historical factors (e.g., increased mortality during World War II). It could also reflect age misreporting, which is often observed at the very oldest ages, or other data quality issues arising from question and form design problems or misalloca­tion of extreme ages during data processing (Gavrilov and Gavrilova, 2011; Meyer, 2012; Preston, Elo, and Stewart, 1999). All these issues may bias interpretations of actual trends for the centenarian population.

The population 65 and over will increase from 35 million in 2000 to 44 million in 2013 (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade). By 2030, there will be about 72.1 million older persons, almost twice their number in 2007. People 65+ represented 12.6% of the population in the year 2007 but are expected to grow to be 19.3% of the population by 2030. The 85+ population is projected to increase from 5.5 million in 2007 to 5.8 million in 2010 and then to 6.6 million in 2020 (15%) for that decade.

Minority populations are projected to increase from 5.7 million in 2000 (16.3% of the elderly population) to 8.0 million in 2010 (20.1% of the elderly) and then to 12.9 million in 2020 (23.6% of the elderly). Between 2007 and 2030, the white\*\* population 65+ is projected to increase by 68% compared with 184% for older minorities, including Hispanics (244%), African-Americans\*\* (126%), American Indians, Eskimos, and Aleuts\*\* (167%), and Asians and Pacific Islanders\*\* (213%).

### Disability and Activity Limitations[[8]](#footnote-8)

Some type of disability (sensory disability, physical disability, or mental disability) was reported by 52% of older persons in 2007. Some of these disabilities may be relatively minor but others cause people to require assistance to meet important personal needs. Almost 37% of older persons reported in 2005 a severe disability and 16% reported that they needed some type of assistance as a result. Reported disability increases with age. 56% of persons over 80 reported a severe disability and 29% of the over 80 population reported that they needed assistance. There is a strong relationship between disability status and reported health status. Among those 65+ with a severe disability, 64% reported their health as fair or poor. Among the 65+ persons who reported no disability, only 10 % reported their health as fair or poor. Presence of a severe disability is also associated with lower income levels and educational attainment.

In another study which focused on the ability to perform specific activities of daily living (ADLs), over 27% of community-resident Medicare beneficiaries over age 65 in 2006 had difficulty in performing one or more ADLs and an additional 12.5% reported difficulties with instrumental activities of daily living (IADLs). By contrast, 91% of institutionalized Medicare beneficiaries had difficulties with one or more ADLs and 73.4% of them had difficulty with three or more ADLs. [ADLs include bathing, dressing, eating, and getting around the house. IADLs include preparing meals, shopping, managing money, using the telephone, doing housework, and taking medication.] Limitations on activities because of chronic conditions increase with age. As shown in Figure 9, the rate of limitations on activities among persons 85 and older are much higher than those for persons 65-74.

Figure 9: Percent of Persons with Limitations in Activities of Daily Living by Age Group: 2006



It should be noted that (except where noted) the figures above are taken from surveys of the noninstitutionalized elderly. Although nursing homes are being increasingly used for short-stay post acute care, about 1.3 million elderly are in nursing homes (about half are age 85 and over). These individuals often have high needs for care with their ADLs and/or have severe cognitive impairment, due to Alzheimer's disease or other dementias.

# Chapter 3Providers of Care

So who takes care of the person who is unable to take care of themselves any more? These Providers of Care can be divided into three categories: Informal Caregivers, Formal Assistance for the Informal Caregiver, and Formal Caregivers.

## Informal Caregivers

Informal caregivers are the backbone of the Long Term Care system in the US today. These caregivers are on call 24/7 to keep their loved ones in the comfort and security of their home. This form of care is generally unpaid and may help avoid or delay institutional placement of the elderly individual, and/or the need for more "formal" services. About 11% (3.7 million) of older Medicare enrollees received personal care from a paid or unpaid source in 1999.Nearly one in four (23% or 22.4 million) US households was involved in helping care for a person 50 years old or older.[[9]](#footnote-9) The typical caregiver is a married woman in her mid-forties, providing an average of 18 hours per week of caregiving while working full time. She lives near the care recipient and has an annual household income of approximately $35,000.[[10]](#footnote-10) The degree of involvement by informal caregivers has remained fairly constant for over a decade; and if the informal caregivers were replaced by home care staff, the estimated cost would be $45-94 billion a year. [[11]](#footnote-11) Another study placed the national economic value of informal care giving at $196 billion a year, or 18% of total national health care spending ($1.1 trillion in 1997).[[12]](#footnote-12)

A 1999 study by MetLife Mature Market Institute found that caregivers tend to under-estimate the length of time they would be providing care to the elderly individual. Most estimated they would spend less than two years caring for the individual. In fact, the average length of time spent caregiving was about eight years, with one third of the respondents stating they provided care for 10 or more years.[[13]](#footnote-13) Additionally, the study reported that on average, caregivers helped with expenses such as food, transportation or medications in the amount of an average of $19,525 over a two to six year time period.

One of the biggest concerns with informal caregivers is caregiver burnout. A person untrained as how to take care of someone in need of long term care is often unaware of the energy, time, and knowledge needed to provide the care effectively. They can then feel overwhelmed. This can lead them to provide inadequate care, neglect or abuse the person they are supposed to take care of. This is why informal caregivers need to recognize that they may need to use formal caregivers to fully meet the individual’s needs.

## Formal Assistance for the Informal Caregivers

Services exist that provide assistance to the individual who stays in their own home, or for those who are being taken care of by an informal caregiver. These include:

### Home Health Care

Many aging adults choose to live on their own for many years while dealing with chronic conditions or illnesses. Home Health Care is defined as medical and non-medical services provided to ill, disabled or infirm persons in their residences. It may cover skilled nursing care as well as other services such as therapy or assistance with the activities of daily living. Home Health Care services are not available in some geographical areas and can be costly, depending on frequency of use. Most Home Health Care Providers train their staff on Alzheimer’s for no additional fees.

### Adult Day Care

The National Adult Day Services Association estimates that there are over 5,000 adult day centers in the United States that serve over 260,000 participants and family caregivers. Sixty-three percent of surveyed centers provide transportation to and from the center. About half of those surveyed center do not charge a fee. Where centers do charge a fee, it averages under $10 each way.[[14]](#footnote-14) This type of program allows the individual to go to an Adult Day Care Center where they receive companionship, food and care for several hours a day from one to five days a week. Some even provide a frail individual with therapeutic and rehabilitative programs. The individual is being cared for by an informal caregiver. These programs allow the caregivers to have some personal time. The caregiver gets time to attend to personal business and other activities. Day Care provides a respite, and reduces burnout. For the individual living alone, they have an opportunity to receive daily stimulation they might not get otherwise. Some of these programs are nonprofit, while others are for profit. The cost for this type of program is an alternative to be considered for an individual not living in a more formalized setting. According to the 2012 MetLife survey, the average adult daycare charges $70 a day or $18,200 a year.

### Care Management Services

Useful in determining and locating appropriate services is the case manager. While family caregivers can provide the loving attention the person needs, many times they are unable to make decisions concerning the type of care needed. When the possible care giver is located hours away, they may be unable to locate the necessary services, The single source for arranging a single service or for multiple services is the case manager. The process begins with a extensive evaluation of the current medical situation. The formulation of a detailed plan of action is developed based on that assessment, followed by implementation of that plan. The progress is measured with continuous reassessment of the plan is based on the patient’s current needs. The National Association of Professional Geriatric Care Managers is a great source for locating Case Management Services. Those services while essential can be costly to some individuals.

### Respite Care

This benefit can be an important service to the informal caregiver throughout the caregiving experience. Respite care includes adult day care or an overnight stay in a nursing home facility for the informal giver to get a rest period. A short break from the caregiving duties can reduce the chance of burnout by the informal care giver and in extreme situations can lead to elder abuse. In 2000, the Older Americans Act was amended under Public Law 106-501 to establish the National Family Caregiver Support Program (NFCSP). Federal funding is allocated to the states in partnership with local service providers to put into place a system of support for family caregivers. The program can allow for the patient to stay in a nursing home over a weekend and give the caregiver a break from those responsibilities and worries. The caregiver can get a few hours, a few days to take a break. To find that local service, a person can call Eldercare at 1-800-677-1116, Monday through Friday, 9 a.m. to 8:00 p.m. Eastern Standard Time.

### Hospice Care

Hospice Care is limited to terminally ill patients. Hospice strives to keep patients comfortable, pain-free, and alert during the remaining days of life. During this difficult time, support is provided to the family as needed. Hospice care is usually provided in the home. The patient has the comfort of being in familiar surroundings of their home along while having medical assistance as needed. Most patients prefer this arrangement over the sterile environment of a hospital. The majority of costs of hospice are paid by Medicare. These would include services of home health aides, social workers, doctors, nurses, therapists, and bereavement counselors, as needed.

## Formal Caregivers

Several types of formal caregivers exist as options for the individual who wants or needs to move from their home or the home of a family member. These are Shared Living Arrangements, Assisted Living, Nursing Homes, and Continuing Care Retirement Facilities.

### Shared Living Arrangements

Shared living offers housing arrangements that provide private living space and common facilities, such as meeting rooms, recreation facilities, and dining areas that are shared by residents. Living space may be private apartments or bedrooms. Shared living facilities are developed by corporations, individuals, and nonprofit groups. In most communities, these living arrangements are licensed by health or social service agencies. The nature and extent of regulations governing the operations of shared living facilities vary widely from state to state.

Shared living arrangements are available under several different names and forms. Adult foster care is a single-family home that provides a residence for unrelated older persons unable to function independently. Congregate housing is multi-unit rental housing, usually with support services such as meals, housekeeping, and social and recreational activities. Personal care housing is a group living arrangement that provides non-medical services such as meals, housekeeping, and personal care. Other names for this type of housing are, group home, board and care home, or domiciliary care. A retirement home or a retirement community is an independent living accommodation for persons who prefer to live independently, but in a safe, structured environment.

The purpose of shared living arrangements is to allow a person to continue to live as independently as possible for as long as possible. Costs vary by the type and size of accommodation chosen and by the extent of services offered. Many shared living arrangements offer comprehensive services short of medical or nursing care. Often all or some meals and housekeeping services are provided.

### Assisted Living

Assisted Living is one of the fastest growing types of shared living arrangements for older persons. Assisted living facilities provide a combination of housing and personalized care in a professionally managed group living setting with a homelike environment. Facilities may range from detached houses and cottages in a campus-like setting to full apartments with complete kitchens, as well as single rooms without kitchens. Some facilities have special units to accommodate people with the early stages of Alzheimer’s disease. In return for a monthly fee, residents get a place to live, and may receive at least one of an array of services that include meals, laundry and housekeeping, medication monitoring, personal care, and transportation outside the facility.

Included in the definition of assisted living are homes that serve as few as three or four people to facilities that serve several hundred residents. Some facilities provide their own standard package of services to all residents, while other facilities make services available based on a resident’s needs for service and willingness and ability to pay for specific additional services.

Assisted living facilities differ from personal care homes in the emphasis on supervision and ability to offer assistance as needed rather than on a scheduled basis. Some offer comprehensive services that are just short of medical or nursing care. Geared to the more frail elderly, these services often include assistance with one or more of the activities of daily living such as bathing and dressing. If private-pay nursing is necessary, a resident usually must arrange and pay for this. If constant nursing care is needed, a resident normally leaves an assisted living facility for a nursing home.

The philosophy of assisted living is to allow each resident the right to make choices about his or her health and safety. Since these choices may include activities or habits that others consider risky, this philosophy accepts the fact that the resident also has the right to incur a degree of risk. The interpretation of this philosophy varies among facilities. In considering any assisted living facility, prospective residents and their families will want to clarify the management’s philosophy on assisted living.

The cost of assisted living facilities for the most part must be borne by individual residents and their families. A 2012 MetLife survey found that the average cost for an assisted living facility has grown to $3,550 a month. Those increases costs excess the rate of inflation. With assisted living facility costing $42,600 a year, it can drain a person’s savings quickly. In fact, according to a 2012 survey by the National Center for Assisted Living, they found that about 2/3 of assisted living residents spend personal funds to pay for their stay. Some Long Term Care insurance policies may cover aspects of care in assisted living facilities, while Medicare does not.

Appendix A has a list of questions to ask when choosing an assisted living facility.

### Continuing Care Retirement Communities (CCRCs)

CCRCs are a combination of many different senior housing options. Most CCRCs include an apartment or townhouse that allows relatively independent living, an assisted living facility, and a skilled-nursing facility. The reason many people choose a CCRC is because it provides a variety of housing and service choices; the intent of most residents is to spend the rest of their lives in the CCRC.

Regulations of CCRCs vary depending on each state. The written terms of the contract signed by the resident vary dramatically. Most CCRCs require an entrance fee, while others are pure rentals. Some CCRCs’ buy-in fees are as low as $50,000 or much larger amount. The person moving into a CCRC is using the proceeds from the sale of the resident’s former primary residence to pay the entrance fee.

Monthly service fees are accessed in addition to the entrance fee. Usually this monthly service fee is level for all residents. In some CCRCs, the fee increases as the resident’s demand for services increases. It takes more labor to provide care for someone needing skilled nursing care, thus the high charges. In exchange for these monthly payments, a lifetime of worry-free care is provided to the resident. Most residents of CCRC look for that peace of mind.

Even in the best of times, residents can expect increases in monthly fees regardless of their level of care because of rising costs. Some use a uniform fee regardless of care level. This is very attractive to some people who want to keep a level monthly expenditure without regard to what the future may hold. One of the ways to do this is including a Long Term Care insurance policy in the monthly fee. If the policy includes inflation protection, it protects the client and the CCRC against increasing costs.

Most CCRCs are looking for relatively healthy individuals at the time of entry. Fees are lower with this approach, because there is a lower demand for services for those who are healthy. The healthy individual will need little in way of supervision, assistance and medical care. As time marches on, the healthy individual may need assistance with housekeeping, management of medicines, activities of daily living and finally custodial care. This demand for increased services may not happen for 5 or 10 years.

The contract outlines what percentage of the entrance fee will be reimbursed to the residents or their estates when they move or die. “Refund” rates would typically be 70 to 90 percent of entrance fee. The CCRC uses the interest earned on the entrance fee to pay for services. The resident can be responsible for paying income tax on the inputted interest income.

The one key worry with CCRCs is bankruptcy. If it is a rental CCRC, residents can move to a new CCRC. If the resident paid in a big entrance fee, it could be lost in a bankruptcy. The resident could be financially vulnerable when they need long term care the most. Before taking on this type of risk, the prospective resident should do research on the CCRC.

Some CCRCs use a true real estate trust. Units are bought and sold like a condominium when residents move or die. A profit on their unit can be made, if it becomes more desirable. They could lose money if the property goes down in value.

### Nursing Homes

Nursing homes (sometimes called skilled-nursing facilities) provide both short term and long term care. Many residents enter a nursing home for what is called skilled or rehabilitative care after first being hospitalized. Those stays are usually short, and in 1997, 30 percent of residents left the nursing home because they had either stabilized or recovered. The average duration of their stay was 45 days. Only 16 percent of nursing home residents were under the age of 65. Those who are under age 65 are there because of some accident or illness that left them without the ability to live independently. According to the US Census Bureau in 2011, 66% of nursing home residents are family. The median age of residents was 82.6 years old.[[15]](#footnote-15)

Nursing homes provide 24-hour nursing care, skilled care, and personal care. Skilled care is given under a doctor’s orders by licensed medical personnel. Examples of skilled care would be physical, occupational, and speech therapy. Someone would receive such care after a stroke. Personal care, often called custodial care, is help with functions such as eating, dressing and bathing.

Although 40 percent of people receiving Long Term Care are adults under age 65 (3 percent being children), the majority of people needing Long Term Care are seniors. Our odds of needing Long Term Care in a nursing home increase as we age. With use of more assisted living facilities, many nursing homes are facing the fact that their occupants are much older, much frailer, and more likely to be on public assistance than in prior years.

People aged 90 and over are more likely to live in skilled-nursing facilities/nursing homes and to have a disability than those aged 85 to 89 or those of other, younger age groups within the 65-and-over

population.4 While the likelihood of living in a nursing home is extremely low at ages 65 to 69 (1.0 percent) and ages 75 to 79 (3.0 percent), it dramatically rises to 11.2 percent at ages 85 to 89, 19.8 percent at ages 90 to 94, 31.0 percent at ages 95 to 99, and 38.2 percent at 100 years of age and over (He and Muenchrath, 2011). The prevalence of disabilities is about 13 percentage points higher in people aged 90 to 94 compared with those aged 85 to 89, and this difference is consistent for both men and women.

##### Nursing Home Beds Vacancy Rates by State

The nursing home industry has excess capacity today that should meet the influx of patients as the “baby boomers” age. In the past, seniors moved to warmer climates. That trend is declining because the vast majority of those retiring in the next 10 years are planning to age in place. In some state the overcapacity means that some of those surplus beds are never filled and that excess will cause the cost of care to increase since those costs are based on per occupied bed.

Alabama 9%; Alaska 29%; Arizona 20%; Arkansas 39%; California 22%; Colorado 16%; Connecticut 8%; Delaware 17%; D.C. 9%; Florida 26%; Georgia 9%; Hawaii 8%; Idaho 27%; Illinois 25%; Indiana 25%; Iowa 34%; Kansas 19%; Kentucky 10%; Louisiana 23%; Maine 10%; Maryland 17%; Mass.11% ; Michigan 16%; Minnesota 6%; Mississippi 11%; Missouri 30%; Montana 22%; Nebraska 17 %; Nevada 22%; New Jersey 14%; New Mexico 13 %;New York 6 %; North Carolina 12%; North Dakota 7%; New Hampshire 10%; Ohio 32%; Oklahoma 31%; Oregon 28%; Pennsylvania 13%; Rhode Island 12%; South Carolina 11%; South Dakota 8%; Tennessee 11%; Texas 30%; Utah 28%; Vermont 11%; Virginia 14%;Washington 17% ,West Virginia 9%; Wisconsin 16%; Wyoming 18 %; USA 19% ( Source: OSCAR, January 07, 2002)

Appendix B has a checklist detailing services provided by Nursing Homes. This checklist will enable a person to make educated decisions regarding their care.

# Chapter 4Cost of Care

How much will it cost to receive the various forms of Long Term Care? Many factors influence the answer to this question. This question will affect a majority of Americans at some time in their life since 3 in 4 Americans over 65 will need some form of home care with many needing care for many years.



For example, a lady in a small Illinois town found she needs long term care. The nursing home she chooses charges $175 per day, for a total of $63,825 for her nursing home care for a year. How about incidental expenses? Who pays for the haircuts or in the case of the ladies, the permanents? Those extra charges are not figured in. In addition, this nursing home takes clients out to stores to buy their personal items, new clothing, shoes, etc., and the cost of those items are not included in the nursing home price. This does not count dental care if that were needed. How much will she need for these expenses? It is important to take into consideration these costs based on the person's past spending patterns.

While the last items are much more variable, certain costs remain fixed for an individual needing long term care. The following details some of these fixed costs.

## Financial Costs

First, it is important to see who pays for Long Term Care. According to a 2012 study[[16]](#footnote-16), Medicare paid for only 12.6% of nursing home expenses (keep in mind that Medicare covers a limited number of days for skilled care in a Medicare-approved facility). 46.8% of the expenses were paid for by Medicaid for people who qualified at the poverty rate. 33.1% of the people paid privately for their care, while only 5.3% of costs were covered by insurance.[[17]](#footnote-17)

It is important to look at costs of care for the different types of care.

Today, the average nursing home costs for Semi-Private Room are $81,030. The average cost per day is $222. Depending upon the geographic area as well as the particular nursing home, this cost can vary between $65,000 and $150,000 per year.[[18]](#footnote-18) At a modest inflation rate of 6%, the average nursing home will cost almost $200 per day in 2014 and over $255 per day in 2019.[[19]](#footnote-19) A person requiring around the clock care in a private facility with 24 hour aids can cost upwards of $150,000.[[20]](#footnote-20)

Another consideration is the effects of inflation on the cost of Long Term Care. If you could find a nursing home that charges $200 a day, in 10 years that cost would rise to $326 per day. The chart below shows the effects of inflation at different time periods and different rates of inflation.

|  |
| --- |
| **Effect of Inflation on Room Charges for Nursing Home Care** |
| **Rate of Inflation** | **2014** | **2019** | **2024** | **2034** |
| 5% | $200 | $255 | $326 | $526 |
| 6% | $200 | $267 | $358 | $641 |
| 7% | $200 | $281 | $393 | $774 |
| 8% | $200 | $294 | $432 | $932 |

Certain diseases will require more intensive care over a longer amount of time than others. Additionally, the costs for care today will only increase in time as inflation increases. The chart below illustrates this for several types of diseases that result in a person's stay at a nursing home.

|  |
| --- |
| The Cost of Nursing Home Care |
| **LeadingCauses** | **Lengthof Care[[21]](#footnote-21)** | **Total Cost of Care(stay commencing 2009)** | **Total Cost of Care(stay commencing 2029)** |
| Alzheimer's | 96 months | $667,930 | $1,772,018 |
| Diabetes | 48 months | $338,965 | $895,237 |
| Cancer | 36 months | $242,111 | $641,594 |
| Pulmonary | 36 months | $242,111 | $641,594 |
| Stroke | 21 months | $128,121 | $339,520 |
| Cardiac | 16 months | $97,601 | $258,256 |

**Note:** Calculations based on yearly cost of $69,715 in 2009 for semi-private room. Annual inflation calculated at 5%. Average length of nursing home stay is 2.7 years.

Nursing home costs vary depending on several variables. One of the most important is location. Look into the costs for nursing homes in your area. A national survey found the most expensive place to receive care is Anchorage, Alaska; the lowest was Shreveport, Louisiana. Typically, costs are higher in major metropolitan areas, but as in the case of Alaska, extremely rural areas can also cause an increase in the cost of care.

The same survey found that Home Health-Care costs vary considerably as well. The average hourly rate for a home-health aide is $21.00. If the senior needs homemaker assistance, the hourly rate is $20.00[[22]](#footnote-22). A cost for a licensed practical nurse would be much higher.

CCRCs require the lump-sum entrance at the beginning of their residency, along with monthly fees. The fees vary by the size of the unit and by the location and type of CCRC. Typically, an average entrance fee for one and two-bedroom apartments range between $59,000 and $121,000 with the average monthly fee for one person living in a one or two bedroom unit ranging between $1,000 and $1,600.[[23]](#footnote-23)

Outside of nursing homes, many people find themselves single-handedly caring for a parent. In those cases, caregivers pay out-of pocket expenses averaging $19,525 and lost wages and benefits totaling $659,139 over their lifetimes.[[24]](#footnote-24) 33% of working women cut work hours to care for a chronically ill loved one, 29% passed up on job promotion training or an assignment, 16% quit their jobs, and 13% retired early.[[25]](#footnote-25)

## Emotional Costs to the Caregiver

Perhaps the more "expensive" costs for long term care can be those that are not able to be measured in any quantifiable way. These are the emotional costs to the caregiver - whether the caregiver is actually providing the care or is in charge of seeing that the person is being cared for by others.

For example, married couples are doing exactly what they promised to do on their wedding day: grow old together. They have had a traditional marriage - the man worked outside of the home while the woman stayed home to raise the children. When the man retired, his wife continued to be the primary caretaker of the home, while he slowly learned how to contribute more at home. Suddenly, his wife is diagnosed with Alzheimer's and is now dependent upon her husband to take care of her. Is he equipped to do so? Perhaps not. Will he need help? Probably. Will he be able to pay for that help? Perhaps. But most importantly, will he be able to provide the care that his wife needs both physically and emotionally? And will he be able to then take care of himself when he needs assistance? These are all questions to take into consideration when deciding if Long Term Care insurance is necessary for you.

Another example: a man and his wife move from one part of the country to another to live closer to one of their daughters. As the daughter notices they are slowly deteriorating, she arranges for them to move into a nearby Continuing Care Retirement Community. They were fortunate enough to have the money to pay for their stay. A few years later, her father passes away. Her mother begins to lose her ability to get out of bed, dress herself and bathe herself, but remains coherent. The daughter sees her mother needs additional help, so she moves her into the assisted living side of the CCRC. A short time later, the staff informs the daughter that her mother becomes very incoherent at night, and tends to wander the halls without knowing where she is. They recommend that the daughter either move her mother to another facility or hire aids to be with her full time. The daughter knows that her mother will be very disturbed if a move occurs, and doesn't want her condition to deteriorate further. Her house has many stairs with no possibility of alterations to make it feasible for the mother to move in with her - plus she doesn't feel she can give up her job to take care of her. Do they have the money for full time aids?

A whole book could be given to cover the many different examples of how people need long term care. Another whole book could cover the effects on the family and friends who in turn take care of those individuals. The theme would be: it takes as much of a commitment (if not more) than it takes to raise a child.

People at the end stages of their life very closely resemble the life stages of a baby - but in reverse order. As a baby grows into a child and a teen and then an adult, a parent can take pride in all of their advances, physically, emotionally, and psychologically. A child taking care of their parent in the end stages of their life can be over-whelmed physically, emotionally, and psychologically as their parent regresses back from an adult, to a teen, to a child, to a baby. A person can prepare themselves to see a parent change; but it can be a whole other situation to actually have to change their parent's diapers, bathe them, and feed them as their parents once did for them. Imagine how it feels for a spouse to have to do the same things for their spouse, while at the same time perhaps undergoing some of the same changes themselves.

Overtired and overwhelmed, a caregiver can find they are unable to perform their necessary duties as effectively as they should. They may then feel guilty for this or they may inadvertently strike out emotionally or physically at the individual in their care.

This is not to say a family member will not be able to be a quality caregiver. Many people are able to perform these tasks with no problems. Others find they can perform the tasks with a bit of outside assistance. Others recognize it is best for all involved to receive outside help from the beginning, or by arranging for their loved ones to be taken care of by someone else. It is just as important to ask these questions before the need arises, and to be sure that the financial means are there to meet the

need as well.

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# Chapter 5Medicare

Medicare is the health insurance plan that covers 94 percent of America's aged population and those individual who have been on Social Security disability for over two years. Medicare is like the health insurance most of us have in our working years. It is designed to pay for treatment of illness and injury and some preventative care. Many people mistakenly think that Medicare will cover their long term care. The fact is, it does not. Medicaid, to be covered in the next chapter, is the program that covers long term care for those individuals with limited financial resources.

Medicare was created in 1965 under Title XVIII of the Social Security Act. In addition to providing health insurance for those ages 65 and older, Medicare also covers some younger people including people with certain disabilities. Prior to Medicare, retirees typically had no health insurance; therefore, the Medicare program is a critical component in ensuring financial security for seniors in our country.

There are two parts to the original Medicare: Part A and Part B. Part A is provided free for most workers (or their spouses). Those meeting the requirement of 40 or more credits of Medicare-covered employment and are age 65 or older. Those individuals with 30 to 39 credits can purchase the coverage for $244.00 a month. Individuals with less than 30 credits can purchase Medicare for $443.00 a month. Part A has a deductible of $1,260 in 2014. Part B costs will rise to $104.90 per month starting January 1, 2015 and is the same in 2014 for those with incomes of less than $85,000. The rates for Part B are determined by a formula that sets the premiums at 25% of the estimated costs for the program. The other 75% comes out of the general revenue of the federal government. This is an important consideration when choosing the type of Medigap plan. Part B deductible is $147.00 in 2015.

Medicare benefits to retirees are funded by payroll taxes paid by current workers and their employers. The current rate is 1.45% of earnings paid by each worker and matched by their employer. The US Census reports number of workers is 151 million. People's increasing life span and higher costs for medical technology have placed intense financial pressure on the Medicare Program. As the baby boomer generation turns 65, more individuals will be using the program. The Social Security Trustees reported in May of 2015 observed that, without reform, the Medicare trust fund will be bankrupt in 2030. See the chart below:

Social Security Trustees’ Report 2014[[26]](#footnote-26)



 Steven Moses, a Medicare expert, states that Medicare is grossly unfunded. The Affordable Care Act (ACA) became law in 2012 which added a new income stream based 3.8% capital gain tax that moved Medicare trust solvency from 2016 to 2030. The future choices are clear: reduce benefits, raise payroll taxes, improve efficiency in the system, increase enrollment age, higher deductibles or a combination some or all of these.

Attempts have been made over the past 20 years to curb expenses for the program, and various changes have been made. At one time, Medicare would pay the fee charged for services directly to the provider. Now a person entering the hospital is assigned a diagnostic code which states how much reimbursement the hospital will get - that does not change for each individual, no matter what services the person gets. Also, home health care reimbursement is handled the same way; it is paid per person served, regardless of the amount of time spent with that person.

Patients with complicated health-care needs, who require a lot of care, were favored under the old payment system: The provider’s revenue, under the old system, was based on the amount of care provided. That has changed. Now the only way a home health care agency makes more money is to take in more patients and limit the number of complicated cases taken in.

Another result of this change in Medicare reimbursements is the explosion of private pay home health-care agencies that do not accept Medicare or Medicaid. They choose their patients, and often can hire the best staff. This has ripple effects on the care available for the Medicare client, making it more desirable to be able to privately pay for any care you need. This practice leaves those needing the care the most and with little financial resources, without any services. Without this home health care, the formerly semi- independent person ends up in the nursing home, and the cost to Medicaid increases.

## Medicare Home Health-Care Coverage

Medicare pays for home health care for the treatment of an illness or injury for beneficiaries who meet all of these four conditions:

* The family doctor decides that the person need medical care in their home and makes a plan for that care.
* The person needs at least one of the following: intermittent skilled nursing care, physical therapy, speech language pathology services, or occupational therapy.
* The person is homebound.
* The home health-care agency must be Medicare-approved.
* Once the person fail to meet one of the conditions, Medicare will stop paying. Additionally, once person’s rate of recovery reaches a plateau, Medicare will cease to pay.

Medicare part A currently pays in full, with no required copayment, for home health care services if the person meet the four conditions. If the person has only Medicare Part B coverage, it covers medically necessary home health services and does not require the patient to pay a deductible or, with the exception of medical equipment, the usual 20 percent coinsurance.

Medicare pays approved charges for the following Home Care Services:

* Skilled nursing
* Physical therapy
* Speech therapy
* Occupational therapy (covered only if patient is part of the plan that covers this)
* Medical social services (covered only if patient is part of the plan that covers this)
* Home health aide services (covered only if patient is part of the plan that covers this)

It is important to remember that Medicare stops paying for services when the patient plateaus or fails to improve. Medicare Supplemental Insurance (Medigap) Insurance is available to older persons and is designed to pay for copayments and deductibles associated with Medicare's payment for acute health care services. However, if Medicare does not cover a service, the Medigap policy will not cover it either.

## Medicare's Nursing Home Coverage

It is important to note from the start that Medicare does not cover Long Term Care in a nursing home. Medicare defined long term care as needing three months or more of regular care for a chronic condition. Benefits can stop early if the patient fails to show progress. Medicare will only pay for up to 100 days of care in a Medicare-approved skilled nursing facility, if all of the following conditions are met:

* The move to the skilled nursing facility must be within 30 days of a hospital stay.
* The hospital stay must have been for at least three days.
* Care must be medically necessary (skilled-nursing or skilled rehabilitation care).
* The patent must need skilled care for a medical condition that was treated in the hospital or started in the hospital.

Medicare was not designed to cover Long Term Care. In some cases, Medicare will cover up to 100 days of skilled nursing care in a nursing home. There is a co-pay starting on the 21st day. However, most people who need nursing home care do not need skilled care and so do not qualify for Medicare coverage. Remember, skilled-nursing care is medically necessary. It either improves your condition or maintains your condition and prevents it from getting worse. It is also provided by or under the supervision of a registered nurse and under the direction of a physician. Of those who need skilled care, most find the need ends within the first 20 days, and Medicare stops paying the bill at that point.

In addition to the skilled care requirement, there are other criteria a Medicare beneficiary must meet to have Medicare pay for his or her Long Term Care in a nursing home. For example, the beneficiary must have first spent three days in a hospital (not counting the day of discharge) before going into the nursing home. Medicare can’t be counted on to pay when planning for patient’s long term care needs.

If the person qualifies to receive Medicare payment for nursing home care, Medicare will pay a limited amount for a limited time period. Total Medicare payment differs according to the skilled services required for care. Medicare determines payment according to the national average daily rate for care in a skilled nursing facility.

As long as the skilled nursing is needed, Medicare pays for 100 percent of the covered services for the first 20 days in the nursing home. For days 21 to 100, Medicare pays for all covered services after the 2015 copayment of $157.50 per day. After 100 days, Medicare pays for nothing.

After Medicare Part A stops paying because of the time limit, Medicare Part B, if you have it, pays for specialized rehabilitative services delivered within a skilled nursing facility by speech language pathologists and audiologists, physical therapists, and occupational therapists.

As a person can see, Medicare was intended to pay for acute care, not long term care. Other plans must be made to pay for long term care in a nursing home.

The Medicare Supplemental Insurance (Medigap Insurance) also pays for the copayments and deductibles associated with Medicare's payment for nursing care services. Most Medigap policies pay the copayment for days 21 to 100 in a skilled nursing facility. No Medigap policies pay for long term nursing care. Additionally, as soon as Medicare stops paying, Medigap policies stop paying as well.

# Chapter 6Medicaid[[27]](#footnote-27)

Medicaid is the nation’s health care safety net. It began in 1965 as a program primarily covering people who qualified for cash assistance. Medicaid provides health and Long Term Care services to more than 43 million low-income families and elderly and disabled individuals. It is the health insurance program for more than one in seven Americans and accounts for more than 15 percent of our nation’s spending on health care. Medicaid accounts for the primary source of federal financial assistance to the states, and represents a major shared state and federal commitment to improving the lives and the health of America’s low-income population. Medicaid’s impact on the millions of Americans it has served over its 44 year history has been significant. It serves as the health insurance provider for low-income adults and children. It is a comprehensive source of medical and Long Term Care coverage for people with disabilities, and a supplement to Medicare for the elderly. Medicaid provides assistance with prescription drugs, Long Term Care, Medicare premiums and cost-sharing obligations.

## The Basics

**States that choose to participate in Medicaid must cover a minimum set of benefits for certain groups.** States may, at their option, cover additional types of services and receive federal matching funds for the costs of those benefits. Because states have flexibility to design their own benefits packages (subject to federal minimum requirements), benefits vary significantly from state to state.

**Required services mandated Services that the states must provide.** Most Medicaid beneficiaries are entitled to coverage for the following basic services, if the services are medically necessary:

* Hospital care (inpatient and outpatient)
* Nursing home care
* Physician services
* Laboratory and x-ray services
* Immunizations and other early and periodic screening, diagnostic, and treatment (EPSDT) services for children
* Family planning services
* Health center (FQHC) and rural health clinic (RHC) services
* Nurse midwife and nurse practitioner services

**Optional Services that states can provide.** States have the option of covering additional services and receiving federal matching funds for those services, which include:

* Prescription drugs
* Institutional care for individuals with mental retardation
* Home- and community-based care for the frail elderly, including case management
* Personal care and other community-based services for individuals with disabilities
* Dental care and vision care for adults

**Level of Services must be adequate in amount, duration, and scope.** States have discretion to vary the amount, duration, or scope of the services they cover, but in all cases the service must be “sufficient in amount, duration, and scope to reasonably achieve its purpose.” For example, a state may not limit coverage for inpatient hospital care to three days per year or limit the number of emergency visits to one per year.

**Level of services must be offered throughout the state.** States may not vary the amount, duration, or scope of covered services based on the individual’s residence. For example, a state may not offer coverage for 20 hospital days per year to residents of urban areas but only 10 hospital days per year to residents of rural counties.

**States cannot change the amount, duration, or scope of a covered service “solely on the basis of an individual’s diagnosis, types of illness, or condition.”** For example, states may not exclude Medicaid beneficiaries with diabetes from coverage for prescription drugs, or Medicaid beneficiaries with dementia from coverage for nursing home care.

**States may impose nominal cost-sharing on some services for some groups of beneficiaries.** States may impose nominal cost-sharing on most non-emergency services, including prescription drugs. An example would be the state that charges $50.00 for use of an emergency room for a non-emergency visit. However, they may not impose any co-payments (or other cost-sharing) on the services to children, pregnant women, and nursing home residents.

Medicaid benefits are a defining element of Medicaid’s individual entitlement. Under federal law, if a state chooses to participate in Medicaid (all do), then every resident of the state who meets the state’s Medicaid eligibility requirements is entitled to have payment made on his or her behalf for covered services. There is no single Medicaid benefits package. This is because states, subject to minimum federal requirements, have broad discretion to determine which categories of benefits their Medicaid programs will cover. They also have discretion to impose nominal cost-sharing on certain groups of eligible individuals with respect to certain services. The result of this broad discretion is wide variation from state to state in the scope and content of the Medicaid coverage offered to beneficiaries.

In 1998, Medicaid covered 20.7 million low-income children, 8.6 million low-income adults (mostly women) in families with children, over 4 million elderly individuals (age 65 and over), and nearly 7 million individuals with disabilities. A program designed to provide health care coverage to individuals with such diverse health needs will necessarily have to cover a wide range of services. Additionally, Medicaid beneficiaries tend to have poorer health status and greater health care needs than other individuals. Not only are Medicaid beneficiaries generally in poorer health than other Americans, but aged and disabled individuals insured by Medicaid are also substantially more impaired than are other aged or disabled individuals. For example, almost 60 percent of Medicaid beneficiaries with a chronic disability are limited in their major life activity (e.g., going to school for children and working for adults) because of the disability, compared to 37 percent of privately insured disabled persons.

Similarly, low-income elderly people who are enrolled in Medicaid are in poorer health than higher income elderly people. Over 40 percent of poor and near-poor (income below 200% of the federal poverty level) elderly people perceive their health to be fair or poor, compared to 20 percent of elderly people with incomes above 200 percent of the poverty level. Poor and near-poor elderly people are also more likely to suffer from chronic conditions that require on-going medical treatment, including arthritis, hypertension, and diabetes. The failure to get proper medical care because of lack of insurance, results in a far sicker population among the poor. An example would be an untreated case of hypertension can lead to kidney problems. Now in place of one health condition, there are two to treat.

As noted above, Medicaid offers two types of coverage for the low-income elderly:

1. Coverage for the full Medicaid benefits package (e.g., physician, hospital, nursing facility, prescription drug, and other services), plus assistance with Medicare premiums and cost-sharing; and
2. Assistance with the costs of Medicare premiums, and cost-sharing only. Some Medicare beneficiaries qualify for the full sharing, while others qualify only for coverage for Medicare premiums and cost sharing. The income standards for assistance with Medicare premiums and cost sharing are higher than those an elderly person must meet in order to qualify for the full Medicaid benefits package. Full Medicaid coverage is generally not available to elderly individuals with incomes above 100 percent of poverty ($11,636 in 2014), unless they qualify as “medically needy” by incurring large medical expenses.

## Qualifying for Medicaid

But how does a person qualify for Medicaid? There are several ways to qualify; these methods are called "Channel" and are discussed below.



### SSI-Related Channel

Subject to one important exception, states are required to cover elderly individuals receiving cash assistance under the Supplemental Security Income (SSI) program. In 2014, to qualify for SSI, an elderly individual must have had an income of less than $902.50 per month ($1,214.17 per month for a couple) and countable resources (varies by state) of less than $2,000 ($3,000 for a couple). These figures do not include the $30 monthly income for personal items (varies by state). About 3.6 million elderly persons (9.7%) were below the poverty level in 2007. This poverty rate is a statistically significant increase from the poverty rate in 2006 (9.4%). Another 2.4 million or 6.4% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level)[[28]](#footnote-28).

Not all of SSI recipients automatically qualify for Medicaid, however. The so-called “209(b)” option, named for the section of the 1972 Social Security Act Amendments. When the SSI program was enacted, it allows states to use their 1972 state assistance eligibility rules in determining eligibility for the elderly instead of the federal SSI rules. This act adjusts income standards for inflation each year. However, if a state uses its more restrictive 1972 standards, it must also allow individuals to “spend down” into eligibility by deducting incurred medical expenses from income. (Elderly individuals generally cannot deduct their medical expenses in calculating their income in order to qualify for SSI). Eleven states had elected the “209(b)” option under the Medicaid Act as of 2001. These sections apply income standards, resource standards, and/or resource methodologies, which is more restrictive than those applicable under SSI. Those states are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

Another option available to states is to extend Medicaid coverage to individuals who receive state supplementation payments (SSP), but not SSI payments. Under SSI law, states have the option of providing cash payment (SSP) to supplement the basic federal SSI payment. States also have the option of making an SSP payment to elderly individuals whose income exceeds the SSI income standards. In2009, all but six states provided some amount of supplementary payment and those benefits vary by state. Under the SSP-only eligibility option, states may make Medicaid available to elderly individuals receiving these payments. In 2009, 25 states reported making Medicaid coverage available to elderly individuals living independently and receiving state supplementation payments but not SSI benefits.

Seniors who are getting SSI are also getting Social Security benefits. In some cases, cost-of-living increases of the Social Security benefit may cause an individual to lose his or her SSI (or SSP) benefits. Although these individuals may lose their SSI or SSP payments, they remain eligible for Medicaid in those states that cover elderly individuals receiving SSI or SSP benefits. That is because under the so-called “Pickle Amendment,” these states are required to disregard the Social Security cost-of-living increases received by the individual for Medicaid purposes.

### “Medically Needy” Channel

Many low-income elderly individuals and couples with Medicare coverage have incomes that exceed the SSI eligibility level ($902.50 per month for an individual, $1,214.17 for a couple in 2014) and medical expenses that Medicare does not cover. States that want to offer Medicaid coverage to assist these individuals or couples with their medical expenses have the option of covering them with federal matching funds through the “medically needy” channel. In 2009, 35 states, including the District of Columbia, had elected to offer coverage to the “medically needy.” This eligibility channel is often used by elderly individuals residing in nursing facilities or by individuals living in the community with high prescription drug or medical equipment expenses.

Under the “medically needy” option, a state establishes an income standard, as well as a resource standard. In counting income or resources for the elderly, a state must apply methodologies no more restrictive than those under the SSI program. An applicant can qualify under the income eligibility faster than under the resource eligibility rules. In determining income eligibility, the state deducts the medical expenses an individual has incurred over a budget period (not more than six months) from the individual’s countable income. If the individual’s income, minus incurred medical expenses, is less than the state’s “medically needy” income standard, and if the individual’s countable resources are less than the state’s “medically needy” resource standard, then the individual is eligible for Medicaid coverage for the remainder of the budget period. At the end of the budget period, the individual’s “medically needy” eligibility must be re-determined for a new budget period.

### Nursing Facility Channel

Under the “medically needy” channel, there is no upper limit on the amount of monthly income an individual can receive and still qualify for Medicaid coverage. So long as the individual’s incurred medical expenses are sufficiently high enough to reduce the individual’s income to the state “medically needy” income standard during the budget period, the individual will qualify for Medicaid. In states with “medically needy” coverage, many individuals in nursing homes qualify this way. However, states that wish to provide Medicaid coverage for the elderly in nursing facilities but want to set an upper limit on the beneficiary’s income have another option: the so-called “special income rule” for individuals in nursing facilities and other institutions.

Under the “special income level” option, a state may set an income standard at up to 300 percent of the SSI benefit ($2,707.50 per month in 2009) for individuals in nursing facilities and other institutions. Institutionalized individuals with Social Security, pension, and other income of more than this amount may not qualify for Medicaid, even if their monthly costs of care in the nursing facility exceed their income. If their countable income is under the state-established limit, these individuals must also meet the SSI resource test in order to qualify for Medicaid. Individuals who qualify through this channel must apply all of their income, except for a small personal needs allowance, towards the cost of nursing home care. As of September 1996, 33 states had elected to cover this group; 14 of these states did not cover the “medically needy.”

The high cost of nursing facility services makes Medicaid an important benefit for the elderly at risk of nursing facility care. It also makes nursing facility residents a high-cost population for state Medicaid programs. The tension between beneficiary need for financial protection and state concerns about costs has led to the development of Medicaid eligibility policies specific to the coverage of nursing facility services for the elderly (and disabled).

### **Transfer of Assets in the Medicaid Program**

The Deficit Reduction Act of 2005 introduced new rules that discourage the improper transfer of assets to gain Medicaid eligibility and receive long-term care services.

### **Background**

The Medicaid program provides coverage for long-term care services for individuals who are unable to afford it. Some individuals, with assistance from financial planners and attorneys, have found ways of arranging assets so that they are preserved for the individual and/or family members, but are not countable when Medicaid eligibility is determined. In order to ensure the availability of long-term care services for people that truly need them, the Deficit Reduction Act of 2005 (DRA) addresses key areas related to transfers of assets for less than fair market value. Tightening Medicaid asset transfer rules discourages the use of such "Medicaid planning" techniques and makes it more difficult for individuals with the resources to pay for their own long-term care services to inappropriately transfer assets in order to qualify for Medicaid. These key areas are: asset review “look-back” periods; asset transfer penalty periods; the treatment of annuities; life estates; notes and loans; the “income first” rule; excluded coverage for substantial home equity; and Continuing Care Retirement Community deposits.

### Key Transfer of Asset Provisions in the DRA

### Extension of Look-Back Period and Beginning Date of Penalty Period

When an individual applies for Medicaid coverage for long-term care, States conduct a review, or "look-back," to determine whether the individual (or his or her spouse) transferred assets (e.g., cash gifts to children, transferring home ownership) to another person or party for less than fair market value (FMV). The DRA lengthened the “look-back period” to 60 months (five years) prior to the date the individual applied for Medicaid. When individuals transfer assets at less than FMV they are subject to a penalty that delays the date they can qualify to receive Medicaid long-term care services**.** Previously the penalty period began with the month the assets were transferred. This provided an opportunity for individuals to avoid part or all of a penalty by transferring assets months or years before they actually entered a nursing home. Under the DRA, the penalty period, for transfers made on or after February 8, 2006, now begins on either the date of the asset transfer, or the date the individual enters a nursing home and is found eligible for coverage of institutional level services that Medicaid would pay for were it not for the imposition of a transfer penalty—whichever is later.

For example, assume that 12 months before applying for Medicaid, an elderly individual transferred $25,000 in savings to her granddaughter and that on average, the monthly cost to a private (i.e., non-Medicaid) resident in a nursing facility is under $5,000 per month. Under the statutory formula, the amount transferred is divided by the average monthly cost to yield a number that represents the number of months of exclusion from coverage. In this case, she would be excluded for five months ($25,000 divided by $5,000). However, because the exclusion begins to run from the date of the transfer, and because in this case the transfer occurred 12 months before application, there would be no exclusion from coverage in this case. If she had transferred $100,000 to her granddaughter 12 months prior to application, she would be excluded from coverage for eight months ($100,000 divided by $5,000 equals 20 months minus the original 12 months).

### Treatment of Annuities

Prior to the DRA, annuities were often used to shelter assets, especially in situations where one member of a couple entered a nursing home. To discourage the use of annuities to shelter funds for heirs while qualifying for Medicaid long-term care services, the DRA changed the treatment of annuities. As a condition of eligibility for coverage of long-term care services, Medicaid applicants are now required to disclose any interest in an annuity. Also, annuities must name the State as the primary remainder beneficiary (or as the second remainder beneficiary after a community-based spouse or minor or disabled child) for at least the value of the Medicaid assistance provided. If the annuity does not name the State as a remainder beneficiary in the proper position, the annuity must be treated as a transfer of assets for less than fair market value. The full purchase price of the annuity is the amount that is subject to penalty. Annuities purchased by or on the behalf of an individual who applied for Medicaid coverage for long-term care shall be treated as an asset transfer for less than FMV unless the annuity meets certain requirements pertaining to retire plans as set forth in the Internal Revenue Service code, or unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

Life Estates

Under a typical life estate, an individual transfers ownership of his or her own home or other property to another person; for example a son or daughter, but retains a right to live in the home for the remainder of the individual’s life. However, some individuals have used this planning mechanism to purchase a life estate in another person’s home, but without intending to ever reside in that home. This type of life estate transaction is really just an attempt to transfer assets for less than fair market value to someone else. To prevent this, the DRA requires that the purchase of a life estate interest in another person’s home be treated as a transfer of assets for less than FMV unless the purchaser actually lives in the home for at least one year after the date of purchase. Additionally, even if the individual lives in the home for at least one year, if the purchase amount of the life estate is greater than the computed value of the life estate’s interest, the difference is considered a transfer for less than fair market value that may be subject to penalty.

### Note and Loans

The DRA requires that States now consider the purchase of a promissory note, loan or mortgage as a transfer of assets for less than fair market value, and thus subject to penalty, unless the following conditions are met:

 (1) the repayment terms are actuarially sound;

 (2) payments are made in equal amounts with no balloon payments; and,

 (3) the note, loan or mortgage prohibits cancellation of the debt upon the death of the lender.

Waiver of Imposition of Transfers of Assets Penalties in Cases of Undue Hardship

The DRA established a hardship waiver that permits States to make an exception to a transfer of assets penalty in cases where imposition of a penalty would threaten the health or life of an individual, or when the application of a penalty would deprive the individual of food, clothing, shelter or other necessities of life. The DRA also allows a long-term care facility to apply for an undue hardship waiver on behalf of a resident, provided the facility has the resident’s consent. Finally, the DRA provides an option under which States can elect to pay for a person’s nursing home care for up to 30 days pending the outcome of a request for an undue hardship waiver.

Mandatory “Income First” RuleThe “income first rule” applies when determining whether to allocate additional resources to the community spouse to bring that spouse’s income up to the minimum monthly maintenance needs allowance under the Medicaid spousal impoverishment provisions. The DRA requires States to first assume that all income that could be allocated from the institutionalized spouse to the community spouse has been allocated to that spouse before allocating any additional resources. More than half of the States already applied this rule before enactment of the DRA.

Excluded Coverage for Substantial Home Equity

The DRA requires States not to pay for Medicaid long-term care services for an individual whose equity interest in his or her home exceeds a certain level. The home equity cut-off is $500,000 (adjusted for inflation), but States can elect to increase that amount up to $750,000 (adjusted to $814,000 in 2014). There is an exception to this requirement for individuals with a spouse or a minor or blind or disabled child residing in the home. Also, States can elect not to apply this provision in cases of documented hardship.

### Deposits with Continuing Care Retirement Communities

Continuing Care Retirement Communities, or CCRCs, typically provide a continuum of care ranging from independent residential living to nursing home care. Often CCRCs require an entrance deposit, which can be substantial. These entrance deposits typically are placed in an escrow account. Previously, these funds or deposits were excluded from a person’s countable resources when determining Medicaid eligibility because they could not be accessed by the applicant. The DRA requires States to consider these funds as countable resources when determining eligibility for Medicaid, provided (1) the funds can be used to pay for care under the terms of the individual’s contract with the facility should other resources of the individual be insufficient; (2) the entrance fee (or remaining portion) is refundable when the individual dies or elects to leave the CCRC; and (3) the entrance fee confers no ownership interest in the community.

State Action

In order to comply with the updated and new provisions relating to the transfer of asset review prior to the determination of an individual’s eligibility to receiving Medicaid long-term care service, States must make the necessary changes to their existing Medicaid State Plan.

Important Links

State Medicaid Directors Letter and Enclosure on DRA § 6011 - 6016 http://www.cms.hhs.gov/smdl/downloads/SMD072706b.pdf http://www.cms.hhs.gov/smdl/downloads/TOAEnclosure.pdf

### Spousal Impoverishment Methodologies

Federal Medicaid law requires states to apply a special set of income and resource methodologies in determining eligibility when one spouse is in a nursing facility and the other remains in the community. (States may, but are not required, to use them when one member of a couple receives home and community-based services under Medicaid). The purpose of these methodologies is to enable the institutionalized spouse to receive Medicaid coverage for nursing facility care while leaving the community spouse with sufficient resources and monthly income to avoid hardship. These methodologies apply to any eligibility channel that a state uses under its Medicaid program in determining Medicaid eligibility for nursing facility residents, including the “medically needy” and “special income level” options. Once Medicaid eligibility has been established, these methodologies also govern the calculation of the amount of the couple’s monthly income that must be applied toward the cost of nursing facility care for the institutionalized spouse.

Spouse Impoverishment Protection Law (for Illinois and some other states):

* Allows the spouse at home protect up to half of their joint countable assets at the time of entry into a nursing home. The limit was increased to $109,560 after being adjusted for inflation. The minimum is $21,912. Countable assets include cash, mutual funds, stocks, bonds, checking accounts, savings accounts, savings bonds, 401(k), IRA, cash value of life insurance policies and revocable trust. Changes are made based on the change in the Consumer Price Index (CPI).
* The Spouse Maintenance Needs Allowance Standard was increased to $2,739 monthly based on changes in Consumer Price Index. The at home spouse can receive up to $2,739 in monthly income and would not affect their spouse in the nursing home. The spouse in the nursing home will pay all the income in their name to the nursing home and the balance of the nursing home charges will be paid by Medicaid. The spouse in the nursing home is allowed to keep $30 for personal needs. This amount is adjusted to the CPI.

The person in need of Long Term Care (nursing home or home health care) can qualify for public assistance after the assets have been reduced to the eligible amounts. They will still qualify for the burial allowance and the $2,000 for disregarded assets and funds set aside for exempt merchandise (casket, vault, crypt, mausoleum, lot and opening and closing charges, plus any sales tax).

The value of the house and surrounding land plus one vehicle is not included in the “spend down” requirement. Other assets must be spent down. These assets include insurance policies with over $2,000 in cash value, bank accounts, certificates of deposits, mutual funds, stocks, bonds and other assets.

The community spouse can receive up to $2,739 monthly from the patient's income and the balance, if any, will be used toward the spend down to cover the cost of the nursing home or home health care.

A great many people have benefited from the Spousal Impoverishment Allowance. People considering qualifying for this assistance should make an application to Public Aid before they spend all of their assets. An asset assessment review will take place and they will be instructed on how they will be allowed to transfer assets. Listed below are the 2009 Limits for each state.

**2014 Limits**

The table below gives the minimum assets and income each state allows nursing-home residents and their spouses to keep. The federal government sets new minimum and maximum amounts each year, but states can set their own minimum requirements at any level between the federal limits.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **State** | **Your asset allowance** | **Your spouse's minimum asset allowance** | **Your personal monthly needs allowance** | **Your spouse's minimum monthly income allowance** |
| Alabama\* | $2,000 | $25,000 | $30 | $1,750 |
| Alaska\* | $2,000 | $109,560  | $75 | $2,739  |
| Arizona\* | $2,000 | $21,912  | $93.45 | $1,750 |
| Arkansas\* | $2,000 | $21,912  | $40 | $1,750 |
| California | $2,000 | $109,560  | $35 | $2,739  |
| Colorado\* | $2,000 | $109,560  | $50 | $1,750 |
| Connecticut | $1,600 | $21,912  | $65 | $1,750 |
| Delaware\* | $2,000 | $25,000 | $50 | $1,750 |
| District of Columbia | $2,600 | $109,560  | $70 | $2,739  |
| Florida\* | $2,000 | $109,560  | $35 | $1,750 |
| Georgia\* | $2,000 | $109,560  | $30 | $2,739  |
| Hawaii | $2,000 | $109,560  | $30 | $2,739  |
| Idaho\* | $2,000 | $21,912  | $40 | $1,750 |
| Illinois | $2,000 | $109,560  | $30 | $2,739  |
| Indiana | $1,500 | $21,912  | $52 | $1,750 |
| Iowa\* | $2,000 | $24,000 | $50 | $2,739  |
| Kansas | $2,000 | $21,912  | $50 | $1,750 |
| Kentucky | $2,000 | $22,000 | $40 | $1,750 |
| Louisiana\* | $2,000 | $109,560  | $38 | $2,739  |
| Maine | $2,000 | $109,560  | $40 | $1,750 |
| Maryland | $2,500 | $21,912  | $66 | $1,750 |
| Massachusetts | $2,000 | $21,912  | $72.80 | $1,750 |
| Michigan | $2,000 | $21,912  | $60 | $1,750 |
| Minnesota | $3,000 | $29,389 | $84 | $1,750 |
| Mississippi\* | $2,000 | $109,560  | $44 | $2,739  |
| Missouri | $1,000 | $21,912  | $30 | $1,750 |
| Montana | $2,000 | $21,912  | $50 | $1,750 |
| Nebraska | $4,000 | $21,912  | $50 | $2,739  |
| Nevada\* | $2,000 | $21,912  | $35 | $1,750 |
| New Hampshire | $2,500 | $21,912  | $56 | $1,750 |
| New Jersey | $2,000 | $21,912  | $35 | $1,750 |
| New Mexico\* | $2,000 | $31,290 | $58 | $1,750 |
| New York | $4,150 | $74,820 | $50 | $2,739  |
| North Carolina | $2,000 | $21,912  | $30 | $1,750 |
| North Dakota | $3,000 | $109,560  | $60 | $2,739  |
| Ohio | $1,500 | $21,912  | $40 | $1,750 |
| Oklahoma\* | $2,000 | $25,000 | $50 | $2,739  |
| Oregon\* | $2,000 | $21,912  | $30 | $1,750 |
| Pennsylvania | $2,400 | $21,912  | $45 | $1,750 |
| Rhode Island | $4,000 | $21,912  | $50 | $1,750 |
| South Carolina\* | $2,000 | $66,480 | $30 | $2,739  |
| South Dakota\* | $2,000 | $21,912  | $60 | $1,750 |
| Tennessee\* | $2,000 | $21,912  | $40 | $1,750 |
| Texas\* | $2,000 | $21,912  | $60 | $2,739  |
| Utah | $2,000 | $21,912  | $45 | $1,750 |
| Vermont | $2,000 | $109,560  | $47.66 | $1,750 |
| Virginia | $2,000 | $21,912  | $30 | $1,750 |
| Washington | $2,000 | $41,493 | $41.62 | $1,750 |
| West Virginia | $2,000 | $21,912  | $50 | $1,750 |
| Wisconsin | $2,000 | $50,000 | $45 | $2,282 |
| Wyoming\* | $2,000 | $109,560  | $50 | $2,739  |

Value of Home limited by state Medicaid Rules

### Home and Community-Based Services Channel

Under the “section 1915(c)” waiver authority, states have the option of receiving federal Medicaid matching funds for covering home and community-based services to elderly individuals at risk of going to a nursing home. (States can cover HCBS waiver services on a statewide basis or only in certain areas). One purpose of this benefit’s flexibility is to enable states to eliminate the institutional bias inherent in a benefits package that covers only nursing facility care. However, benefits design is only part of the solution to institutional bias. If eligibility criteria for nursing facility residents are more generous than those for individuals who live at home, many of the low-income elderly will move into nursing homes. If they are in need of long term care, it may be precluded from Medicaid eligibility. The elderly will use the community-based services, so long as they can remain at home.

To enable states to avoid this anomalous result, the federal Medicaid statute allows them to apply the same eligibility rules to individuals in need of home and community-based services as they would apply to individuals in nursing facilities. For example, a state that has elected the option of covering institutionalized individuals under the special income level may apply this same income rule (up to 300% of the SSI benefit level) to individuals in the community. Similarly, states with “medically needy” coverage could apply their “spend down” to individuals needing home and community-based services as well as those in nursing facilities. As of 1999, every state had at least one section 1915(c) waiver targeted at the elderly. As of September 1996, 34 of the 50 states offering home and community-based waiver services to the elderly reported using a special income rule of 300 percent of SSI, 15 reported using “medically needy” spend-down rules, and 34 applied spousal impoverishment rules.

### Poverty-Level Channel

In 2012, SSI benefits without state supplementation were about 74 percent of the federal poverty level for an individual and 82 percent of poverty for a couple (not counting the $30 for personal items). States have the option of extending full Medicaid coverage to elderly individuals at higher poverty thresholds. Specifically, states may cover elderly individuals whose income does not exceed 100 percent of the federal poverty level and whose countable resources do not exceed the SSI threshold of $2,000 for an individual or $3,000 for a couple. In counting income or resources, states may use the SSI methodology, or they may use any methodology that is “less restrictive” than the SSI methodology. This flexibility enables states to effectively raise the poverty-level income standards or resource standards for this population beyond 100 percent of poverty or $2,000 if they choose. Under this option, elderly individuals are not permitted to “spend down” into Medicaid eligibility by incurring large medical expenses, as they are able to do through the “medically needy” channel. As of April 2009, 19 states had expanded income eligibility standards for the elderly to at least 100 percent of poverty.

### PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

The BBA established the PACE model of care as a permanent entity within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a **State option**. The State plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services (DHHS) can enter into program agreements with PACE providers.

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area.  Although all PACE participants must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE participants nationally reside in a nursing home.  If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

**Services**

* Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible.  Care and services include:
* Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
* Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
* Home health care and personal care
* All necessary prescription drugs
* Social services
* Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
* Respite care
* Hospital and nursing home care when necessary

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the interdisciplinary team for the care of the PACE participant.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

# Chapter 7Veteran’s Benefits

The Veteran’s Administration was created in 1930 to coordinate services to United States veterans. Currently there are about 24 million veterans. The oldest veterans are from World War II (14%), Korean War (13.4%), Vietnam (33%) and the rest accounting for about 40%. By 2010 the veteran population is expected to decline to 22 million; however, almost half will be over the age of 65. Can a veteran count on VA Long Term Care benefits? It depends upon their priority level based on service related disability, as well as financial need.

## Recent Legislation

In October of 1996, Congress passed Public Law 104-262, the Veterans’ Health-Care Eligibility Reform Act of 1996. It stated that when a veteran applies for enrollment, he or she will be assigned as a member of one of the following priority benefits and will receive priority for care based on these guidelines:

*Priority Group 1*: Veterans with service-connected disabilities rated 50 percent or more.

*Priority Group 2*:Veterans with service-connected disabilities rated 30-40 percent.

*Priority Group 3:* Veterans who are former POWs; veterans with service connected disabilities rated 10 -20 percent; veterans discharged from active disability incurred or aggravated in the line of duty; veterans who received the Purple Heart; and veterans awarded special eligibility classification under 48 U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation.”

*Priority Group 4:* Veterans who are receiving aid and attendance or housebound benefits; veterans who have been determined by the VA to be catastrophically disabled. More information on aid and attendance is covered later in this chapter.

*Priority Group 5:* Nonservice-connected veterans and noncompensable service-connected veterans rated 0 percent disabled, whose annual income and net worth are below the established dollar thresholds. (Nonservice-connected means “an eligible veteran who has been discharged from active military duty and does not have an illness or injury that has been determined to have been incurred in or aggravated during military service.)

*Priority Group 6:* All other veterans who are not required to make copayments for their care including:

* Veterans seeking care solely for disorders associated with exposure to herbicides while serving in Vietnam; or exposure to radiation during atmospheric testing or during the occupation of Hiroshima and Nagaski; or for disorders associated with service in the Gulf War; or for any illness associated with service in the Gulf War or during the period of hostility after November 11, 1998.
* Compensable (a veteran who has been rated by the VA as being service-connected and who received monetary benefits) disability would have 0 percent service-connected veterans.

*Priority Group 7:* Nonservice-connected veterans and noncompensable 0 percent service-connected veterans with income and net worth above the established dollar thresholds and who agree to pay specified copayments.

## TRICARE for Life Benefit

This benefit implemented in October 2001 is a great health insurance benefit for retired military personnel and their eligible beneficiaries who are on Medicare. It is free for Medicare-eligible retirees of the uniformed services, their family members (not including dependent parents and parents-in-law), and survivors. Retired guard and reservists, widows and widowers are also covered. Detailed information on this may be found by calling 1-888-DOD-LIFE or online at www.tricare.osd.mil.

For eligible beneficiaries, Medicare is their primary payer, with TRICARE for Life being secondary. TRICARE for Life will normally pay Medicare deductibles and coinsurance for service that both plans cover. It also helps cover costs for prescription drugs. However, TRICARE is a health insurance, and not a Long Term Care program.

## The VA and Long Term Care

The uniform benefits package available to all enrolled veterans includes inpatient hospital care; ambulatory care; emergency care (in VA facilities); rehabilitative, home health, respite and hospice care; medically necessary medications and medical equipment; and adult day health care.

The VA may provide nursing home care in VA facilities when medically indicated and to the extent resources and facilities are available to both service- and non-service-connected veterans. Certain Nonservice-connected and zero percent service-connected veterans with higher income levels are required to make copayments for their care. Veterans who have been furnished hospital, nursing home, or domiciliary care in VA facilities may be transferred to community nursing homes at VA expense. Under this contract program, nursing home care at VA expense for Nonservice-connected veterans is limited to a period of time not to exceed six months following hospitalization in a VA facility. Contract care for veterans who received hospital care for a service connected disability is not subject to the six month limit. In recent years, federal government funding of veteran benefits continues to decline. This leaves the Veteran’s Administration with the problem of providing services to older veterans at reduced levels. In some cases, veteran’s benefits have been cut off or reduced.

For the most up-to-date information about benefits, contact the local VA office or use the VA’s web site: www.va.gov for the most up to date information.[[29]](#footnote-29)

### Aid & Attendance Allowance[[30]](#footnote-30)

The Aid and Attendance pension benefit may be available to wartime veterans and surviving spouses who have in-home care or who live in nursing-homes or assisted-living facilities.

Many elderly veterans and surviving spouses whose incomes are above the congressionally mandated legal limit for a VA pension may still be eligible for the special monthly Aid and Attendance benefit if they have large medical expenses, including nursing home expenses, for which they do not receive reimbursement.

To qualify, claimants must be incapable of self-support and in need of regular personal assistance.

The basic criteria for the Aid and Attendance benefit include the inability to feed oneself, to dress and undress without assistance, or to take care of one’s own bodily needs. People who are bedridden or need help to adjust special prosthetic or orthopedic devices may also be eligible, as well as those who have a physical or mental injury or illness that requires regular assistance to protect them from hazards or dangers in their daily environment.

For a wartime veteran or surviving spouse to qualify for this special monthly pension, the veteran must have served at least 90 days of active military service, one day of which was during a period of war, and be discharged under conditions other than dishonorable.

Wartime veterans who entered active duty on or after September 8, 1980, (October 16, 1981, for officers) must have completed at least 24 continuous months of military service or the period for which they were ordered to active duty.

If all requirements are met, VA determines eligibility for the Aid and Attendance benefit by adjusting for un-reimbursed medical expenses from the veteran’s or surviving spouse’s total household income. If the remaining income amount falls below the annual income threshold for the Aid and Attendance benefit, VA pays the difference between the claimant’s household income and the Aid and Attendance threshold.

The Aid and Attendance income threshold for a veteran without dependents is now $18,234 annually. The threshold increases to $21,615 if a veteran has one dependent, and by $1,866 for each additional dependent. The annual Aid and Attendance threshold for a surviving spouse alone is $11,715. This threshold increases to $13,976 if there is one dependent child and by $1,866 for each additional child.

Additional information and assistance in applying for the Aid and Attendance benefit may be obtained by calling 1-800-827-1000. Applications may be submitted on-line at <http://vabenefits.vba.va.gov/vonapp/main.asp>. Information is also available on the Internet at [www.va.gov](http://www.va.gov) or from any local veterans’ service organization.

# Chapter 8

# Alternatives to Long Term Care Insurance Policies

Do options exist for the person who does not have a Long Term Care policy to cover long term care costs? Yes. However, most involve spending down equity that could otherwise be passed on to future generations. These are most important considerations when debating whether to purchase long term care insurance or not, if there is room in the budget.

## The House as a Resource

The simplest use for a person’s home is as a ready source of cash. When the greatest need is for cash and other considerations are secondary, the sale of the house makes a lot of sense. Getting a fair appraisal of the home is very important. If this home has been owned for a long time, ensure the person take into account the full value of the home as it has appreciated over time. I know of one couple who built a house in 1960, did limited improvements and sold the house for $75,000. The house was built for under $10,000 including the lot. The home is the largest asset for most families. It is important to note that the price received for the house is not the net gain. Costs such as realtor's fees, appraisal fees, real estate taxes, and closing costs must be paid. On the sale of the above home, the net amount received was $72,723 after deducting the fees and cost of $2,276. This property was sold without a realtor. It is not unusual to the cost and fees to exceed 7% of the sales price. If there are any question about the value, get it appraised or have three realtors do a market value survey. The Taxpayers Relief Act permits home owners to exclude up to $250,000 of profit made on the sale of their principal residence from the capital gains tax ($500,000 for married taxpayers filing joint returns). This exclusion is not limited to any one sale, but can be taken every two years.

An alternative is to rent the home out. This could be an excellent source of regular income for paying for Long Term Care costs. That is of course, there is a need for a regular income rather than the entire lump sum with a little or no mortgage on your home. Renting out the house, leaves the owner with the alternative of using the home later or leaving it as an inheritance. That rental income must be large enough to pay any mortgages, taxes, and other expenses. The extra income must provide enough to cover the costs of long term care. The major disadvantage is the owner retains the responsibilities of being a landlord - including upkeep of the property. Those responsibilities of finding the right person or firm to do the repairs and/or maintenance is more than most elderly persons want to handle. A person can always hire a real estate company to manage the property, but their fees can be as much as 15% plus any repair cost.

Another choice would be to take in a roomer, or share the home with a family member or friend. With the right person, this could be the perfect answer for both parties. It is always wise to get the details on this living arrangement in writing, letting the rent, duties and responsibilities of each party. That agreement can protect the senior from being taken advantage of in the future.

## Home Equity Conversion/Reverse Mortgages

The difference between the amount of homeowner’s mortgage and the market value of their house is called the equity. A reverse mortgage allows the homeowner a way to convert this equity into cash without having to selling the home or making regular mortgage payments. The collateral for the loan is the equity built up have in the home. The borrower must be age 62 to qualify for a reverse mortgage. That loan can be used for many purposes, including paying for health care needs or as the entrance fee to an assisted living facility. A great many senior think they will lose the title and ownership interest if they do a reverse mortgage. That is not the case.

Many choices are available in the payments from a reverse mortgage. It can be in the form of a single lump sum of cash, regular monthly checks, or a line of credit. Not all states allow the use of line of credit in reverse mortgages. Nearly all reverse mortgages guarantee the borrower a lifetime tenancy in the home, meaning that homeowner can stay in their house for the rest of their life. The mortgage would come due if the home is sold or the homeowners moves out permanently. Some reverse mortgage plans offer options to a lifetime of monthly checks regardless of where the homeowner resides. Other options include getting a monthly check for an agreed period of time, and at the end of that period, the homeowner must turn over the title of the property to the lender. This type of contract should not be entered into lightly. It is really important understand the terms of the loan that is agreed to. If there are any doubts about it, have the contract reviewed by your attorney. If there is no personal attorney, contact the local bar association and ask for the names of several attorneys that specialize in real estate.

With reverse mortgage, the person still remains the homeowner. The responsibility for maintaining the property, paying property taxes, and keeping it insured is still the homeowners. Failure to pay the property taxes or insurance will result in foreclosure action by the lender. The National Reverse Mortgage Lenders Association reports that sales of reverse mortgages continue to grow. The demand for reverse mortgages continues to grow over the past decade as senior look for added income.

The loan comes due at the time of death of the homeowner and the loan balance must be paid from the proceeds of the sale of the home. When considering a reverse mortgage to pay for Long Term Care and the plan is to stay in the home forever, the loan would not be due until the homeowner’s death. At that point, the house would be sold by the heirs and the loan balance paid off. The home could stay in the family, if the heirs pay off the loan themselves. A very frank discussion with the family members about the homeowner’s wishes and the family’s desires should happen before taking on a reverse mortgage.

A large majority of reverse-mortgage loans cannot be reversed. This means the lender holds the home as collateral for the loan. The lender cannot look to other assets or income, or to the heirs for repayment of this loan. If the lender pays much more than the value of the home because the homeowner lived a longer than expected, the lender has not recourse beyond the home. As long as maintaining obligations under the loan agreement and living in the home, the homeowner cannot be forced out.

There are some disadvantages to a reverse mortgage. Those would include originations fees that can be as high as 2% of the value of the home. Other costs are the title insurance, the appraisal, and a survey. The costs are a onetime charge that could be as high as $3,500 on a $100,000 home. There can also be a monthly service charge that could run as high as $35.00 a month to maintain the loan. The rates are set by a formula by “Fannie Mae” based on the one year Treasury bill. Fannie Mae is the largest provider of collateralized mortgages obligations in the country. Lenders can provide discounts on some of the cost and services to borrowers, but rates are fixed. Another thing to consider with reverse mortgages is the effect on Medicaid. Because Medicaid is a need based program, the reverse mortgage can affect eligibility. Social Security and Medicare are not affected by reverse mortgages.

## Annuities

An annuity is a special type of contract issued by an insurance company. Most purchasers of annuities buy an annuity to protect themselves from outliving their money. Some people purchase annuities because of the income-tax deferral on the earnings. Annuities are ideal for those saving for retirement. Others purchase annuities because they guarantee a lifetime income stream. Annuities are the only product that guarantees this income stream for life. Depending on who is making the investment decision determines if an annuity is fixed or variable. Under fixed annuities, the insurance company makes all of the investment decisions and assumes the investment risks. Variable annuities allow the contract owner to make investment choices and take all the risks. Purchasers of variable annuities should have some understanding of the stock market and be willing to take investment risks. Variable contracts have no guarantees, while fixed annuities are full of guarantees as to minimum interest rates and safety of principal. Most states have an insurance guarantee fund that provides limited protection to holders of annuities and life insurance contracts. This fund protects against a company defaulting on their contracts. Most guarantee funds protect the values in an annuity for $100,000 and life insurance death benefits to $300,000. We will examine fixed annuities here because they fit the needs of the vast majority of seniors.

Deferred annuities offer some distinctive characteristics that make them especially attractive. The pay-in can be in a lump sum or in an installment plan over many years. The earnings on the money held in an annuity grow tax deferred. That feature appeals to retirees and those saving for retirement. The annuity owner pays no income tax on the earnings until they take money out. By contrast, earnings in a savings account or in a mutual fund, for example, are taxable income to that account owner in the year the money is earned. An additional feature of an annuity allows it to transfer to a named beneficiary without going through probate process when the account owner dies. This works the same way for life insurance. The proceeds pass directly to the beneficiary named in the contract and in most states protected against the claims of creditors. Because annuities and life insurance contracts are agreements between the contract owner and the insurance company, the contract laws apply and not probate laws. With estates, you hear of wills being overturned in a court. Very rarely does this happen with these contracts unless the beneficiary is responsible for the death of the insured or annuitant. Most deferred annuities allow early withdrawals for long term care. This early withdrawal can be with or without penalties, depending on the contract. When an annuitant takes money out before age 59 ½, there is a tax penalty of 10%. The penalty may not apply in all cases. It is a good idea to review this with an insurance producer or the person’s accountant

Immediate annuities are purchased in one lump sum payment. The person receiving the monthly payments from the insurance company is called the annuitant. The amount of the monthly payment is based on the lump sum pay-in and the type of payout elected. Almost all annuities are lifetime annuities, which mean the insurance company makes these payments for the rest of the person's life. This payment does not change in the future because the annuitant lived longer than expected or the interest rates declined. The annuitant can elect to have the payments end at their death. The life only will have the highest payout amount. Another option is call the refund option, under this option the beneficiary of the annuitant gets any balance left after the annuitant dies. If the annuitant recovered the amount paid in, no other payment would be made. The third option is some certain period and life thereafter. Under this option the annuitant chooses the time period (10, 15 or 20 years) and the annuity paid for as long as the time selected and if the annuitant lives longer, it continues to pay. The payments end at the end of the period if the annuitant dies or as long as the annuitant lives. The typical purchaser is a person who believes they are healthy and will live longer than their friends. This is another alternative for covering the costs of long term care.

As a general rule, annuities do not require medical underwriting. Some annuities have an accelerated benefit for long term care. Those types of annuities may require some underwriting because of possible early payout. Immediate annuities should be bought by those in relatively good health.

There are a number of options in how the annuitant gets money out of an annuity. The first option is life only. Under this option, the annuitant gets a larger check for as long as they live. Under this type, at death, the beneficiary gets nothing. The second option is life with period certain. Under this type, the annuitant is guaranteed a money check for their life. If they die before the end of the period (10, 15 or 20 years), their beneficiary gets the check for the time left. The longer the period certain, the lower the monthly check. The third option is refund option. With this option, the beneficiary is guaranteed the balance of the money paid into the annuity after the annuitant dies. If the annuitant got all of the money in monthly checks, the beneficiary gets nothing. The fourth option is a fixed amount option. Under this option, the annuitant gets an equal amount each month until the principal plus the earnings are gone. Higher the interest rate results in a longer pay out period. The earnings are based on current interest rates and are subject to change. The last option is the fixed period option. Under this option, the time period for monthly checks is stated and the size of the checks will depend on the current interest rates versus the rates at the time it is written. Under these last two options, a person can outlive their money.

Long Term Care rider can be added to an annuity contract. This rider requires a period as a resident in a nursing home like 90 days and the patient must make a written request for this benefit. In place of a structured payout, the insurance company pays the monthly charges of care as care is received. The insurer sends a statement each time a payment is made on behalf of the insured showing the change is the value of the annuity.

## Life Insurance

Life insurance offers lots of flexibility. There are two types of life insurance, term and permanent. Since term insurance builds no cash value, it is pure protection only. Term insurance can be bought for a flat premium for one to 30 years. Term can be best compared to renting a house. If you rent a house for 5 years and move, you get nothing back. Most insurance companies allow term policy owners to convert their term coverage to a cash value policy without any medical questions or examination. At initial purchase, term insurance is the cheapest form of life insurance. The longer the period of coverage, the more expensive it becomes. At some point, the insured will have to renew the term contract at their present age. Coverage gets more expensive as a person ages and at some point in time, the policy will terminate. This termination occurs because the insured can no longer afford the premium, or at some point the policy is not renewable after some stated age. Insured are unwilling to pay $80,000 a year for a $100,000 death benefit.

Permanent insurance costs more at first than term insurance. The primary reason is the cash value benefit in a permanent plan. There are some permanent needs for life insurance like final expenses and estate taxes. In the short run, whole life is the most expensive type of life coverage. The insurance company figures the rates based on a fixed interest earned on investments, an assumed expense rate, an expected profit, an expect rate of death and the knowledge that the policy matures at age 100. The insurance company’s profit is based on those assumptions. If the investments do better than expected or expenses and death rates are lower, the company has extra profits. If the company is a mutual company, it can share those profits with their policyholders (owners) in the way of dividends. The other type of insurance company is a stock company and dividends are paid to the shareholders and not policyholders. The key thing to remember is dividends are not guaranteed. Just because a company has paid dividends for the last 20 years, does not mean it will pay dividends this year or any future years. Whole life contracts offer the strongest guarantee: These contracts guarantee the premium charged will not change and they have a guaranteed cash value that can be borrowed against with at guaranteed interest rate. If the policyowner elects to, they can surrender the policy for the cash value and the coverage ends. The premiums can be paid for a fixed number of years or as long as you live.

Life insurance offers various ways to finance long term care cost. Most insurance companies offer the following riders on permanent life insurance policies:

1. The first rider is an accelerated death benefit. The trigger for this benefit requires the insured to be terminally ill to collect. The way most contracts work is the insured can elect to receive up to 50% of the death benefit once they have been certified to be terminal. To receive this benefit, a request must be in writing. At the time of death, the previously received amount would be deducted from the death benefit. The other accelerated benefit rider provides a benefit that is payable after the insured is in a nursing home for some fixed period, i.e., 90 days. The insurance company would reimburse the insured for the cost each month and provide a statement showing the amount paid so far and the remaining amount available for long term care. The policy would still provide a death benefit in the future less any payments made to the insured.

2. Terminally ill insured could sell their life insurance policy using a viatical company. A viatical company purchases the policy from the insured for a sizable discount off of the death benefit. Making the premium payments on the policy becomes the responsibility of the viatical company. The beneficiary has nothing coming at death. The company will collect the benefits when the person dies. The insured receives a lump sum based on their life expectancy and their medical condition. The amounts paid to the policyholder can be below 50% of the death benefit. Before using a viatical company, learn what the accelerated death benefit rider on that particular policy provides at little or no cost. These viatical contracts are not reversible, so great care should be taken.

3. Similar to the viatical companies are the life settlement companies. A life settlement company buys the policy for less than the death benefit except they work with people over 65 in good health or bad health with less than 12 years life expectancy.

The National Association of Insurance Commissioners (NAIC) has set standards for viatical and life settlement companies. They are responsible for standardizing forms, regulations and policy provisions for all the states. In addition, regulations have been developed to set standards for accelerated benefits riders as well. Benefits can still vary, so it's wise to learn as much as possible about the policies, and compare those riders.

### Money Guard Concept

This approach provides life insurance with a Long Term Care Rider. The person would purchase a single premium universal life policy with $100,000. That premium would provide $166,000 of death benefit with a guaranteed cash value of $100,000 and a rider that would pay $6,000 a month for up to 72 months. If the person goes into the nursing home and the benefits paid are less than the death benefit of $166,000, the balance would be paid to the beneficiary. The cash value of the contract is reduced by the payout for nursing home care. The alternative to this idea is to purchase a single premium Long Term Care Insurance contract for a greatly lower premium than the Money Guard.

## Self-Insurance

Planning for long term care is important. There is no law that says anyone has to buy Long Term Care insurance. If there are the financial resources and determine to take the risk and to pay as cost occur, the person can pay for their long term care out of pocket. A total review of assets including the home, vacation home, money in the bank, money invested, current earnings and other assets will help determine if self-pay is possible. A person might be able to pay for the long term care, but they will need monthly income of at least $4,000 a month or more. The amount of assets needed to meet that income would be something over $1,000,000 to provide that amount without taking in to account inflation. A person may not be able to count on stocks and bonds to provide that money. The value of stocks and bonds can change overnight. All one has to look at is the change in the Dow Jones Industrial Average in the Fall of 2008 for the loss of 30% + and a similar losses in the NASDAQ. In August of 2015, the DOW 30, S& P 500 and other indexes loss over 10% of value in a month. More importantly, once the assets are used, they are gone. Without additional planning, a person must depend on the government to pay for those costs.

# Chapter 9Requirements for Long Term Care Insurance

## General

Under the Insurance Code, the minimum period of coverage is 12 months under a LTC policy. LTC policies can be issued as expense incurred, indemnity, prepaid or other basis. The policy would cover one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or person core services provided in a non-hospital setting. The services must be provided in a Medicare approved facility. Those policies are individual or group plans as well as any riders added to another type of contract, i.e., life insurance or annuity. The payment of benefits must be based on cognitive impairment or the loss of functional capacity (bathing, eating, transferring, etc).

LTC policies can be issued by an insurer, fraternal benefit societies, nonprofit health, hospital, health services corporations, prepaid health plan, health maintenance organization (HMO) or any other similar organization authorized to issue life or health insurance in Indiana.

LTC insurance cannot include coverage offered under the basic Medicare supplement coverage, basic hospital expense coverage, basic medical/surgical expense coverage, hospital indemnity coverage, major medical expense coverage, disability income coverage, accident only coverage, dread disease or specified accident coverage, or limited benefit health coverage. LTC policies may include benefits for the care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.

## Preexisting Condition

No policy issued in most states can use a more restricted defined than “Pre-existing condition”. “Meaning the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care service within 6 months of preceding the effective date of coverage for an insured person.” Once a policy is in effect for six months, no exclusion for preexisting condition is permitted. This section does not limit the amount of information requested during the underwriting process.

## Limitations

Once a LTC policy is issued, it cannot be cancelled, nonrewed or terminated on the grounds of age, or deterioration of the mental or physical health of the insured individual or certificate holder. When an existing policy is being replaced or converted, there can be no new waiting period, except when the insured voluntarily elects to increase in the benefit. In addition, no contract can be issued that covers only skilled care facility or offer lesser coverage for lower levels of care. Contracts issued in Indiana are not permitted to require prior hospitalization as a condition for being transferred to a care facility.

## The Underwriting Process

The insurer can use an application that elicits a complete health history from the applicant. The answers provided by the insured and the rest of the underwriting process will determine the availability of insurance and the pricing of the policy. Most companies will require a telephone interview with the insured. There are a number of companies that require a face to face interview to assess the applicant as part of the underwriting process. In some cases, the policy could exclude coverage or limit benefits.

## Free Look

The policyholder shall have the right to return a policy with 30 days of delivery and get a full refund of premiums paid without providing a reason for the request. That notice must be prominently printed on the first page of the policy and state the 30 day return of premium for any reason.

## Outline of Coverage for an Individual Policy

At the time of initial contact with the prospective insured, an outline of coverage must be given. This outline shall meet the standardized format set by the Director of Insurance. The form will descript in detail the benefits, exclusions, renewal requirements, how premiums can increase, waiting periods, and reductions in coverage. The outline is designed to summarize and give an overview and not the contract itself. It will state where the policy is a tax qualified long term care policy under 7708B (b) of the IRS code of 1986.

## Group Certificates

As with individual policies, group certificates must provide disclosure of benefits, exclusions, limits and reductions in coverage. A statement must direct the certificate holder to the group master policy for the contractual provisions. Any group coverage issued in another state must meet the requirements of Indiana.

## Policy Summary

The policy summary shall be delivered to the insured at the time of policy delivery. This summary will explain the benefits, limitations and exclusions. If the long term care benefit is a rider to a life insurance policy, the summary will explain the rider’s effects on future death benefits, limits of coverage, current and projected lifetime benefits. Once these benefits start for long term care, the insurer will provide a statement showing current and projected benefits, benefits remaining, changes in death benefit and cash surrender values due to the pay-out of this benefit at least once a month.

## Claim Denial

If a claim is denied for long term care benefits, the insurer shall provide a written explanation of the reason for the denial and make all information directly related to the claim available to the insured within 60 days of the written request. In the denial letter, the insurance company must provide notice to the insured that the insured has the right to file a complaint with the Department of Insurance. For the insured to get the information on the denial, the insured must make a written request to the company for that information.

## Policy Termination Values

Insurers are permitted to offer reduced benefits if the policy is discontinued or refund of the some of premiums paid. This is not required, but is at the option of the insurers to provide this benefit. If this benefit is added, the benefit must meet or exceed the state minimum requirement.

# Chapter 10Things to Consider BeforeEntering a Nursing Home

There are a number of planning decisions to be made some time in your life. Consideration must be given to health decisions and quality of life issues. We read in the newspapers from time to time about the control of medical care for some incapacitated person and lawsuits being filed by various family members because the incapacitated person did not make an advance health care directive. The person choosing to use an advanced directive states what level of care is to be given to them before the event. The person making the election can require the family and medical personnel to prolong life as long as possible. Or the person can elect to limit medical care to relieve pain and not prolong life. This only happens when it has been medically determined the person has a short time until death, and the condition is incurable and irreversible. This directive relieves the family of making that emotional decision for someone in a coma or otherwise incapacitated. It also removes any doubts as to why it is done. The wishes of the incapacitated person are stated clearly and are made long before an event. This kind of decision should be made by everybody, not just the elderly. As a matter of practice, most nursing homes ask the incoming resident if they want to make an election at the time they become a resident. This is fine for the person who has legal capacity, but what about the person with Alzheimer’s disease or an advanced mental disease? Most people never have that conversation with their parents, spouse or children. The lack of action can create heartaches, emotional trauma, unnecessary legal expenses and financial stress or ruin for the family.

Even if person has executed a Health Care Power of Attorney or Advance Health Care Directive, they still have the right to give directions to physicians and other health care providers as long as you have the capacity of doing so. These documents become effective when the person is unable to make an informed decision regarding health care. A Health Care Power of Attorney is different from a Living Will (Advance Health Care Directive) because it allows the person to appoint someone to make health care decisions for them. A Living Will only allows the person to express their wishes concerning life-sustaining procedures

As a matter of my review of current coverage with clients, I asked if the person has made a will, living will, advance health directive or medical power of attorney or estate planning. I have found asking those questions starts a discussion for the family and the person’s wants and needs. A sample document for a living will is on the next page for your review. My recommendation is to contact their attorney for legal advice as to the need and execution of those legal documents. Many producers know a number of local attorneys and can recommend several, who they have worked with in the past. Some producers provide a list to choice from and leave it up their client to contact someone on the list. Other producers do not feel comfortable about making recommendation. In that case, the recommendation is to contact the local bar association for names of local attorneys.

## Sample of a Living Will

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| --- |
| Declaration made this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2004. I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , residing in the City of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare: If at any time my attending physician certifies in writing that: (1) I have an incurable, injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration): \_\_\_\_\_\_\_\_\_ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.\_\_\_\_\_\_\_\_\_ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.\_\_\_\_\_\_\_\_\_ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative or my attorney in fact with health care powers.In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal. I understand the full import of this declaration and I am competent to make this declaration. Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_The individual signing has been known to me personally and I believe him or her to be of sound mind. I did not sign the individual's signature above for or at the direction of this individual. I am not a parent, spouse, or child of this individual. I am not entitled to any part of the declarant's estate or directly financially responsible for this individual's medical care. I am competent and at least eighteen (18) years of age. Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness One: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Two: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

### Other Considerations

It makes sense to do a review of assets. The planning process is different for single individual versus the married couple. For the single person, the options are more limited. Medicaid rules were covered in previous chapter. If the individual has assets and income to cover the first 60 months of care, there is still an opportunity to protect assets. The individual should review their options with a qualified elder law attorney. Without proper planning, assets must be used for care. Attempts to hide assets can subject the parties to civil and criminal actions by the state.

Community spouses are afforded more protection under the Spousal Impoverishment. Spousal Impoverishment Act is designed to protect the stay at home spouse from becoming poor. Information on Spousal Impoverishment was covered in an earlier chapter. A review of all assets and legal documents are in order. Key course of action is to meet with an elder law attorney, CPA, and qualified insurance professional. The level of education of insurance professionals does vary greatly. Those insurance professional with a designation of Certified Financial Planner (CFP), Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Life Underwriter Training Council Fellow (LUTCF) have the education to provide proper advice. If the person has no advisor, it is always wise to check with your family, friends or a professional organization like the local Bar Association.

# Chapter 11

# LONG TERM CARE Partnership INSURANCE

**HISTORY**

Enabling legislation for the Long Term Care Insurance Program (LTCIP) was passed in 1987. Federal approval was received in December 1991. This pilot program was offered in New York, Connecticut, Indiana and California under grant money provided by Robert Wood Johnson Foundation. The first LTCIP policies were available in May 1993. Some states passed tax legislation providing a state tax deduction for premiums paid for LTCIP policies. The Deficit Reduction Act of 2005 permitted other states to establish Partnership policies with each dollar of benefits received, one dollar is protected (aka, dollar for dollar) from Spend down requirements.

**PURPOSE**

The purpose of the LTCIP is to provide incentives for the purchase of private long term care (LTC) insurance through a partnership between the Medicaid program and private LTC insurance companies. The LTCIP helps state residents plan for their LTC needs without fear of impoverishment. The LTCIP assists the State with containing the growth of Medicaid LTC expenditures by encouraging persons to purchase private insurance. The LTCIP seeks to improve the quality of LTC insurance policies, make LTC insurance more affordable, and increase public understanding of LTC risks, costs, and financing options.

**OUTCOMES**

The desired outcomes of the LTCIP are to increase the number of citizens who are

educated about their risks and who have purchased high quality, private long term

care insurance coverage. Additionally, the LTCIP seeks to improve LTC policies

available in the state and, over time, to promote containment of State Medicaid

expenditures for long term care.

**STATISTICS**

**Companies with Partnership Long Term Care Policies**

Since LTCIPpoliciespromise benefits many decades into the future, the insurance company’s ability to meet those claims is extremely improve to the policyholders. **Listed below are the three main suppliers of ratings of insurance companies: AM Best, Moody’s and Standard & Poor’s.**

**Financial Stability Ratings – Explanation of ratings are below.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **A.M. Best Company** |  | **Moody’s** |  | **Standard & Poor’s** |
| **Superior** | A++ |  | Aaa |  | AAA  |
|  | A + |  |   |  |   |
| **Excellent** | A  |  | Aa |  | AA  |
|  | A |  |   |  |   |
| **Very Good** | B++  |  | A  |  | A  |
|  | B+ |  |   |  |   |
| **Fair** | B  |  | Baa  |  | BBB  |
|  | B |  |   |  |   |
| **Marginal** | C++ |  | Ba  |  | BB  |
|  | C+ |  |  |  |   |
| **Weak** | C  |  | B  |  | B  |
|  | C |  | Ca  |  |   |
| **Poor** | D |  | C |  |  CCC |
| **Other** |  |  |  |  | pi = Public Information only |
| **Regulatory Action** | E  |  |   |  | R  |
|  | F  |  |  |  |  |
|  | S  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  | **Rating Modifiers** | **Modifiers:** |  | **Modifiers:** |
|  | g=Group p=Pooled v=Reinsured, u=Under Review  |  | **1=High end generic category 2=Middle of generic category 3=Low end generic category** |  | Plus (+) or Minus (-): Relative standing within major rating category |

**FOR MORE INFORMATION**

The Federal government has established a website for current information on long term care with offering a planning kit and calculators. Be sure to visit [www.longtermcareinsurance.gov](http://www.longtermcareinsurance.gov).

Continuing Education Requirements for
Agents/Telemarketers of Long Term Care Insurance

Before marketing any long term care insurance product in most states, an agent must obtain 8 hours of continuing education (c.e.) in long term care and long term care insurance. Once the 8 hours are completed, in order to continue to market long term care insurance in most states, an agent must complete 4 hours of c.e. in long term care, long term care insurance, Medicaid, or the Long Term Care Insurance Program (LTCIP) every 2 years thereafter. In most states, the Long Term Care training counts against the continuing education requirement.

**\*Before marketing LTCIP policies (also known as " Partnership " policies), an agent must have completed the 8-hour traditional LTC insurance c.e. requirement.** Upon completion of the 8-hour course, an agent must then meet only traditional long term care insurance c.e. requirements (4 hours every 2 years) in order to continue selling LTCIP policies. All c.e. classes taken for long term care insurance and for the LTCIP count towards the c.e. requirement for renewing an agent's license.

**Medicaid’s Perspective of Assets & Income**

**Important Note:** The Medicaid program uses the term “resources” to mean assets. The

Medicaid program distinguishes resources and income in determining eligibility and calculating

the amount that a Medicaid recipient must contribute to medical expenses. The LTC

Partnership policy asset disregard applies to resources. Whether a resource or income is counted,

and how it affects eligibility, depends on many factors. The information below is general in

nature only. It is intended to give examples of certain types of resources and income. There are

many other types of resources and income that might affect Medicaid eligibility. The listing of an

item below does not necessarily mean that it will count toward Medicaid eligibility; depending on an individual’s circumstances, some resources and income might be exempt or unavailable for

Medicaid purposes. For a determination of a specific individual’s circumstance, the circumstance

and all related documents should be submitted to state agency handling the Medicaid for a thorough review.

**Annuities**: Prior to being annuitized, the balance is a resource. After it is annuitized,

the payments are income in the month received\*\*. Withdrawals prior to annuitization

are considered resources.

**Bank Accounts and Certificates of Deposit**: The balance on the \*first day of the

month is a resource. Interest earned is income in the month received.

**IRAs**: Balance in the account on the \*first day of the month (minus any penalty the

person would incur for early withdrawal if under age 59 ½) is a resource. Dividends

and interest earned is income in the month received. Withdrawals are considered

resources (including minimum distributions).

**Life Insurance with Cash Value**: The cash value is considered a resource.

**Mutual Funds**: Balance in the account on the \*first day of the month is a resource.

Dividends or interest are income in the month received. Capital gains distributions to

the fund’s shareholders are income. Shares that are redeemed are resources.

**Retirement Plans**: Whether it is considered a resource or income depends upon

multiple factors. Each retirement plan would need to be reviewed and considered

separately.

**Stocks and Bonds**: Balance on the \*first day of the month, based on current share

price, is a resource. Dividends are income during the month received. Shares that are

redeemed are considered resources.

\*”First day of the month” – Medicaid is concerned about the applicant’s financial picture as of the first moment of the first day of the month in which the applicant would be receiving benefits. For more information about how the date of application affects the date benefits begins; contact your local office of Medicaid.

\*\*Income earned from resources is counted as income regardless of whether it is paid directly to the

recipient or reinvested into the resource.

**Examples of Exempt vs. Non-Exempt Resources Under Medicaid Program**

**Note**: The Medicaid program uses the term “resources” to mean assets. Whether a resource is counted and how it affects eligibility depends on many factors. The information below is general in nature only and only applies to Medicaid for the aged, blind, or disabled. It is intended to give examples of certain types of resources. There are many other types of resources that might affect Medicaid eligibility. The listing of an item below does not necessarily mean that it will count/not count toward Medicaid eligibility; depending on an individual’s circumstances, some resources might be unavailable for Medicaid purposes.

**Exempt (not counted) for Medicaid eligibility purposes**

Burial or Funeral Trusts (if irrevocable AND the amount is tied to specific funeral or burial services AND the second beneficiary is either Indiana Medicaid or the individual’s estate).

Home (if any of the following live there: spouse, child under age 18, disabled or blind child, or if the recipient is expected to return home) up to the state limits of $500,000 (OR & FL $750,000).

Household furnishings

Life Insurance (if term insurance; OR if has cash value and the face value is $10,000 or less AND the beneficiary is the recipient’s estate or the funeral home)

Personal Effects (excluding collections)

Resources Protected by Using an LTC Partnership Insurance Policy

Vehicle

**Non-Exempt (counted) for Medicaid eligibility purposes**

Cash

Cash Value of Life Insurance (if doesn’t meet criteria to be considered exempt)

Certificates of Deposit

Checking and Savings Accounts

IRA’s

Money Market Funds

Mutual Fund Shares

Pension Funds (if option exists to withdraw a lump sum AND as long as employment doesn’t have to end to receive the withdrawal)

Real Property (if criteria for the home to be exempt is not met, then it must be offered for sale or rent at fair market value)

Savings Bonds

Stocks and Bonds

**NOTE: The asset protection earned by using an LTC Partnership policy is meant to protect the countable assets of the policyholder (since the exempt assets are already not counted by Medicaid).**

**Closing Medicaid Eligibility Loopholes**

**Annuities**

The purchase of an annuity within the 5 year look back period will result in a transfer penalty unless the annuity is:

- Actuarially sound (repay purchase price within life expectancy)

- Issued by a commercial entity or a nonprofit organization

- Have substantially equal monthly payments (vary by 5% or less per year)

Requirements apply to annuities purchased or annuitized on or after February 8, 2006.

[This regulation’s intent was to shut down the practice of purchasing an annuity with a minimal monthly payout with a large lump sum final payment.]

**Transfer of Income (DRA of 2005)**

- A penalty will be imposed for renting property for less than fair market value.

- A penalty will be imposed for transferring income streams, including income-producing property if the transferor doesn’t retain the income.

- Transfers between spouses are allowed.

- Partnership protected assets may be transferred, once protected, without penalty.

Applies to transfers taking place, or leases entered into or renewed, on or after February 8, 2006.

**Transfer Penalty for Inaction**

- Failing to take action to receive assets to which an individual is entitled is considered a transfer. (Example – failing to elect to take the spousal share of an estate)

-No penalty will be imposed if: (a) the individual is unaware of his/her right to receive assets, (b) individual is not competent and has no guardian to act on his/her behalf, (c) taking action is not cost-effective, (d) for a surviving spouse if the deceased spouse made other equivalent arrangements to provide for the surviving spouse.

**U.S. Savings Bonds**

As of February 2006, savings bonds are considered to be available and thus countable resources for Medicaid eligibility purposes beginning on the date of purchase.

In addition to the above rules, the legislature passed the following law:

**Liens**

Medicaid was given authority to place a lien on the real property of a Medicaid recipient who is in a nursing facility or other institution and is not expected to return home. The lien is enforced if the property is sold or upon the death of the Medicaid recipient. No lien is permitted if any of the following people reside on the property:

• recipient’s spouse

• recipient’s child who is under age 21

• recipient’s disabled child

• recipient’s sibling who has lived in the home for 12 months and has an ownership interest

• recipient’s parent

• any individual (other than a paid caregiver) who resided in the home for 2 years and provided care to the recipient that delayed nursing home admission.

A lien may not be enforced while the recipient is survived by a spouse, a minor or disabled child, or a parent, even if those individuals do not live on the property.

**Spousal Impoverishment Protection Law**

The Spousal Impoverishment Protection Law applies for nursing home admissions occurring on or after September 30, 1989. The purpose of the law is to allow the community spouse to keep some of the couple’s income and assets while still qualifying the nursing home spouse for Medicaid.

A "snapshot" is taken of the couple’s assets to determine the community spouse’s share. "Snapshot" involves the couple’s assets at the time of the Medicaid applicant’s FIRST date of continuous (minimum 30 days) institutionalization (nursing facility or hospital).

When a nursing home spouse is applying for Medicaid, the couple will need to complete a resource assessment tool based upon the resources (assets) owned at the "snapshot" date AND an application for Medicaid (which asks for information about current resources). The community spouse’s share is calculated from the resource assessment tool. The nursing home spouse’s eligibility is determined from the application. Assets of a married couple are generally considered to be jointly-owned no matter in whose name they have been placed

.

ASSETS:

The community spouse is allowed to keep a maximum of HALF of the non-exempt assets up to a total of $117,240 or least a minimum of $3,448 (2014 figures).

The nursing home spouse is allowed from$999 to $2,000 (depends on the state) in non-exempt assets to be eligible for Medicaid.

INCOME:

The community spouse is allowed to keep all income that is solely in his/her name, plus half of all jointly-owned income. If his/her income does not equal at least $1750 to $2,931 per month (depend state of residency), he/she may keep some of the nursing home spouse’s income to get up to the minimum level of $1,750 to $2,931 (2014 figure) each month.

The nursing home spouse must contribute all of his/her income towards the nursing home cost except for a small amount per month for personal needs and any dollar amounts for health insurance premiums, taxes, and medical expenses not covered by Medicaid. This contribution of income towards his/her care is called his/her "liability."

### Prenuptial Agreements

Under the DRA of 2005, assets listed in a prenuptial agreement are not protected under the Spousal Protection Act if they exceed those limits. The prenuptial agreement protects assets from claims of the other spouse. For more details contact an attorney working in elderly law area.

### Divorce of Spouse

In the past, one of the planning options was for the community spouse to divorce the inpatient spouse. Under the DRA of 2005, those assets transferred within 5 years of admittance to a nursing home are recoverable above the Spousal Impoverishment limits.

**Medicaid Estate Recovery**

Medicaid estate recovery is required by federal law (Social Security Act - 42 USC 1396p)

as well as by State laws.

In cases where a Medicaid recipient dies and has an estate, the State is to file a claim against the recipient’s estate in order to be reimbursed for services it paid on behalf of the recipient when the recipient was age 65 or older. In addition, the claim includes payments for services provided to a recipient age 55 or older if the services were provided on or after 10/1/93. The claim includes the cost of all types of Medicaid services provided to the recipient.

**Assets subject to recovery**

All assets in the recipient’s probate estate are subject to recovery. Assets that were exempt (not counted) for Medicaid eligibility purposes may be subject to estate recovery. (Probate is the process by which the real and personal property of a deceased person is distributed to heirs (if there is no will) or to beneficiaries named in the will.) Some assets outside of the recipient’s probate estate are subject to recovery.

**Assets not subject to recovery**

Proceeds of a life insurance policy or annuity.

The some states can exclude jointly-held real property with rights of survivorship or other income generating property.

Real estate used for the support, maintenance, or comfort of the surviving spouse, dependent child under age 21, or a dependent that is non-supporting due to blindness or disability.

Personal effects, keepsakes, and ornaments of the deceased.

***Assets protected by the use of a long term care partnership insurance policy***.

**Filing of a Claim**

There is no time limit as to when the State has file its claim. However, it is still important for claims to be filed in a timely manner. Most estate recovery efforts do not involve court proceedings. Court proceedings usually occur for estates valued at, or greater than, $25,000.

The State may waive its claim against a deceased recipient’s estate if enforcement of the claim would result in undue hardship for the survivors. Basically, “undue hardship” means the survivors would become eligible for public assistance if the State enforced its claim.

**Other points about LTC Partnership Policies**

Medicaid asset protection is a feature found in Long Term Care Insurance Program insurance policies (better known as “ Partnership policies”). Medicaid asset protection allows you, the policyholder, to keep more assets than normally allowed when, and if, you need help with long term care from the Medicaid program. Only assets—not income—are protected.

**Using a 5% Compounding Interest**

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| --- | --- | --- | --- | --- | --- | --- |
| **Total**  | **Premiums**  | **Paid\* &** | **Value of** | **Benefits** | **At Age** |  **85** |
| **Purchase age** | **45** | **55** | **60** | **65** | **70** | **75** |
| **Annual Premiums** | **$556** | **$765** | **$989** | **$1,410** | **$2,237** | **$3,575** |
| **Total Premiums paid to age 85** | **$47,620** | **$48,300** | **$54,494** | **$60,380** | **$67,747** | **$63,715** |
| **Value of Benefits at age 85** | **$513,919** | **$315,502** | **$247,204** | **$193,691** | **$151,762** | **$118,909** |
|  |  |  |  |  |  |  |

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**\*** Premiums can increase in the future, but only with approval from the Department of Insurance, and only on a class basis.

The policy in the above example is a Partnership comprehensive policy (covers nursing home care, assisted living and home and community based care) providing an initial maximum benefit of approximately $75,000. The daily nursing home benefit is $100 per day with a home/community care benefit of $100 per day. The policy has an elimination period of 45 to 60 days. At $100 per day, the policy would pay benefits for approximately 21 months in a nursing home. The average cost of nursing home care in 2008, is approximately $69,715 per year ($191 per day).

The above example is for illustration purposes only and is based on an average of representative insurance policies available. The actual premiums for a specific individual may be higher or lower depending on the specific benefits contained in the policy, the age at purchase, the elimination period, the underwriting standards, and the insurance company from which the policy is purchased.

**Long Term Care Insurance Program**

**Medicaid Asset Protection**

**STEP 1**

**Make sure you purchased a Partnership policy.**

Check the front page of your policy for information that appears as follows:

This policy qualifies under the Indiana Long Term Care Insurance Program for Medicaid Asset Protection.

This policy may provide benefits in excess of the asset protection provided in the Indiana Long Term Care Insurance Program.

**STEP 2**

**Amount of Coverage Initially Purchased.** Turn to the schedule page in your policy. The schedule page shows the policyholder's name, the policy's effective date, the policy number, and the specific amount of benefits you purchased.

**STEP 3 Policy Benefits Used.**

**Notes:** (1) If a person bought an unlimited maximum benefit, you will earn dollar-for-dollar asset protection because you will not use all the policy benefits due to it paying benefits as long as you need care. (With an unlimited maximum benefit, your odds of ever needing Medicaid assistance are reduced.)

(2) If a person purchases a fixed benefit amount. The policy provides a dollar-for-dollar asset protection in the following situations:

a. Reduction in Benefits. If you choose to reduce your policy benefits to an amount less than the fixed benefit amount, the person will earn dollar-for-dollar asset protection.

b. Sharing Benefits. If you and your spouse purchased Partnership coverage that allows you to share your maximum benefit (through one policy that you both own jointly or through two individual policies with a rider that allows you to access each other’s benefits):

1. One spouse may use all of the benefits, leaving no coverage and no asset protection for the other spouse.

2. If one spouse uses benefits (but not all of them), and the dollar amount of remaining benefits for the second spouse is less than the State-set dollar amount for the year when the first spouse stopped using benefits, the second spouse will earn dollar-for dollar asset protection.

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| **Risks and Costs**  |
| Long term care is a range of services provided to people who either need ongoing help with activities daily living (bathing, dressing, eating, toileting, continence, transferring) due to a chronic condition or limited ability to function; or, need continual supervision to ensure the safety of themselves or others due to a cognitive impairment.Risks of needing long term care:* For persons who turned age 65 in 2008, 43% will enter a nursing home at some point in their lives. Women are at higher risk than men, with slightly more than half entering a nursing home at some point in their lives.
* Single persons are five times more likely to need nursing home care than are married persons.
* Approximately 85% of nursing home residents are women.
* Of those who enter a nursing home, 55% will need care for at least one year. One in five will need care for five or more years.
* As of January 1, 2006, 2 million people were receiving care in approximately 16,800 nursing homes in the U.S.
* Over 40% of Americans receiving long term care are under age 65. Ten percent of nursing home patients are under age 65.

Costs of long term care: * The average cost of nursing home care in 2008, is $69,715 per year. With an average length of stay of 2.5 years, the average cost for a nursing home stay is more than $195,000 for a shared room.
* The average cost for a home health nurse (RN) is $38.29 per hours. The average cost for a home health aide is $11.68 per hour. The cost for a home health aide to provide assistance for four hours a day, five days per week would cost approximately $22,000 annually.
* **Medicare** pays less than 10% of nursing home costs.
* **Medicare** was not designed to pay for long term care. Therefore, strict requirements exist in order to qualify for **Medicare** coverage for nursing home care. For instance, a person must:

(a) be in a hospital 3 days prior to discharge before being admitted to the nursing home(b) be admitted to a Medicare-certified facility(c) be placed in a Medicare-certified bed(d) need daily skilled care (care provided by a licensed nurse or therapist).Should a person meet these requirements, **Medicare** will pay 100% for the first 20 days of nursing home care. From day 21 to day 100, **Medicare** pays everything except for $133.50 per day in 2009 (this figure usually increases each year) which the person must pay. **Medicare** stops paying after day 100. If the patient shows no improvement during those 100 days, the benefits will stop at that point.* More than one-third of all nursing home care is paid for by individuals directly out-of-pocket.
* Although half of all nursing home care is paid for by **Medicaid**, an individual must "spend down" his/her assets to the poverty level ($999 to $2,000 varies by state) to qualify for assistance.

The following industry data compiled by the American Association for Long-Term Care Insurance from leading LTC insurers.   Data may be used when properly sourced to: "American Association for Long-Term Care Insurance, 2015-16 LTCi Sourcebook."  Policy data is based on 2014 applicants for individual policies.* **8 Million Americans are protected with long-term care insurance.**
* **400,000 new Americans obtain LTC insurance coverage in 2007.**
* **$3.5 Billion in LTC insurance claims paid (2007).**
* **180,000 individuals received LTC insurance benefits (2007).**
* **$1 Million claim benefit for a single individual surpassed.**

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| **Ages When People Apply** |
| Under35 | 5.3% |
| 35-44 | 6.5% |
| 45-54 | 25% |
| 55-64 | 55.2% |
| 65-74 | 7.8% |
| 75orOlder | .2% |
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| **Daily Benefit Amount** |
| Less than $50 | 5% |
| $50 - $99 | 10% |
| $100 - $149 | 35% |
| $150 - $199 | 33% |
| $200+ | 21.5% |
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| **Elimination Period** |
| 20 - 30 Days  | 0.2% |
| 31 - 89 Days  | 1.5% |
| 90 - 100 Days | 93% |
| 100+ Days  | 4.7% |

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| **Benefit Period** |
| 1 Year | <.2% |
| 2 Years | 7.8% |
| 3 Years | 40.2% |
| 4 Years | 19.5% |
| 5 Years | 13.3% |
| 6-10 Yrs  | 18.9% |
| Lifetime | 0.1% |

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| **Age of Claimant For New Claims Opened In 2014** |
| Under Age 50 | 0.5% |
| Age 50 – 59 | 2.5% |
| Age 60 – 69 | 9.5% |
| Age 70 – 79 | 32.3% |
| Age 80+ | 55.2% |

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| **Percentage of Claims Paid For** |
| Home Care | 43.0% |
| Assisted Living | 30.5% |
| Nursing Home | 25.7% |

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**Common Questions about Partnership Policies**

**How will you know how much asset protection you have earned?**

When you are using benefits from your Partnership policy, your insurance company will send you quarterly reports showing how much asset protection you have earned. When you have used all of your policy benefits, the company will send you a final Service Summary Report. You will need the Service Summary Report if you choose to apply for Medicaid assistance. **Keep these asset protection reports with your policy.** Remember: Once you have earned asset protection, you may then do anything you with wish your protected assets.

**What happens if you use all of your Partnership policy benefits and still need long term care services?**

If you continue to need care after you have used your policy benefits, you may choose to apply for help from Medicaid. During the eligibility process, Medicaid will not consider from your assets an amount equal to the amount of asset protection you have earned. By using a Partnership policy, you have earned asset protection, not income protection.

Medicaid is a federal and state-funded medical assistance program. It pays for long term care services for persons who meet certain guidelines.

**Eligibility**

Eligibility for Medicaid is not automatic. You, or someone on your behalf, must apply for Medicaid. You must be living in Indiana at the time you apply for help from your state Medicaid. (see “Important News” on the next page.) You must also your state Medicaid eligibility criteria in effect at that time. You will need to bring your Service Summary Report with you when you apply. This report will indicate the amount of asset protection you have earned by using your Partnership policy.

**Once You Are Eligible**

Once you are eligible to receive Medicaid benefits, you must continue to live in State while receiving this assistance. The types of services you receive under Medicaid may be different from the services you received under your Partnership policy. You may receive more services under Medicaid than you did under your Partnership policy (example: coverage for prescriptions). However, there may be some services you received under your Partnership policy which are not available under Medicaid (example: assisted living is not currently covered under Medicaid). Medicaid may require that part of your income be used toward your care. Medicaid determines the amount of your income contribution based upon your individual circumstances (i.e. living in your own home or a nursing home, single or married, etc…)

Premiums paid for Partnership policies may be deducted on your state tax return. Please read your state Tax Return Instruction Booklet for more details, or consult with your tax advisor.

 Reciprocity agreement exists between all the partnership states except for New York Connecticut, Indiana and California Medicaid programs. This means that each of these states’ Medicaid programs can honor asset protection earned under the other state’s Partnership policies. Asset protection honored under a reciprocal agreement will be on a dollar-for-dollar basis only.

Important News from Medicaid

For an application or more information on Medicaid, contact the local Office of Family and Children in the county where you live.

For information about the particular policy you own, contact either the insurance company listed on your policy or the insurance agent who sold you the policy.

The Long Term Care Insurance Program is also known as the "Partnership."

Partners are:

Public Sector

- Your state thru the Departments of Medicaid & Insurance

Private Sector

- Long Term Care Insurance Companies

- Agents (producers)

State adds unique benefit to Partnership policies: **Medicaid Asset Protection**.

This State-added feature does not affect the price of the policies.

Medicaid Asset Protection: *a minimum of $1 of asset protection is earned for every $1 of benefits used* under a Partnership policy. The $ amount of asset protection earned would be disregarded when determining the person's eligibility for Medicaid assistance. *Note: This is asset protection; not income protection*.

Comprehensive coverage, which companies must offer, includes nursing home and home & community-based care. Facility-only policies provide coverage for only institutional care.

Benefits in the policy may be used in any state. However, to receive the Medicaid Asset Protection, the person must return to their home state\* when needing Medicaid assistance. (\*Or live in a state that has a reciprocal agreement). The following exempt states have no reciprocal agreement and they are: CT, NY, IN and CA.

All participating companies must have a policy available with a maximum benefit equal to one year of nursing home care at the minimum daily benefit. However, companies may offer any additional maximum benefit options they desire.

 LTCIP policies may include inflation protection at some stated percentage compounded annually in order to make the policy benefits meaningful over time. This benefit varies between the states.

All LTCIP policies use a state-defined benefit trigger. Therefore, comparison shopping between policies is easier for potential purchasers.

Federally tax-qualified LTCIP policies are available.

LTCIP policyholders may be able to take an tax deduction for premiums paid.

**2015 Figures**

**MEDICARE**

Part A: Hospital deductible - $1,260 per benefit period

Hospital co-insurance for days 61 – 90 - $304 / day

Hospital co-insurance for days 91 – 150 - $608 / day

Skilled nursing facility co-insurance

Days 21 – 100 - $157.50 / day Nothing after 100 days.

Part B: Premium - $109.40 / month

Deductible - $147/ year

**MEDICAID (see the chart in Medicaid Chapter)**

**Financial criteria for the Aged, Blind and Disabled**

Individual Couple

Income: $ varies / month $ varies / month

Countable Assets: $1000 to $2000 varies by state

**Spousal Impoverishment Protection Law**

**When one spouse is institutionalized and the other remains in the home:**

Income for \*Community Spouse = minimum of $varies / month

Income for Institutionalized Spouse = all goes towards care except for $52 / month

Known as the “personal needs allowance”

Countable Assets for Community Spouse = minimum of $23,448 (2014)

Maximum of ½ of the couple’s assets up to $117,240 (2014)

Countable Assets for Institutionalized Spouse = must be spent down to $1,500

\*”Community” spouse also means a spouse living in an assisted living facility.

**STATE PARTNERSHIP**

Minimum daily nursing home benefit - $50 (varies by State)

State-set dollar amount for total asset protection – benefits received

**HIPAA FEDERAL TAX DEDUCTION LIMITS**

**Health Insurance Portability and Accountability Act of 1996**

**(HIPAA)**

**President Clinton signed into law the HIPAA on August 21, 1996.**

The Act states that long term care insurance will be treated in the same manner as health and accident insurance is treated under the Federal Income Tax Code.

This means that *Benefits* paid by a policy will **not** be counted as taxable income to the policyholder; and *Premiums* paid for "tax qualified" policies can be counted as a non-reimbursed medical expense for those itemizing their deductions for federal income tax purposes. The Act's provisions only apply to what the Act defines as "Qualified Long Term Care Insurance Contracts."

**A "Tax Qualified" policy is:**

Any policy issued **prior to January 1, 1997**. These policies are grandfathered under the Act. For group policies, if the master policy was issued prior to 1997, then it is grandfathered. This means all certificates issued under the group policy, even after January 1, 1997, would be considered tax qualified certificates (as long as the master policy does not change to add additional benefits; see last pointin document). Policies issued **after January 1, 1997** must meet a set of standards described in the Act in order to be "Tax Qualified" policies. This has resulted in most, if not all, insurance companies revising and re-filing their policies for Indiana Department of Insurance approval.

Premiums paid by an employer for a "Tax Qualified" policy will be deductible from the employer's federal income tax. However, long term care insurance *cannot* be included as part of an employer's cafeteria benefits plan or flexible spending arrangement.

The Act provides the following schedule for how much of the insurance premium can be applied as an unreimbursed medical expense for the Federal tax purposes:

**2014 Taxable Year Premium Limitation**

|  |  |
| --- | --- |
| **Age Group** | **Includable Premium Amount for 2014** |
| Age 40 and under | $360 |
| Age 41 to 50 | $680 |
| Age 51 to 60 | $1,360 |
| Age 61 to 70 | $3,640 |
| Age 71 and over | $4,550 |

Individuals can use their actual premium amount up to the limitation noted in the

chart. The Premium Limitation amounts will be increased annually by an amount

equal to the medical care cost component of the Consumer Price Index.

For **self-employed**, the deduction is the same as any other health insurance. If the business paid the premium, and then the deduction for tax year 2009 is 100%. *(Eligible premium is the actual insurance premium subject to the age limits in the chart above.*

*Example: If the premium paid during 2009 was $600 and the individual was 45, the 100% deduction would apply to the maximum limit allowed for a 45 year old which is $450. Therefore, $450 would be the deduction.)*

 The deduction under the Act **is not a straight tax deduction**. In order to benefit

from the tax deduction, an individual must: Itemize their deductions and have an amount of non-reimbursed medical expenses that **exceeds** 7.5% of their Adjusted Gross Income. The amount a person can use for a deduction is the amount exceeding the 7.5% figure.

The deduction is effective starting with premiums paid in calendar year 1997.

Payments made for "Qualified" long term care services, as defined in the Act, can be counted as an unreimbursed medical expense for federal income tax purposes.

Therefore, co-payments and deductibles paid by an individual out of their own

resources can be counted towards the 7.5% figure noted above.

The major differences found in tax qualified policies consist of changes to the benefit triggers, the addition of an *offer* of a nonforfeiture benefit, and the prohibition of these policies paying benefits at the same time as Medicare is paying benefits. This latter point includes the prohibition of policies paying benefits to cover the Medicare copayments. In addition, services received must be "qualified long term care services" required by a "chronically ill individual" and are provided according to a plan of care prescribed by a licensed health care practitioner.

 The Act defines these services as necessary diagnostic, preventive, therapeutic,

curing, treating, mitigating, rehabilitative services, and maintenance or personal care services.

Under the Act, benefit triggers are used as a means of defining when the

policyholder is considered a "chronically ill individual." *Note: Medical necessity is no longer an allowable benefit trigger.* Benefit triggers are:

***Activities of daily living (ADL)*** *trigger* - The individual is unable to perform (without "substantial assistance" from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity. Activities of daily living are: bathing, continence, dressing, eating, toileting, transferring. At least 5 ADLs must be used in tax-qualified policies. *Tax Qualified Indiana Partnership policies must use a 2 of 6 ADL trigger.*

***Cognitive Impairment***- The individual requires "substantial supervision" to protect such individual from threats to health and safety due to "severe" cognitive impairment. The individual must be re-certified annually as being a chronically ill individual.

The licensed health care practitioner who is prescribing a plan of care must certify the person meets the ADL trigger now and will continue to meet the trigger for the next 90 days. If the person is certified as needing care for at least 90 days, then his/her health improves dramatically and is discharged from care prior to 90 days, the person is *not* penalized for the licensed health care practitioner's error in judgment.

According to Interim Guidance issued by the U.S. Department of Treasury, May

1997, substantial assistance means both hands-on and standby assistance. Hands on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. Standby assistance means the presence of another person within arm's reach of the individual which is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

Under the Interim Guidance, May 1997, substantial supervision means continual

supervision (which may include cueing by verbal prompting, gestures, or other

demonstrations) by another person that is necessary to protect the individual from threats to his/her health or safety. Severe cognitive impairment means a loss or deterioration in intellectual capacity that is (a) comparable to Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory; orientation as to person, place, or time; and deductive or abstract reasoning.

n the Interim Guidance, May 1997, it established "safe harbors" for insurance companies when first refilling a tax qualified policy. Companies which issued policies prior to 1997 using ADL or cognitive impairment triggers, may use the standards from these policies when determining how a trigger is met (defining "needs assistance with", "needs hands-on assistance," "needs direct assistance") in their new tax qualified policies. As a result, companies have the choice, when filing tax qualified policies, of either using the new definitions for "substantial assistance, substantial supervision, and severe cognitive impairment" or the definitions they used in their pre-1997 policies. (Odds are high safe harbors will be eliminated upon the development of regulations by the U.S. Department of Treasury.) The remainder of the requirements under the Act must still be met (i.e. using at least 2 of 5 out of a list of 6 ADLS, 90 day certification by a licensed health care practitioner).

The U.S. Department of Treasury may *not* define a non-tax-qualified policy in the first regulation. They consider the process of defining such a policy as being complicated, and are unsure as to whether they have the authority to do so.

**Grandfathered Policies**

Any material change made to a grandfathered policy will cause it to lose its favorable tax status. The following exceptions are not treated as a material change:

(a) a policyholder's exercise of any right provided under the terms of the contract as in effect on 12-31-96, or a right required by applicable state law to be provided to the policyholder,

(b) a change in the mode of premium payment (for example a change from monthly to quarterly premiums),

(c) in the case of a policy that is guaranteed renewable, a class wide increase or decrease in premiums,

(d) a reduction in premiums due to the purchase of a long term care insurance policy by a family member of the policyholder,

(e) a reduction in coverage (with a corresponding reduction in premiums) made at the request of a policyholder,

(f) the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder,

(g) the addition of a rider (including any similarly identifiable amendment) to a policy issued prior to 1-1-97 in any case in which the rider, if issued as a separate contract of insurance, would itself be a tax-qualified long term care insurance contract,

(h) the deletion of a rider or provision that prohibited coordination of benefits with Medicare, and

(i) the effectuation of a continuation or conversion of coverage right provided under a group contract following an individual's ineligibility for continued coverage under the group contract.

# GlossaryLong Term Care Terms

* **AAA (Area Agencies on Aging)**: These are local non-profit agencies assisting the elderly with questions concerning available benefits.
* **Accelerated Death Benefit:** A feature of a life insurance policy that lets insured use some of the policy’s death benefit prior to death.
* **Activities of Daily Living (ADLs):** Everyday functions and activities individuals usually done without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring. Many policies use the inability to do a certain number of ADLs (such as 2 of 6) to decide when to pay benefits.
* **Acute Care**: Care provided when the patient is not medically stable. These patients require on going professional medical care to keep them medically stable for a short period of time.
* **Adult Day Care:** Care provided during the day for adults, normally at a senior or community center. They provide social, health and support services in the protected setting for seniors. Programs are designed to meet the needs of each person in a group setting.
* **Adult Foster Care**: A live in arrangement where an adult lives with and receives care from a non related person. State certification is usually required.
* **Age Restriction:** Set the ages in which LTC policies can be bought. After a certain age (example age 80) benefits are limited or can not be bought at all.
* **Alternative Care Facility**: A licensed residence other than a nursing home where services are provided. These would include hospice, assisted living facility, etc.
* **Alzheimer’s Disease:** A progressive, degenerative form of dementia that causes severe intellectual deterioration. This disease is named after Alois Alzheimer, who first described the condition in 1906. Presently, this disease is incurable.
* **Appeal:** The process used in resolving a complaint with a health provider including Medicare or Medicaid.
* **Applicant:** The person who seeks a contract of insurance for benefits.
* **Assessment**: An evaluation of the mental and or physical state of a person done by a health professional. This examination is to determine whether a person has experience the loss of cognitive skills or requires assistances with two or more of activities of daily living**.**
* **Asset Disregard**: The value of the real estate, personal property and other assets that is not exempt from Medicaid regulations.
* **Assisted Living Facility:** A residential living arrangement that provides individualization personal care and health services for people who require assistance with activities of daily living. They can range from a small home to a large apartment style complex. Levels of care and services can vary as well. Assisted living facilities offer a relatively independent lifestyle for people who don’t need the level of care provided by nursing homes.
* **Authorized Designee**: The person designed by the policyholder to receive notification of a long term care policy lapsing for nonpayment of premiums.
* **Bathing:** Washing oneself by sponge bath, in either tub or shower. This activity includes the task of getting into or out of the tub or shower.
* **Bed Reservation**: The benefit under a long term care policy that reserves a bed in a nursing home for a resident that is hospitalized. Nursing home normally charges to reserve a bed and the policy pay that charge.
* **Benefit Triggers:** Term used by insurance companies to describe when benefits are paid.
* **Benefits:** Monetary sum paid or payable based on the premiums received by the insurance company.
* **Benefit Period:** The period for which benefits are payable. This is usually stated in days or years and starts after the waiting period has been completed. The benefits may end after some fixed amount or period of time.
* **Caregiver:** An individual who provides unpaid assistance for another person needing help with activities of daily living. Typically, the caregiver is a family member or friend.
* **Care Management Services:** A professional service provided by a nurse or social worker, who may arrange, monitor, or coordinate various care services.
* **Cash Surrender Value:** The amount of money an insured is entitled to receive from the insurance company when terminating a life insurance or annuity policy. The amount of cash value is stated in the policy surrender.
* **Certificate:** The form used by an insurer to show that coverage exists under a group policy.
* **CHOICE**: An Indiana program that provides in-home services for the disabled and elderly. This program is administered by one of 16 Area Agencies for Aging. The formal name is Community and Home Options to Institutional Care for the Elderly and Disabled.
* **Chronic Illness:** An illness that is: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation, or care.
* **Cognitive Impairment:** A reduction in a person’s short or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness. These conditions differ from Alzheimer’s disease or similar forms of senility or dementia.
* **Coinsurance:** The percentage of each claim that is the responsibility of the insured to pay after meeting the deductible.
* **Community-Based Service:** Service designed to help older people stay independent and in their own homes. The Program, “Meals on Wheels”, is an example of this type of service.
* **Continence:** The ability to maintain control of bowel and bladder function. This would include the ability to perform associated personal hygiene dealing with this function (including caring for catheter or colostomy bag).
* **Continuing Care Retirement Communities (CCRC):** A retirement complex that offers a broad range of services and levels of care based on the individual’s needs.
* **Continuous Payment Option:** A premium payment option that requires an insured to pay premiums until something triggers the benefits. Premiums are usually paid on a monthly, quarterly, semi-annual, or annual basis. The policy is not cancelable except for nonpayment of premiums. The insurance company can increase premiums on an entire class of policies under the guaranteed renewable policies. Premiums are normally lower than limited pay policies.
* **Co-payment (aka Co- Insurance):** A fixed dollar amount paid for each medical service received. Example: When visiting the doctor, the fee would be $20, paid by the patient.
* **Custodial Care (Personal Care):** Care to help individuals meet activities of daily living such as bathing, dressing, and eating. Someone without professional training can provide the care.
* **DDARS**: The division of Family and Social Services Administration responsible for providing services to the elderly and disabled. The formal name is The Indiana Division of Disability, Aging and Rehabilitative Services
* **Daily Benefit:** The benefit stated in dollars a person chooses to buy for long-term care expenses.
* **Deductible:** A fixed dollar amount that is the insured’s responsibility to pay before the insurance company begins to pay for medical expenses.
* **Dementia:** Deterioration of intellectual faculties due to a disorder of the brain as determined by a physician.
* **Disability Method:** Method of paying benefits requiring the insured to meet the benefit eligibility criteria. Once qualified, the insured receives full daily benefits.
* **Dressing:** Putting on and taking off clothing and any necessary braces, fasteners, or artificial limbs.
* **Durable Medical Equipment**: Equipment and supplies that permit a person to maintain functional ability. These would include wheelchairs, hospital beds and walkers to name just a few.
* **Durable Power of Attorney**: A legal document providing another person to act on behalf the grantor (the one giving the power of attorney) if the grantor becomes incapacitated and end at the time the disability ends. The power can be full or limited depending on the wording.
* **Eating:** The act of getting food into the body from a plate, cup, or table. This would include a feeding tube or intravenously injections and cleaning them.
* **Elimination Period: T**he length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period on a policy, the lower the premium. It is also known as a waiting period.
* **Exclusion:** Aspecific condition not covered under an insurance policy.
* **Expense-Incurred Method:** The insurance company must decide if you are eligible for benefits and if your claim is for eligible services. The policy or certificate will pay benefits only when the insured receives eligible services. Once insured has incurred an expense for an eligible service, benefits are paid. The coverage will pay for the lesser of the expense incurred or the dollar limit of the policy. The most policies today use the Expense-Incurred Method.
* **Extended Term Benefits:** Full benefits are provided for a reduced time period after policy lapses. Once the period has expired, the contract terminates.
* **Guaranteed Renewable:** An insurance policy cannot be canceled by an insurance company and must be renewed when it expires, provided the benefits have not been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than nonpayment of premiums. Changes in health conditions, marital or employment status do not affect the benefit level. In a guaranteed renewable policy, the insurance company may increase premiums, but only on an entire class of policies, not individually.
* **Hands on Assistance:** Requires physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activities of daily living.
* **Health Insurance Portability and Accountability Act (HIPPA):** Federal health insurance legislation passed in 1996. Policy qualified for certain tax benefits and allows, under specified conditions, Long- Term Care insurance policies can qualify.
* **Health Maintenance Organization (HMO):** A prepaid health plan with a monthly premium and the HMO covers all the costs of medical care within a defined network. The patient chooses a primary care doctor who coordinates all of the patient’s care. The primary care doctor must give referrals to specialist for the patient to see them.
* **Home Health Aids:** A paid individual who assists an older person with activities of daily living and other household tasks like cooking, washing and cleaning.
* **Home Health Care:** Services for medical, social worker, home health aide, and homemaker services are covered. In addition, services provided include occupational, physical, respiratory, speech therapy, or nursing care.
* **Homemaker Services:** Household services done by someone else, because the patient is unable to do household chores.
* **Home for the Aged:** A term for a facility that cares for elderly people. Also called Rest Home and not generally covered under a Long Term Care policy.
* **Hospice Care:** Care provided at home or in a facility with a homelike setting for terminally ill people. A terminally ill person is eligible for this benefit if their life expectancy is six months or less.
* **Independent Living Centers:** Centers that are community bases offering all types of services to those individuals with disabilities.
* **Indemnity Method:** The benefits are a set dollar amount and are not based on the specific service received or on the expense incurred. The insurance company decides if benefits are eligible. Once the company has determines insured is eligible. Benefits are received eligible long term care services; the insurance company will pay that set amount directly to the insured up to the limit of the policy.
* **Instrumental Activities of Daily Living (IADLs):** Those tasks requiring assistance of another person. These would be daily management of medicines, money management, shopping, cleaning of the home and cooking.
* **Lapse:** Termination of a policy when a renewal premium is not paid within the grace period or the benefits have been exhausted.
* **Lifetime Maximum**: The maximum dollar amount paid during the lifetime of the policyholder.
* **Living Will:** A legal document setting the person’s wishes in advance and directs the level of the use of life-sustaining procedures in the event the person is terminally ill or has experience an injury that would leave the person incompetent.
* **Medicaid:** A joint federal/state program that pays for health care services for the poor or those with very high medical bills relative to income and assets.
* **Medicare:** The federal program providing hospital and medical insurance to people aged 65 or older and having a certain illness or disabled persons. Benefits are limited for nursing home and home health services.
* **Medicare Supplement Insurance:** A private insurance policy that covers many of the gaps in Medicare coverage (also called Medigap insurance coverage).
* **Medigap Insurance:** Policies designed to pay what Medicare doesn’t. There are nine standard forms of coverage (A to J).
* **National Association of Insurance Commissioners (NAIC):** Membership organization made up of state insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.
* **Noncancelable Policies:** Insurance contracts where rates and benefits are guaranteed for the lifetime of the policy and cannot be cancelled by the insurance company.
* **Nonforfeiture Benefits:** A feature of a policy that returns part of the premiums to policyowner if they cancel their policy or quit paying premiums. The refund would be offset by benefits received.
* **Nursing Home:** A licensed facility providing general nursing care to those who are chronically ill or unable to take care of their daily living needs is often referred to as a Long Term Care Facility.
* **Older Americans Act (OAA):** Legislation establishing federal Administration on Aging in 1965. Federal funding is provided to state governments to run aging related services. OAA through the Area Agencies for Aging (AAA) provide services to individuals age 60 and older with the “greatest social or economic need”. Those services include meals on wheels, transportation and in home assistance.
* **Out of Pocket Maximum:** The maximum amount that an insured would be required to pay in any given year after the deductibles and coinsurance payments have been made.
* **Paid-up Policy:** The benefits received under this policy will be determined based on the amount of premiums already paid. The benefits may not be the same as originally purchased.
* **Personal Care:** Care to help individuals meet personal needs such as bathing, dressing, and eating. A nonprofessional may provide care.
* **Personal Care Home:** A term for a facility that cares for elderly people. It is often not covered under a Long Term Care policy.
* **Physical Therapy:** Rehabilitation therapy increases mobility following an illness or injury.
* **Pre-existing Condition:** This term means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment. This condition for which medical advice or treatment was recommended by or received from a provider of health care service within six months of preceding the effective date of coverage for an insured person.
* **Primary Care Physician:** The general practitioner that handles all medical needs of a patient for Health Maintenance Organization or other point of service plan. As the “gate keeper”, this doctor controls access to other medical services.
* **Programs of All-inclusive Care for the Elderly (PACE)**: Combination of medical, social and long term care services for frail individuals. This program is available only in certain states under Medicaid.
* **Provider**: Any medical professional or institution that provides medical or related services to a patient.
* **Reduced Paid-up Benefits:** A nonforfeiture option that reduces the daily benefit but retains the benefit period on the policy until death. For example, a person buys a policy for three years of coverage with $150 daily benefit. If the policy lapses, the daily benefit will be reduced to $100. The exact amount of the reduction of the deduction depends upon amount of premiums paid on the policy. The benefit period on the policy continues to be three years. Unlike extended term benefits which must be used in a certain amount of time after the lapse, reduced paid-up benefits can be used at any time after the lapse (until death).
* **Rescind:** When the insurance company cancels (voids) a policy. When a policy is rescinded, it is as if the policy never existed.
* **Respite Care:** Provides an occasional break to the family member who is the caregiver and relieves them from daily caregiving responsibilities. This care is provided by a third party and can be for few to several days.
* **Rest Home:** A term used for a facility that cares for elderly people. It is often not covered under a Long Term Care policy.
* **Rider:** Addition to an insurance policy that changes the provisions of the policy and is a part of the policy.
* **Shortened Benefit Period:** A nonforfeiture option that reduces the benefit period but retains the full daily maximums applicable till death. The period of time for which benefits will be shorter. For example, a policy is purchased for three years of coverage with $150 daily benefit, but if the policy lapses, the benefit period is reduced to one year, with full daily benefits paid. The exact amount of the reduction depends upon the amount of premiums paid on the policy. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, shortened benefits may be used any time after the premiums lapses (until death). Another type of shortened benefit period would happen when the daily room charges are higher then the policy pays. In this case, the benefit period could be shortened to cover the full cost until the total meets the original amount under the policy.
* **Skilled Care:** Daily nursing and rehabilitative care that must be ordered by a physician and can be performed only by, or under the supervision of, skilled medical personnel. This care usually requires 24 hours a day and must follow a plan of care ordered by a physician. The individual gets skilled care in nursing home; however, this is not always the case.
* **Speech-Language Therapy**: The treatment for defects and diseases of the voice, speech, and spoken and written language including the use of substitutive devices or treatment. This would include examinations, studies or treatment.
* **Spend Down:** A requirement where an individual uses most of his or her income and assets to meet Medicaid eligibility requirements.
* **Stand-by Assistance:** Caregiver stays close to watch over the individual and to provide physical assistance if necessary.
* **State Health Insurance Program (SHIP):** Federally funded program to train volunteers to provide counseling on the insurance needs of senior citizens.
* **Substantial Assistance:** Hands on or standby help required to do ADLs.
* **Substantial Supervision:** The presence of a person directing and watching over another who has a cognitive impairment.
* **Supplemental Social Security (SSI):** A program funded by the federal government to provide additional income for certain qualified low income individuals.
* **Tax-Qualified Long Term Care Insurance Policy:** A policy that conforms to the standards set in Internal Revenue Code of 1986, Section 7702B (b) and offers certain federal tax advantages. In many states, there is a state tax credit as well.
* **Term Life Insurance:** Covers a person for a period of one or more years. It pays a death benefit only if death occurs during the policy term. Coverage stops at the end of the policy period, and premiums can increase based on current age. It generally does not build a cash surrender value.
* **Third Party Notice:** Benefit which lets the insured name someone for the insurance company to notify if the coverage is about to end because the premium hasn’t been paid. This person can be relative, friend, or professional advisor, such as a personal attorney, banker or accountant.
* **Toileting:** Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
* **Transferring:** Moving into and out of bed, chair or wheelchair.
* **Triggers (benefit triggers):** Term used by insurance companies to describe when to pay benefits for long term care.
* **Underwriting:** The process of examining, accepting, or rejecting insurance risks, and classifying those selected to charge the proper premium for each risk.
* **Universal Life Insurance:** A kind of permanent policy that lets the policyholder varies their premiums for each renewal date. The cash accumulations will vary with the amount paid in, cost of insurance and interest rates. This type of policy does not cover the guarantees a whole life contract has.
* **Waiver of Premium:** A provision in an insurance policy where the insurance company pays the premiums while insured is receiving benefits based on physical or medical condition.
* **Whole Life Insurance:** Policy that builds cash value and covers a person until age 100. The premiums can be paid over one’s lifetime or installments. Premium options include a single premium payment or a limited payment period.

# Appendix AQuestions to Ask When Choosing an Assisted Living Facility[[31]](#footnote-31)

|  |
| --- |
| **Contracts, Costs and Financing** |
| What is the monthly fee? What is not included? |  |
| Can the fee change? When, how often and why? How are you involved and what notice is given? |  |
| Does the contract clearly describe the responsibilities of the home and the resident? |  |
| Can you make changes in the contract? |  |
| What is the grievance procedure? |  |
| **Admission, Discharge and Transfer** |
| What kind of assessment is done to determine your needs? What are the qualifications of the person conducting the assessment? |  |
| Are there limits to the amount of care you can receive? |  |
| What are the reasons for discharge? Who makes the decision? What notice is given? |  |
| How does the facility assist you if you need to be discharged? |  |
| What happens if your funds run out? Is there any financial assistance? |  |
| **Independence and Risk** |
| What if you want an exception to a policy, e.g. skipping breakfast? |  |
| What if you refuse meals or don't want to adhere to a special diet? |  |
| What if you are confused and refuse meals or meds or wander the neighborhood? |  |
| What if you don't like the staff person assigned to you or the people at your table? |  |
| What input do you have in activity and meal planning? |  |
| **Services and Responsibilities** |
| Is there a set schedule for help with such needs as bathing and dressing? Can it be changed? |  |
| How is staff scheduled to meet emergency or unplanned needs like incontinence, unexpected outings, or unanticipated problems? |  |
| Who notifies the responsible party in emergencies, when toiletries need replacement, when a status change is noted? |  |
| What is your responsibility in an emergency or when your condition changes? |  |
| What is the housekeeping schedule? |  |
| Who's responsibility if there is an accident that destroys property?  |  |
| **Staff and Training** |
| How many staff are there for each shift? What are their responsibilities? |  |
| Who gives direct care? What training and certification do they have? |  |
| How many residents are assigned to each direct-care staff person? What other duties does this person have? |  |
| Is there any special training for staff to learn about dementia or Alzheimer's? |  |
| Are staff trained to deal with aggressive individuals or in behavior modification? |  |
| What kind of emergencies are staff expected to handle and how are they trained for them? |  |
| **Wellness and Health Care** |
| Is there a nurse? What are the nurse's responsibilities and hours? Who is responsible when the nurse is not on duty? |  |
| Are there regularly scheduled visits by a nurse or other health provider? |  |
| Where are records kept? Are they confidential? |  |
| Is there a plan of care? How and with whom is it developed or revised? How are you involved? |  |
| What if you don't agree with your plan of care? |  |
| What health services are available in the facility? What does the facility provide and what can outside agencies provide? |  |
| Who gives medications? If not a nurse, how are staff trained and supervised? |  |
| How and by whom is the medication system managed? |  |
| **Activities, Socializing, and Support** |
| What kinds of activities are provided? |  |
| Who develops and supervises activities? What is their background? |  |
| Are there activities outside the home? How often? How are residents transported? Are staff included? |  |
| Can you walk the grounds? Are the channels accessible? Are there enclosed walking areas? |  |
| Can religious needs be met? Are there services in the home or transportation to them? |  |
| **Meals and Nutrition** |
| What times are meals served? |  |
| What happens if you are late, miss a meal, or refuse a meal? |  |
| Can special diets be accommodated? Does the person have specific training to do this? |  |
| Does a nutritionist or dietitian review meals and special diets? If yes, how often? |  |
| **Safety** |
| What kind of security system is in place? |  |
| Which doors are locked and when? When doors are locked, how does one access the facility? Are exit doors alarmed? |  |
| Are there safety locks on the windows? |  |
| Is there an emergency generator or alternate power source? |  |
| Is there a fire emergency plan? Are there fire drills? Are emergency plans publicly displayed? |  |
| Are there call bells in each room? How often are they checked to be sure they are working correctly? |  |
| Is the home layout conducive to wandering? What safety measures are in place? |  |
| **Transportation** |
| What transportation is provided by the facility? How can special appointments be scheduled and at what cost? |  |
| Is transportation wheelchair accessible? |  |
| What qualifications does the driver have? How are these verified? |  |

# Appendix BNursing Home Checklist

**Name of Nursing Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Visit:\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Comments** |
| **Basic Information** |
| The nursing home is Medicare-certified |  |  |  |
| The nursing home is Medicaid -certified |  |  |  |
| The nursing home has the level of care needed (e.g. skilled, custodial), and a bed is available |  |  |  |
| The nursing home has special services if needed in a separate unit (e.g. dementia, ventilator, or rehabilitation), and a bed is available. |  |  |  |
| The nursing home is located close enough for friends and family to visit. |  |  |  |
| **Resident Appearance** |
| Residents are clean, appropriately dressed for the season or time of day, and well groomed. |  |  |  |
| **Nursing Home Living Spaces** |
| The nursing home is free from overwhelming unpleasant odors. |  |  |  |
| The nursing home appears clean and well-kept. |  |  |  |
| The temperature in the nursing home is comfortable for residents. |  |  |  |
| The nursing home has good lighting. |  |  |  |
| Noise levels in the dining room and other common areas are comfortable. |  |  |  |
| Smoking is not allowed or may be restricted to certain areas of the nursing home. |  |  |  |
| Furnishings are sturdy, yet comfortable and attractive. |  |  |  |
| **Staff** |
| The relationship between the staff and the residents appears to be warm, polite and respectful. |  |  |  |
| All staff wear name tags. |  |  |  |
| Staff knock on the door before entering a resident's room and refer to all residents by name. |  |  |  |
| The nursing home offers a training and continuing education program for all staff. |  |  |  |
| The nursing home does background checks on all staff. |  |  |  |
| The guide on your tour knows the residents by name and is recognized by them. |  |  |  |
| There is a full time Registered Nurse (RN)at the nursing home at all times, other than the Administrator or Director of Nursing. |  |  |  |
| The same team of nurses and Certified Nursing Assistants (CNAs) work with the same resident 4 to 5 days a week. |  |  |  |
| CNAs work with a reasonable number of residents. |  |  |  |
| CNAs are involved in care planning meetings. |  |  |  |
| There is a fulltime social worker on staff. |  |  |  |
| There is a licensed doctor on staff. Is he/she there daily? Can he/she be reached at all times? |  |  |  |
| The nursing home's management team has worked together for at least one year. |  |  |  |
|  | **Yes** | **No** | **Comments** |
| **Residents' Room** |
| Residents may have personal belongings and/or furniture in their rooms. |  |  |  |
| Each resident has storage space (closet and drawers) in his or her room. |  |  |  |
| Each resident has a window in his or her bedroom. |  |  |  |
| Residents have access to a personal telephone and television. |  |  |  |
| Water pitchers can be reached by residents. |  |  |  |
| There are policies and procedures to protect resident's possessions. |  |  |  |
| **Hallways, Stairs, Lounges, and Bathrooms** |
| Exits are clearly marked. |  |  |  |
| There are quiet areas where residents can visit with friends and family. |  |  |  |
| The nursing home has smoke detectors and sprinklers. |  |  |  |
| All common areas, resident rooms, and doorways are designed for wheelchair use. |  |  |  |
| There are handrails in the hallways and grab bars in the bathrooms. |  |  |  |
| **Menus and Food** |
| Residents have a choice of food items at each meal. (Ask if your favorite foods are served.) |  |  |  |
| Nutritious snacks are available upon request. |  |  |  |
| Staff help residents eat and drink at mealtimes if help is needed. |  |  |  |
| **Activities** |
| Residents, including those who are unable to leave their rooms, may choose to take part in a variety of activities. |  |  |  |
| The nursing home has outdoor areas for resident use, and staff help residents go outside. |  |  |  |
| The nursing home has an active volunteer program. |  |  |  |
| **Safety and Care** |
| The nursing home has an emergency evacuation plan and hold regular fire drills. |  |  |  |
| Residents get preventative care, like a yearly flu shot, to help keep them healthy. |  |  |  |
| Residents may still see their personal doctors. |  |  |  |
| The nursing home has an arrangement with a nearby hospital for emergencies. |  |  |  |
| Care plan meetings are held at times that are convenient for residents and family members to attend whenever possible. |  |  |  |
| The nursing home has corrected all deficiencies (failure to meet one or more Federal or State requirements) on its last state inspection report. |  |  |  |

# Appendix CAgencies working with Seniors

**Agency Phone**

**Administration on Aging (800) 326-3221**

**Department of Veteran Affairs (800) 827-1000**

**Medicaid (312) 353-1133**

 **rochiora@cms.hhs.gov**

**Medicare (general information) (800) 633-4227 voice**

 **(877) 486-2048 TTY/TDD**

**Medicare (Beneficiary Services) (312) 353-7180**

 **rochiora@cms.hhs.gov**

**Medicare Managed Care (312) 353-5737**

 **rochiora@cms.hhs.gov**

**Office of Civil Rights (800) 369-1019**

**Quality of Care Issues (816) 426-5746**

**Railroad Retirement Board (800) 808-0772**

**Regional Home Health Intermediary (800) 583-2236**

**Renal Disease Network (800) 456-6919**

**Social Security (Regular) (800) 772-1213**

 **http://www.ssa.gov**

**Social Security (deaf or hard of hearing) (800) 325-0778**

1. Source: U.S. Census Bureau, Population Estimates < http://factfinder.census.gov/bkmk/table/1.0/en/PEP/2013/PEPAGESEX [↑](#footnote-ref-1)
2. [www.aaltci.org](http://www.aaltci.org), based on SSA Society of Actuaries, June 2015 [↑](#footnote-ref-2)
3. Current Population Survey, Annual Social and Economic Supplement, "Income, Poverty, and Health Insurance Coverage in the United States: 2007" P60-235, issued August, 2008 by the U.S. Bureau of the Census, related Census detailed tables on the Census Bureau web site, and from Fast Facts and Figures About Social Security, 2008 Social Security Administration) [↑](#footnote-ref-3)
4. http://aspe.hhs.gov/basic-report/information-poverty-and-income-statistics-summary-2013-current-population-survey-data [↑](#footnote-ref-4)
5. Ibid. [↑](#footnote-ref-5)
6. [↑](#footnote-ref-6)
7. Data releases from the web sites of the National Center for Health Statistics (including the Health Data Interactive data warehouse, accessed 12/30/2008); from the Agency for Healthcare Research and Quality and from the Bureau of Labor Statistics web site. [↑](#footnote-ref-7)
8. Americans with Disabilities: 2005, December 2008, P70-117 and other Internet releases of the Census Bureau, the Centers for Medicare and Medicaid, and the National Center on Health Statistics, including the NCHS Health Data Interactive data warehouse [↑](#footnote-ref-8)
9. National Alliance for Caregiving and AARP, *Family Caregiving in the US, Findings from a National Survey, 1997.*  [↑](#footnote-ref-9)
10. National Alliance for Caregiving and AARP, 1997. [↑](#footnote-ref-10)
11. Administration on Aging, United States Department of Health and Human Services, Fact Sheets: Family Caregiving, 2003, [↑](#footnote-ref-11)
12. P.S. Arno, et all. *The Economic Value of Informal Caregiving,* Health Affairs, 18(2), March/April 1999. [↑](#footnote-ref-12)
13. The MetLife Juggling Act Study, *Balancing Caregiving with Work and the Costs Involved, November 1999.*  [↑](#footnote-ref-13)
14. 2012 MetLife Survey [↑](#footnote-ref-14)
15. 2012 Metlife Survey [↑](#footnote-ref-15)
16. 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Service [↑](#footnote-ref-16)
17. ibid. [↑](#footnote-ref-17)
18. ibid [↑](#footnote-ref-18)
19. ibid. [↑](#footnote-ref-19)
20. ibid [↑](#footnote-ref-20)
21. Healthcare Financing Review, 2012. [↑](#footnote-ref-21)
22. 2012 MetLife Market Survey [↑](#footnote-ref-22)
23. United Seniors Health Council, p 49. [↑](#footnote-ref-23)
24. MetLife, 2012 [↑](#footnote-ref-24)
25. MetLife, 2012. [↑](#footnote-ref-25)
26. http://www.socialsecurity.gov/oact/TRSUM/index.html [↑](#footnote-ref-26)
27. This information was reprinted with permission from Henry J. Kaiser Family Foundation. The Kaiser Foundation, based in Menlo, California, is a nonprofit, independent national care philanthropy and is not associated with Kaiser Permante or Kaiser Industries. website.www.kff.org Information for this section was condensed [↑](#footnote-ref-27)
28. Based on data from Current Population Survey, Annual Social and Economic Supplement, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," P60 235, issued August, 2008, by the U.S. Bureau of the Census and related Census detailed tables on the Census Bureau web site [↑](#footnote-ref-28)
29. United Seniors Health Council, pp. 38-9. [↑](#footnote-ref-29)
30. Information from Veterans Administration Website: http://vabenefits.vba.va.gov [↑](#footnote-ref-30)
31. Derived from the United Seniors Health Council and the Consumer Consortium on Assisted Living (web site: www.ccal.org). [↑](#footnote-ref-31)