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Additional Information

Introduction: How To Use This Guide

The Consumer's Guide To Long term Care was developed for people concerned about how to plan and provide to long term care for themselves or a spouse, parent or loved one. It contains information to help you make decisions now and in the years to come that will allow you to retain more control of your life should you need long term care. We suggest that you share the guide with your family and friends, using the information to initiate discussions about your long term care needs and financial options. Sadly, this is a subject that is often ignored until a crisis arises.

This guide is based on the premise that everyone's situation is unique. Your decisions - and those of your family members - as to what type of retirement you want or where you will live when you are elderly depend on your individual values, desires and financial circumstances. In the same way, the best long term care option for you may be different from the one chosen by another family member or friend.

The Information in this guide was prepared to:

1. Provide you with an overview of long term care issues; and
2. Answer basic questions concerning the need for long term care and how to obtain it.

We hope you will take the time to read the guide carefully. You may want to bookmark this site for future reference. As you get older, changes may occur in your life that influence what is important to you. Depending on your situation, a review of certain chapters may prove helpful. Throughout this site, you will find the names and telephone numbers of agencies that can provide you with additional information on specific topics concerning long term care. We also suggest that you consult your tax professional, attorney or financial advisor before making any final decisions relating to long term care planning.

Understanding Long Term Care

When Martha was 50 years old, she never dreamed she would be in this predicament. But, here she is at 82, lying in a nursing home with a broken hip. She has already been here for three weeks, and her doctor is not very optimistic about a complete recovery.

Martha has always been a saver. She planned for emergencies. She thought medicare would pay most of the costs; she even purchased a Medicare supplemental policy. Now, she has learned that in her case, Medicare will only pay for the first 14 days. Apparently there is rule about needing to receive therapy daily, not just once or twice a week. At $120.00 a day for nursing home expenses, her savings will be used up quickly. And then, what will she so? Most of us would like to be able to look into twenty a crystal ball to wee what our lives will be like ten, twenty or thirty years from now. Will we be healthy, or will we need care and assistance from others? Will we spend time in a nursing home like Martha? Will we need long term care?

What is Long Term Care?

Long term care is the kind of assistance you need when you need help with personal care. The need for this assistance usually results from a disabling or long term medical or physical condition. Long term care services can include in home care, as well as nursing home or community based care.

Martha is now receiving long term care in a nursing home. As she improves, she may be able to have services brought to her home - such as home delivered meals, chore worker services or perhaps physical therapy.

Will I Need Long Term Care Services As I Get Older?

Anyone may need long term care services. An accident or a sudden, serious illness can create a need for services, as can the slow progression of chronic diseases such as rheumatoid arthritis. Alzheimer's disease or Parkinson's disease. Age or frailty may also be contributing factors. People who live to be very old are more apt to need long term care services than those who die at a younger age.

In addition to age and disability, there are other factors that determine the likelihood of needing long term care.

Gender

Women are more likely to need long term care than men. One reason may be their longer life expectancy; women outlive men by about eight years. At any given time, of age 75 or over, 30 percent of women, but only 17 percent of men, need assistance with personal care.

Marital Status

Women tend to marry men that are older. Since women also have longer life expectancies, they usually outlive their husbands. It is not unusual to see an older man being cared for by his younger wife. When a woman needs long term care services, they are more often provided by a daughter or daughter-in-law, or in a nursing home.

Only 25 percent of people who were married at the time of their death spent some time in a nursing home. In contrast, 40 percent of those who were widowed, divorced, separated or never married spent time in a nursing facility.

Functional Limitations

Women have more chronic disease that impair mobility, such as arthritis and osteoporosis, than men. Men have more acute health episodes that lead to earlier and quicker death.

Mental (Cognitive) Impairments

Mental impairment often leads to the need for long term care. People with mental impairments stay in nursing homes longer than those who only suffer from physical infirmities. Also, some families have a genetic disposition toward Alzheimer's disease, stroke or other mentally disabling conditions.

Family Circumstances/Support Systems

Whether a person can remain at home is often dependant on his or her support system. Many older people do not live near their children; their support system consists of neighbors and friends who may not always be available. If an older person does live near family, family care givers may work full time or be unable to offer as much help as is needed.

What Are the Risks Of Needing Long Term Care?

Nursing home Care:

A study on nursing home use prior to death is shown below.

Age of Death	% Who Had Used Nursing Homes Prior to Death
65 - 74	17
75 - 84	36
85 - 94	60

Note: Women are twice as men to enter a nursing home.
Source: 1986 National Mortality Followback Survey

Home and Community Care

Only a small percentage of people who need long term care assistance live in nursing homes. At ages 65 to 79, only 17 percent of those living at home need assistance; this number jumps to 28 percent for those 75 to 84 and almost half (49 percent)at age 85 plus. The most common type of assistance needed is help with walking.

What Can I Do To Reduce My Chance of Needing Long Term Care?

Some of us will need assistance with activities of daily living (ADLs) when we are very old no matter how well we take care of ourselves. Diseases such as arthritis and osteoporosis affect mobility and may lead to dependence on other people. However, recent research demonstrates that we are more in control of our own aging than previously assumed. Good nutrition and regular exercise are the key ingredients to a healthy and active old age. And the earlier we get started, the better. High fiber, low fat diets decrease the incidence of cancer, heart disease and many other "modern" ailments as well. Exercise may be equally as important as nutrition in helping us to remain active through our lifetime.

Although our muscles decrease in size as we age, weak muscles are not a normal part of aging. Elderly people who exercise have minimal deterioration in muscle tone. Walking, combined with moderate stretching exercises to retain flexibility, is by far the best exercise. Although illness or injury can affect the muscles and joints, with good medical treatment, even this damage can be greatly reduced. There is no magic treatment that allows us to stay fit. It takes determination, discipline, belief that good nutrition and exercise are worth the effort, and a little bit of luck!

Of course there are some things we cannot control. Alzheimer's and similar diseases that affect the functioning of the brain and nervous system often lead to the need for long term care. Over half of nursing home residents experience a cognitive impairment like Alzheimer's disease. Not only is this a devastating condition, but currently there is no know cure.

Planning For Long Term Care

Long term care services are available in many communities. These programs try to support older people in the most independent living situation possible. These home care services include:

- **Home health care:** from a nurse or other medical personnel
- **Personal care:** help with bathing, grooming and transferring from chair to bed
- **Homemaker services:** housekeeping, cooking and grocery shopping
- **Hospice:** support for people with terminal illness
- **Respite care:** temporary relief to care givers
- **Adult day support centers:** day care that provides recreation and social stimulation
- **Special day care:** for persons with special needs

Home care services assume that a person receiving these services has additional assistance from family or friends. When such support is not available, the individual may need to move to an assisted living facility or residential care facility to have his or her needs met. These facilities provide room and board plus personal care (help with bathing, grooming and medications) in a supervised environment. If a higher level of long term care is needed, the individual may have to be cared for in a skilled nursing facility. These types of facilities are discussed further in this guide.

How Do I Find Out About Long Term Care Services?

Information about services in your local area is available through the network of Information and Assistance (I & A) programs throughout California. These programs are funded through California's 33 Area Agencies on Aging (AAAs). The AAAs are responsible for the planning and delivery of services for older persons and persons with disabilities. (All states and US territories have similar aging networks.)

Area programs are designed to fit the needs of older people in each specific region. Through your local I & A program you can find out about the location of senior centers, senior nutrition sites, adult day support centers and adult day health care centers. Alzheimer's resource centers, "Meals on Wheels" programs, transportation, care management programs, legal services and health insurance counseling.

When Martha is ready to leave the nursing home, she and the discharge planner should discuss the services Martha will need to stay safely in her home, as well as the cost of these services. How many and what services Martha will need will depend not only on her health, but on the informal support system available to her.

If Martha needs assistance locating and contracting for services, she may want to hire a case manager - providing she has the funds to do so. The case manager can assess her needs, contract for the services and monitor their delivery.

Note: To find out about services where you live, check the telephone directory for the Area Agency on Aging (AAA) nearest you. If you are looking for services for a relative who lives out of state or in another city, the Eldercare Locator, a nationwide toll free information and referral service, can give you the telephone numbers for programs in all areas the United States. From the West Coast, this information is available Monday through Friday between 8:00am and 5:00pm by calling 1.800.677.1116.

For free health insurance counseling, contact your local Health Counseling and Advocacy Program (HICAP) listed in the front of your yellow pages phone directory under Senior Services, or call 1.800.510.2020.

What Are My Housing Options?

Depending on your preference and the state of your health, you may want to stay in your home, or you may be happier in a retirement community or apartment. If you choose to stay in your own home, it is not enough just to locate the services you need. You may also need to adapt it to your changing needs.

If I Choose To Stay In My Own Home, What Housing Modifications Should I Consider?

Safety

Safety is a prime concern. Take a look around your home. Do you need to make changes in physical environment to ensure safety? All staircases should have handrails that are sturdy and easy to grasp. Bathtubs should have grab bars and nonskid mats. Sliding glass doors on the bathtub add another inch or so over which you must step. Removing the glass doors or installing a bathtub that is much lower may be beneficial. Grab bars by the toilet may also be helpful. If climbing stairs becomes difficult, you may want to move your living functions to the first floor. Falls are a major cause of disability and/or death in the home. Throw rugs are a prime suspect in many falls and should be discarded.

If you find that you forget to turn off the burners on your stove occasionally, try using a timer as a reminder or use the microwave when you are alone.

Lighting

Many older people begin to limit their activities when they develop problems with their eyesight. Steps can be taken to reduce hazards caused by changes in eyesight. Even without eye injury or disease, an 80 year old needs three times the intensity of light to see as well as a 30 year old in similar situations. Therefore, lighting should be more intense, but without glare. Hallways, staircases and entry ways should be well lit.

Telephones

Hearing loss can be minimized by installing amplifiers on telephones and by using drapes and carpet to deaden external noise. Phones should be located in areas where they are easy to reach. A cordless phone may be one solution. Anyone living alone should have a phone by the bedside in case of emergency!

Emergency Response Systems

Another consideration for people who live alone is an emergency response system. A small unit attaches to your clothing. If you should fall or need assistance in any way, you press the alarm and a signal shows up on a screen in the emergency room of the local hospital. Some systems require a call in by certain time of each day. If a phone call is not received, someone comes out to check on you. These systems are inexpensive.
Note: Your Area Agency on Aging (AAA) should know which hospitals have emergency response systems. Before leasing or purchasing a system, talk with other users to see if they are satisfied with the product.

Support Systems

Many older people develop support systems with their neighbors. A signal, such as raising the blinds by a certain hour each day, can alert a neighbor to a problem. Most postal workers are trained to report mail that has not been picked up and other signs that a problem may exist. You can find many ways to make your environment safe, allow you to remain at home and delay the need for long term care.

If your health remains good and the neighborhood remains vital, staying in your home has many rewards. here are some financial advantages to continuing to own your own home. However, the positive aspects of staying in your home dan sometimes be outweighed by the responsibilities of home maintenance and repairs. If your health begins fail, cherished neighbors move away or the neighborhood deteriorates, the emotional cost and worry may not make this an ideal living situation.

Are There Different Types of Senior Housing?

Independent Living

Independent living includes senior retirement communities, retirement apartment buildings, mobile home parks and independent single family dwellings with built in services.

Congregate Facilities

Congregate facilities are retirement apartments where housekeeping, meals, laundry and other amenities are available.

Residential Care Facilities

Residential care facilities provide room and board, assistance with personal care and any necessary supervision. They range in size from the small, two to six bed, "mom and pop" operations to facilities with over 200 living units. They are licensed by the California Department of Social Services.

Assisted Living Facilities

Assisted living facilities are often a wing of a congregate facility. They provide assistance with personal care in addition to the services provided in the congregate facilities, These facilities are licensed by the California Department of Social Services as Residential Care Facilities for the Elderly.

Continuing Care Retirement Facilities (CCRC)

Continuing care retirement facilities are retirement communities where an individual purchases his or her own housing unit. Residents pay a one time large entry fee plus a monthly maintenance fee in exchange for the assurance of lifetime long term care. Upon entering a CCRC, a resident is required to sign a legally binding contract. Since this contract has serious financial implications, this decision should be discussed with your financial planner

and the contract reviewed by your attorney. These facilities are licensed by the Departments of Social Services and/or Health Services.

Nursing Facilities

Nursing facilities are licensed by the California Department of Health Services to provide both skilled nursing and custodial care. Residents receiving skilled nursing care are usually convalescing from serious illness or surgery and require continuous observation and rehabilitation. The most common type of care given in nursing homes is custodial care and provides assistance with activities of daily living (ADLs) such as bathing, grooming and toileting. Most residents who are receiving custodial care have cognitive impairments such as Alzheimer's disease, or they are extremely elderly and can no longer care for themselves safely at home.

Paying For Long Term Care

How Much Does Long Term Care Cost?

- Nursing home costs in California can range between $90.00 to $200.00 a day. (The average was $120.00 in 1998)
- Residential care facilities providing assisted living can cost $45.00 to $70.00 or more per day, depending on their size, location, amenities and clientele.
- A live in companion or home maker can cost $155.00 or more a day, depending on where you live. The cost is higher if you need someone with medical training.
- A visit in your home by a registered nurse can cost $100.00 or more per visit.
- A home visit by a medical social worker can cost $110.00 or more per visit.

Am I Likely to Need Care?

The Brookings Institute estimates that the average 65 year old person has a 20 percent chance of having no long term care expenses in a nursing home or at home during their lifetime. The remaining 80 percent will have some expenses.

They have:

- A 58 percent chance of having expenses between $1.00 and $50,000.00
- A 9 percent chance of having expenses between $50,000.00 and $110,000.00
- Almost a 13 percent chance of having expenses of $110,000.00 or more (in 1989 dollars)

However most nursing home stays are relatively short. Seventy five percent of people who enter a nursing home stay one year or less, and 52 percent stay less than three months.

How Much Money Will I Need To Pay for Long Term Care?

People with very high incomes who are able to pay $30,000.00 to $50,000.00 a year for their own long term care probably won't have to worry. They will have the financial resources to pay for it. They can also deduct some or all of their costs as an itemized medical expense on their state and federal income tax returns because of changes in the federal tax law.

If you have the time to save and you invest well, you might be able to save enough to pay for your own long term care. However, that might not be enough to pay for all of your costs if you should need care for an extended period of time, or if you need care before you have saved enough money.

Can I Deduct Any Of The Costs Of Long-Term Care?

Yes, if you meet all of the requirements of a 1996 federal tax law. This law, the Health Insurance Portability and Accountability Act, or HIPAA, amended the federal tax code. Some additional long-term care expenses can now be

deducted as medical expenses. California passed similar legislation allowing a medical deduction for the same long-term care expenses on state tax returns.

Some or all of the costs for personal care and homemaker services - in addition to other long term care expenses - might also be deductible as a medical expense if you meet all of the requirements of this new law. If you itemize your federal and state tax returns , you may be able to deduct certain un reimbursed long-term care costs.

All of your medical expenses must first exceed 7.5 percent of your adjusted gross income (AGI). Then you can deduct amounts that exceed that percentage. You should consult your tax advisor for more information on how this could effect you.

Will Medicare Pay For Long-Term Care?

Most long-term care is furnished in nursing homes to people with chronic, long-term illnesses or disabilities. The care they receive is personal care, often called custodial care. Medicare pays less than 10 percent of all nursing home costs. To qualify for the Medicare nursing home benefit, you must spend three full days in an acute care hospital within 30 days of your admission to a nursing home. You must also need skilled nursing care seven days a week, and/or rehabilitation services at least five days a week. Medicare will not pay for your stay if you need skilled nursing or rehabilitation therapy only once or twice a week.

The longest nursing home stay that Medicare will pay for completely is 20 days. After the first 20 days, if you still require skilled care, Medicare will pay only a part of the nursing home care bill. You will have to pay a co payment for each of the next 80 days if Medicare continues to pay for your stay.

Martha received only 14 days of care paid by Medicare. This was because it was determined during the weekly review of her Plan of Care that she no longer needed skilled or rehabilitative services.

Will Medicare Pay If I Need Care In My Home?

Yes, but only if you meet certain requirements of the Medicare program. These requirements apply whether you are in a Medicare managed care program like an HMO, or receiving traditional Medicare fee-for-service benefits. You must be homebound and require skilled nursing or rehabilitative services. The services you receive must be from a home health care agency that participates in Medicare. You may also receive some personal care services along with the skilled care services.

However, Medicare does not pay for general household services such as laundry, shopping, or other home care services that are needed primarily to assist people in meeting their personal care needs. Remember that Medicare also may not pay for all of the services that a home health agency provided.

Do Medicare HMOs Pay for Long-Term Care?

Some Health Maintenance Organizations (HMOs) have a contract with the federal government to provide Medicare covered services to Medicare beneficiaries. However, members of HMOs generally have no more coverage for a long-term care than someone with any other type of health care coverage.

These HMOs usually provide only those home health and skilled nursing facility services that are covered by Medicare. HMO members ordinarily are not required to pay co payments for these services as long as the HMO determines that their care continues to meet all of the requirements for Medicare coverage.

Does Long-Term Disability Income Insurance Cover Long-Term Care?

No. Disability Income insurance doesn't pay for medical care, personal care, or long-term care. The purpose of this type of insurance is to replace some earned income. Disability Income insurance generally pays a percentage of an employed person's earned income if they are disabled while still employed. Once you retire, you may no longer be eligible for disability income benefits. Unfortunately, because it's called "long-term" disability insurance, some people may assume they are also covered for long-term care services.

Can I Use My Life Insurance To Pay For Long-Term Care?

Life Insurance Policies With Long-Term Care Benefits

Long-term care benefits are sometimes sold as part of a life insurance policy. This arrangement allows the death benefit, sometimes called an "Accelerated Death Benefit", to be used to pat for certain long-term care services. This amount of the policy's death benefit is reduced by any amounts that are paid for long-term care services covered by the policy.

Life insurance policies with this option can be purchased with one large premium payment, or with premiums paid periodically over time. Monthly administrative fees and certain other insurance costs may be deducted from the cash value, or the interest earnings of the policy. Before any long-term care insurance benefits will be paid, the insured person must meet the eligibility rules in the policy. These policies vary widely, and the methods used to calculate the benefits are very complex.

The 1996 federal tax law, HIPAA, may allow you to deduct the portion of the premium that pays for the long-term care benefit. Any long-term care benefits you receive under these policies generally won't be taxed as income. You should consult a tax advisor for information on what you can deduct, what benefits are excluded from income, and what amounts are taxable.***Note:*** While these policies may provide an attractive combination of benefits for some people, they should not be purchased without consultation with an accountant or tax attorney.

Living Benefit Riders

Some life insurance policies can be purchased with an "advanced death benefit" or "living benefit" rider. This option allows your insurance company to pay you a reduced amount of your death benefit as a lump sum, or in periodic payments before you die. These benefits can be paid only when certain conditions are met. For example, benefits could be paid when you are diagnosed with terminal illness, when you have a major organ transplant, or if you are expected to be in a nursing home for the remainder of your life. If you meet the conditions required by the company, you can use the benefits for any purpose, not just long-term care expenses.

If your current life insurance policy does not have a living benefit rider and you want to include one, write to your insurance company and ask if your policy can be modified to include this option

Viatical Settlements

There are companies that will buy your existing life insurance policy for a percentage of your death benefit. You must meet their eligibility criteria which usually requires that you have a catastrophic or life-threatening illness. They pay you a lump sum percentage of your death benefit (usually 50 to 80 percent) and continue paying your premium because they will collect the full death benefit when you die.

These companies must be licensed by the California Department of Insurance. Medical information that is obtained when soliciting a viatical agreement must be kept confidential. Agents must tell you that there may be tax consequences when you sign on one of these contracts. If you are considering a Viatical Settlement, contact your own insurance company first. They may allow you to use some portion of your death benefit to pay for your long-term care expenses.

The 1996 tax law, HIPAA, may allow some or all of the payments from a properly executed Viatical Settlement to be excluded from your income. You should consult your tax advisor before making a final decision.

Note: If your own insurance company cannot help you , call the California Department of Insurance to make sure that any company offering a viatical agreement is properly licensed.

Can Annuities Be Used To Pay For Long-Term Care?

Annuities are insurance contracts that pay interest on the premium you pay the insurance companies. Although these may resemble a Certificate of Deposit, they are not federally insured. Annuities are offered by most life insurance companies under two types of contracts: immediate and deferred.

Immediate annuities make periodic payments for a certain number of years or until a specific event, such as your death, has occurred. If you purchased an immediate annuity, you could receive periodic payments until you die, or until the end of the contract period. With a deferred annuity, payments do not begin until a specific event occurs, such as retirement or when you reach a certain age.

Deferred or immediate annuities are sometimes purchased to create an income stream to pay the cost of long-term care. You pay one large premium up front, and the annuity begins paying then or later. Generally you will have to pay some penalty if you later decide that you want payments to begin sooner, or you want the whole amount in one lump sum. If you need long-term care before deferred annuity payments begin, some companies will waive the surrender fees if asked.

Note: You should consult a tax advisor before purchasing any kind of annuity.

Will A Living Trust Protect My Assets?

If you have a large estate, a living trust avoids the lengthy probate period. You can name yourself as the trustee with a successor who will make decisions for you if you become incapacitated. Generally, if your estate is large enough to warrant a living trust, you should have enough assets to pay for your long-term care. Assets held in a living trust will be counted in determining Medi-Cal eligibility. (See next page for information on Medi-Cal.)

The only type of trust that will protect your assets from the cost of long-term care is a irrevocable trust. However, then you would no longer have any access to your assets. For all intents and purposes the assets become the property of the trustee.

Note: Recent changes to state and federal law are placing greater restrictions on trusts when people later apply for Medi-Cal. For more specific information, check with a free legal services program in your community, your financial advisor or an Elder Law attorney.

What Is Home Equity Conversion?

For many older people, their home is their most valuable asset. "Home equity conversion" or "reverse mortgages" were developed to help older people tap into the equity of their homes. A reverse mortgage may allow you to receive monthly payments based on the equity you own. These payments could then be used to pay for the care you need and allow you to remain in your own home. The amount of monthly payments you can receive from a reverse mortgage depends on your age, the value of your home and the cost of the loan.

There are various types of home equity loans. Some are offered by the lenders through the Federal Housing Administration (FHA) or the Federal National Mortgage Association, while others are offered by financial services companies or insurance companies. Some will only continue making payments as long as you continue living in your own home; others are fixed term mortgages; while others give you a line of credit.

The FHA requires lenders to provide counseling to help you understand these loans and how they work. As with any complex financial contract, you should discuss these arrangements with your financial advisor and accountant or attorney before you enter into any one of these contracts.

How Can I Pay For Long-Term Care If My Finances Are Limited?

Medi-Cal

This is California's version of the Medicaid, a joint federal and state program for people with low incomes and few assets. Medi-Cal provides health care services to people on public assistance and to others who cannot afford to pay for these services themselves.

Medi-Cal pays for physician-approved hospital, medical, prescription drug, and nursing home care. It also covers in-home services through the Personal Care Services Program (PCSP). PCSP uses Medi-Cal benefits to provide chore worker and personal care services at home for those who are eligible. Personal care is assistance with bodily hygiene, personal safety and activities of daily living.

Medi-Cal pays for nursing home care when a stay is medically necessary. Couples anticipating nursing home placement for a spouse need to be aware of special laws intended to prevent impoverishment of the spouse at home.

These laws allow the spouse at home to keep a certain amount of their combined income an assess when the other spouse goes to a nursing home. In 1998, the spouse at home may keep all of the couple's income up to $2,019 each month and up to $80,760 in resources. (The spouse at home can be granted more of their income, if necessary, through a "fair hearing" or by court order.)

Income allotted to the spouse in the nursing facility will go towards his or her share of cost, if any. The spouse can also keep $35 a month for personal needs and up to $2,000 in assets.

Note: The income and asset limits change each year. For more information on Medi-Cal eligibility guidelines and specific income and asset limits, contact your county Department of Social Services.

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) is a care and case management program that helps people live independently. It links older Medi-Cal eligible individuals when they need placement in a a nursing home with various health an social services in their community. For more information on the MSSP program, call 10800-510-2020.

In-Home Supportive Services

In-Home Supportive Services (IHSS) provides non-medical services to eligible aged, blind, and disabled person who are unable to remain in their homes safely without this assistance. An individual may be eligible for IHHS when they meet specific criteria related to eligibility for the Supplemental Security Income/State Supplementary Program (SSI/SSP) for the aged, blind, and disabled. The types of services available through the IHSS program are domestic and related services, such as heavy cleaning, menu planning, laundry services, meal preparation and cleanup, and reasonable shopping errands. The IHSS program is administered by county departments of social services under guidelines established by the state. For further information on the IHSS program, contact your county Department of Social Services.

Should I Rely On Family Members?

Many families do provide personal care for their older family members. However, it is difficult to predict if potential care givers will be availible to provide care when you need it. Family members frequently live far away from their older relatives, and providing daily care is often impossible. Families that do live nearby often provide informal care in the beginning, but few families can provide full time care. Most do not have the financial resources to pay for care in an older person's home or in a nursing home.

What About Retirement Homes?

Alternative housing arrangements are availible in many communities and may be an option for some people. These housing options vary depending on where you live, and use many different names. They are often called retirement homes, assisted living facilities, or life care communities. People often move to one of these places before they need care, and usually intend on staying there the rest of their lives.

Some of these alternative housing arrangements require large cash deposits and a monthly fee; others use a month to month rental arrangement. Some allow residents to move from independent living through more intensive levels of care within the same facility as the become increasingly more dependent. Others provide only some of the services a resident may need, and require them to move at later stages of disability. Some may require you to sing a complicated financial contract and pay a large non-refundable deposit when you first sign up.

Note: You should always have legal contracts reviewed by your financial advisor before you sign one, and particularly if you pay a large deposit.

What About Fraternal Organizations And Churches?

Some fraternal organizations and church auxiliaries have special funds to assist members of their organizations who need help with long-term care. For example, some religious groups sponsor homes that provide social, personal, and medical services for elderly members of their faith. Some offer free services; others charge a fee based on income. If you belong to one of these groups, or a similar group, ask about any type of long-term care that might be available.

If I Am A Veteran, Can The Veterans Administration Help?

The Veterans Administration (VA) provides a wide variety of services for aging veterans through traditional hospital programs, VA nursing homes and the State veterans homes. The VA also offers other programs including home care, adult day care, mental health care, day treatment centers and care giver-support programs. However, the VA recently reduced some of its services due to budgetary constraints.

Note: Not all veterans are eligible for these services, so it is important to inquire before you need assistance. For more information call 1-800-827-1000.

What About Home Companion Care?

Some individuals have been selling "home companion care" to senior citizens, primarily targeting the over 80 population. These "policies" are not long-term care insurance. These contracts require an advance payment of $6,000 to $14,000 plus annual "association" or "membership" fees. They promise to provide one year of home companion or homemaker care, full-time or part-time, and a variety of other member services. Co payments are required for each "service" provided by these contracts.

People selling these products do not pay into the state insurance guarantee fund, and these contracts are unregulated. Some of these products may be under funded and unable to provide the promised benefits. Unlike insurance policies, these contracts only have a three-day (rather than 30 day) "free look" period for cancellation and return of funds. These companies may charge for the same types of services available free or at low cost from government and community based organizations.

Long-Term Care Insurance

Another method of paying for long-term care is long-term care insurance. This type of insurance can cover a wide range of services for individuals when they need long-term care, from home and community-based care to institutionalized care. As with most other forms of insurance, you cannot purchase coverage once you need the company to pay the benefits.

Long-term care insurance is most often sold to individuals who will pay all of the premiums. Some employers offer this type of insurance, although they rarely pay any of the premiums. Some allow the parents, and sometimes the parents-in-law of their employees, to apply for the group coverage. For instance, the California Public Employees Retirement System companies offer long-term care coverage to their employees, retirees, and the parents and parents-in-law of their members. Companies selling this insurance will screen most people for existing medical conditions when they apply for either group coverage or for an individual policy.

The decision to purchase a long-term care policy and the type of policy you select depends on many factors. For example, significant differences exist among policy types, features, benefit options, and eligibility criteria. Choosing among these options can be a challenge. It requires careful consideration of a number of factors related to your risk of needing long-term care and your individual financial planning.

What Is Long-Term Care Insurance?

Long-term care insurance is designed to reimburse you for some of your expenses when you need assistance with basic activities such as bathing, eating, or getting in and out of bed. You may need this kind of help following a disabling stroke, because of a disorder like Alzheimer's disease, or because of advanced age and fragility.

Long-term care insurance is a policy that pays for care in institutions like Skilled Nursing Facilities and Assisted Living Facitilies; at home for home health care, personal care, homemakers services, hospice car and respite care; and in the community for Adult Day Care (or Adult Day Health Care) or Alzheimer's Day care. The care that people generally need in any of these locations is assistance or supervision with the normal activities of daily living (ADLs), or because of a cognitive impairment like Alzheimer's disease. This type of care is often called custodial care or personal care. Medicare does not pay for this type of care, but Long-term care insurance policies do.

What Is A Tax Qualified Long-Term Care Policy?

Congress passed legislation effective in 1997 giving a tax break to people who purchase long-term care insurance that meets certain federal standards.

This legislation is called the Health Insurance Portability and Accountability Act or HIPAA. Policies that qualify for the new tax break use a standard of eligibility for benefits that is stricter than the standards established in California. Policies that are labeled as "Federally Tax Qualified" use the federal standards for paying benefits. Some or all of the premiums for these policies may be deductible on as a medical expense (depending on your age and adjusted gross income), and benefit payments are excluded from income.

Note: Premiums paid for a tax qualified policy qualify as a medical expense. People who itemize medical expenses on their federal tax returns and have total medical expenses greater than 7.5 percent of their adjusted gross income maybe be able to deduct some portion of a premium for one of these policies. Contact your tax advisor for more information.

Policies that use the standards established by California are more generous than the federal standard, so the premiums cannot be deducted. It is not clear under the federal law whether the benefit payments are taxable as income. However, no long-term care benefits have been previously taxed as income.

The federal government has not made any decision on the tax treatment of policies that use California standards. Until a decision is made, companies selling the tax qualified policies are required to also offer people the chance to buy a policy that meets the California standards. Some companies sell both types of policies, while other companies only sell the California policies. Some employers only offer tax qualified policies because they are not required by state law to offer both.

Differences between these two kinds of policies will be discussed in each of the following sections. ***Note:*** All long-term care policies that were sold before January 1,1997 automatically qualify for the new tax breaks. These policies do not have to be replaced with a new tax qualified policy to benefit from these new tax breaks. Consult your tax advisor for more information.

Do All Long-Term Care Policies Offer The Same Benefits?

No, there are three types of long-term care insurance policies. In addition, each type of policy can be designed to qualify for the new tax benefit depending on which set of standards the company uses - the federal standards or the state standards.

Nursing Facility Only

These policies only pay for care in a nursing home or similar facility. Companies selling these policies must also offer a buyer coverage for assisted living in Residential Care Facility for the Elderly (RCFE) or a Residential Care Facility (RCF).

Home Care Only

These policies only pay for care in your own home. They are required to include benefits for home health care, adult day care, personal care, homemaker services, hospice and respite care. Some also include care management services and equipment prescribed for medical purposes. A few companies also pay for modifications to your home if necessary to allow you to continue living in your own home.

Comprehensive Long-Term Care

These policies pay for long-term care at home or in the community, as well as in a nursing home. All of the home and community services required in a Home Care Only policy must also be included in a comprehensive policy. Companies selling this kind of policy must also offer buyers a benefit for assisted living in a Residential Care Facility for the Elderly (RCFE) or a Residential Care Facility (RCF).

Any of these policies can be tax qualified or not, depending on which sort of benefit eligibility standards are used by the company. A tax qualified policy must be labeled as "intended to meet federal tax requirements." Agents selling tax qualified policies are required to show potential buyers a side-by-side comparison of both types of policies to

illustrate the major differences between the wo. You should ask to see this comparison before deciding which type of policy to buy.

If Martha had purchased a comprehensive long-term care insurance policy, many of her long-term care expenses, both in the nursing home facility and in her own home might have been covered.

What Do I Need To Know Before I Purchase A Policy?

Income

Before purchasing a policy, think about your future ability to pay the premium if the company has to raise premiums for all policy holders. A good benchmark is that a premium should not exceed 7 percent of your annual income. Your income may fail to keep up with inflation as you get older, and if your spouse dies, your income might drop. You could then be faced with some tough decisions about what you can afford to continue paying.

Assets

If you have abundant assets, you may plan to pay some or all of your long-term care costs yourself (in other words, self-insure). If your non-housing assets are low (less than the cost of a year in a nursing home) long-term care insurance is probably not a good idea. If you already qualify for Medi-Cal or would spend all of your assets within a few months, you do not need long-term care insurance.

If you are somewhere in between these extremes, long-term care insurance may be worth considering. The amount of insurance coverage you buy should be roughly comparable to the assets you would otherwise have to spend.

Age

Premiums are based on age. The older you are when you purchase coverage, the more expensive the premium will be. Many companies will not sell long-term care insurance policies to a person over 85 years of age. Most people begin to think about long-term care insurance when they are planning for retirement. Most people buy a policy between the ages of 65 and 80.

Health

People with serious health care problems are rarely accepted for long-term care coverage. A few companies will accept you with certain chronic conditions, but your premiums are likely to be higher.

Pre-existing Condition

An insurance company can refuse to pay if you need care during the first six months after you buy the policy because of a condition you had during the six months before you bought the policy. Some insurance companies will pay for care caused by a pre-existing condition if you listed it on your application and they issued you a policy. You should always be certain that the health questions on an insurance application are answered accurately.

Financial Rating Companies

If you are considering purchasing a long-term care insurance policy, there are "rating" companies that rate insurance companies on their financial condition and "cclaims payingability". These companies include AM Best, Duff & Phelps, Moody's and Standard & Poor. AM best reports are often available at public libraries. The other three companies will give ratings over the telephone. Some charge a fee, others do not.

Rate Increases

An insurance agent should be able to tell you about any premium increases of the company you are considering. You should ask about rate increases for any long-term care policies that the company sells now, or has sold in the past. You can also call the company and ask for information about their rate increases.

How Much Does Long-Term Care Insurance Cost?

The cost of long-term care policies varies according to the type of policy and the coverage provided. Policies that only pay for nursing home care are less expensive than those that cover both nursing home and home community care.

Some of the factors that can influence the cost of long-term care insurance include:

- Your age and your health at the time you apply for coverage;
- The deductible or waiting period you choose before the policy begins paying benefits;

- The combinations of benefits you want included in the policy;
- The daily or monthly benefit amount you want the company to pay when you need care; and
- The number of years you want the company to pay the benefits

Note: Premiums for tax qualified policies may be a little less expensive because of the stricter benefit eligibility standards (page 29.).

How Much Will A Policy Pay?

That depends on the benefits you choose. Most policies pay daily amounts (sometimes called "daily benefits" or "daily maximums") from $50 a day to more than $200 a day for the services described in the policy. This means that the company will pay your covered expenses "up to" the daily maximum you choose. You will be responsible for any amounts greater than the daily benefit, and the company will not pay more than the cost of the covered service.

For example: If you choose a daily maximum of $100 per day and your nursing home care expenses are $150 per day, you will be responsible for the difference, $50 per day, or $1,500 a month. (This is your co payment).

While you may have the income to pay this co payment today, you need to be sure that you can pay it in the future too. Nursing home costs have doubled about every ten years, which means that the co-payment you choose will also increase. State law requires insurance companies to offer you the change to buy inflation protection. While this benefit increases the cost of your premium, without it you risk not being able to pay your share of the cost later.

How Long Will A Policy Pay Benefits?

Most policies have a maximum number of days that benefits will be paid once you start using them. This time period is called a "benefit period", "maximum benefit period" or "lifetime maximum". Others refer to it as the duration of your coverage, or the total number of dollars that the company will pay for your care. Companies generally sell coverage in one year increments. You can buy as little as one year of coverage, or lifetime coverage that will pay as long as you live once benefits begin. The premium is higher the longer you want the company to pay benefits, and not many people can afford the premium for lifetime coverage. Most people buy between two and five years of coverage.

What Conditions Must Be Met Before Benefits Will Be Paid?

Elimination, Deductible, or Waiting Period

This is the number of days you must wait after you are eligible for benefits before the policy begins paying for your care. While a few policies have no eliminations periods and pay benefits from the first day, the most common waiting periods are 30 days, 60 days, or 100 days. You will be responsible for the cost of your long-term care expenses during the elimination period you choose when you buy a policy. The policy premium will be lower if you select a longer elimination period, but you will pay the full cost when you first need care.

For example: If your nursing home cost is $100 per day and you have a 60-day waiting period, you will pay the first $6,000 for your care before the policy pays anything. This example assumes that you continue to stay in the nursing home after 60 days. IF your stay was shorter than your elimination period, the policy would pay nothing for your nursing home stay.

While some companies require you to meet the elimination period once during your lifetime, others require you meet it for each period of care. For example, if you need care fora total of 60 days and have a 30 day elimination period, you pay for the first 30 days and your policy pays the remaining 30 days. Then if you do not need assistance for a period of time and later you need to use your benefits again, you would have to pay for your care during a new elimination period.

Note: Remember that you cannot depend on Medicare to pay for the first 100 days you are in a nursing home. Medicare will only pay for the first 20 days and part of the cost from day 21 to 100 while you are receiving daily skilled care and rehabilitation services. If you only need custodial care or personal care services, you or your long-term care insurance will pay for your care, depending on how your policy is designed. Federally tax qualified policies are not allowed to pay the Medicare co insurance after the 21st day. Policies using the California standards do not have this restriction.

Plan of Care

This is a plan for the care you need that is written by your doctor or a medical team, such as those at home health agencies. The Plan determines that you need care, describes the kind of care you need, and how frequently, and for how long you need care.

Some insurance policies require a PLan of Care for personal care and homemaker services; other require one for every benefit. Many insurance companies require that the Plan of Care be updated periodically.

Care Management and Care Assessment

In the past, some policies required you to contact the insurance company's care manager to assess your need for care. Policies sold after 10/6/97 must allow you to use an independent care manager to decide if you need care. Care management is a process to assess, plan, coordinate, and monitor long-term care. Some companies provide this type of ongoing care management as part of your benefit package. The cost may be included in your benefits or deducted from your lifetime benefit limit.

Who Can Provide The Care I May Need?

Policy definitions determine where you can get care and who can provide care.

In California companies must pay nursing home benefits in any state licensed nursing home. Policies that pay benefits for Assisted Living must pay for care in licensed places like Residential Care Facilities for the Elderly (RCFEs), or in Residential Care Facilities (RCFs), sometimes called Board and Care homes. Some policies also pay for hospice care at home or for inpatient care.

Home health care agencies can provide any of the required home care services. Licensed professionals such as nurses, physical therapists, and social workers may also be eligible provides of certain skilled care services.

All policies sold after 1/1/93 that pay for home care must allow unskilled people to provide personal care, homemaker services and some hospice services if the care is recommended in the Plan of Care. While a few policies will pay benefits when family members provide the unskilled personal care, most will not. All policies are required to pay for care in both medical and non-medical adult day care centers, or Alzheimer's day care centers.

What Home Care Services Are Covered In A Long-Term Care Insurance Policy?

In California home care benefits in long-term care policies must include the following services:

- **Home Health Care** - skilled nursing, part-time and intermittent, or other professional services and therapies in your residence, including audiology and medical social services;
- **Adult Day Care** - a licensed day care program that usually provides personal care, supervision, protection or assistance in eating, bathing, dressing, toileting, moving about, and taking medications;
- **Adult Day Health Care** - a level of day care including medical, skilled nursing and therapy services;
- **Personal Care** - assistance in your residence with any activity of daily living (bathing, dressing, continence, toileting, transferring, eating, and ambulating) as well as using the telephone, managing medication, shopping for essentials, preparing meals, laundry, and light housekeeping;
- **Homemaker Services** - assistance with chores or activities that are necessary for you to be able for you to remain in your residence;
- **Hospice Services** - services in your residence that provide physical, emotional, social, and spiritual support for you, your care giver and your family when a terminal illness has been diagnosed; and
- **Respite Care** - short-term care in a nursing facility, in your home, or in a community program to relive the primary care giver in your home.

Note: Personal care, homemaker and hospice services may be provided by a skilled or unskilled person when they are required in a Plan of Care developed by your doctor or a care team under medical direction.

How Do I Qualify For Home Care Benefits In A Long-Term Care Insurance Policy?

Benefit Eligibility Triggers

Eligibilty for home care benefits is usually based on the inability to perform certain "activities of daily living" (ADLs), or an impairment of cognitive ability. These are referred to as "benefit eligibility triggers."

California Policies

Policies that pay for home care and use the California eligibility standards must pay benefits when you are impaired in 2 out of the 7 ADLs listed below:

- Bathing
- Dressing
- Continence
- Toileting
- Transferring
- Eating
- Ambulating

OR, when you need help because of cognitive impairment. (An example would be someone with Alzheimer's disease who needs supervision.)

Tax Qualified Policies

Policies that pay for home care and use the eligibility standards for federally tax qualified policies cannot pay benefits until a health care practitioner certifies that you will need care for at least 90 days because you cannot perform 2 out of the 6 ADLs listed below without substantial assistance from another person:

- Bathing
- Dressing
- Continence
- Toileting
- Transferring
- Eating

OR, when you need help because of severe cognitive impairment.

Impairment In Cognitive Ability

In policies that use the California eligibility standard, impairment means that you need supervision or assistance to protect yourself or others because of mental deterioration caused by Alzheimer's disease or other organic mental diseases. In policies that use the federally tax qualified eligibility standard, you must require substantial supervision because of severe cognitive impairment.

Definitions of Activities of Daily Living (ADLs)

California law requires that one set of ADL definitions for policies using the California eligibility standards and another set for policies using the federally tax qualified eligibility standards. These definitions describe each ADL. When a person cannot do one of these, they have met one of the ADLs necessary to qualify for benefits.

For instance, "bathing" in tax qualified policy means "washing oneself by sponge bath, in either a tub or shower, including the act of getting into or out of a tub or shower."

"Bathing" in a policy with California eligibility standards means "cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in or out of the tub or shower, and reaching head and body parts for soaping, rinsing, and drying." **Note:** The additional ADL (ambulating) in the California eligibility standards may make it easier for some people to qualify for home care benefits. In addition, people with these policies don't need to get certification that they need care for 90 days.

What Other Policy Features Are Available?

Inflation Protection

When you buy individual long-term care insurance, the insurance company must offer you the option to purchase inflation protection. In some cases, you must choose this option at the time you purchase the policy and the cost is

included in the premium. In others, you can purchase inflation protection at stated intervals during the life of the policy. Your premium increases each time you choose this option.

If you buy long-term care insurance through a group like an employer or an association, the offer of inflation protection has been made to the group master policyholder. You may bot be able to purchase this option if the group didn't choose to offer it to their members.

If you choose 5 percent simple inflation protection, your original daily benefit will increase by 5 percent each year. If you choose 5 percent compounded inflation protection, your previous year's daily benefit will increase by 5 percent. Compounded inflation protection increases your maximum daily benefit at a much faster rate than simple inflation protection. Long-term care expenses increase at a compounded rate, and your benefits should too.

Assisted Living

This is a growing and popular option for people when they cannot stay in their own homes. Many of these newer facilities offer independent living with on-site services like meals, supervision, and assistance with ADLs.

Insurance companies are required to offer you the option of purchasing coverage for assisted living either as a rider, or as a benefit in the policy. This benefit must pay no less than 50 percent of the nursing home benefit you choose. Your benefit must be paid in any facility that is licensed as a Residential Care Facility for the Elderly (RCFE) or a Residential Care Facility (RCF). Both of these are designed in California law, and assisted living facilities have one of these licenses.

Flexible Benefits

Long-temr care policies must allow the lifetime maximum amount to be used interchangeably for any type of the benefits covered by the policy. If a policy covers both home and institutional care, the company is allowed to pay less each day for home care than for nursing home care.

However, the company must continue to pay until the maximum amount of the policy is exhausted, unless the person dies, or does not meet other requirements of the policy. ***For example:*** If a policy pays $100 a day in a nursing home for 2 years and the daily home care benefit is $50, it could take for years to use up the maximum benefit for home care, but only two years for the nursing home care.

Downgrades

Companies must allow you to reduce your coverage in exchange for a lower premium. There are three ways this can be done. You can reduce the daily benefit payment or the total number of years the policy will pay. You can also change your coverage from a comprehensive policy to a nursing home only policy if the company sells one. This right to reduce coverage can be exercised anytime after the first year or whenever the premium increases. Companies must also offer this option to you if you stop paying premiums.

Waiver of Premium

Many policies will allow you to stop paying premiums while the policy is paying benefits (usually after a short waiting period). Most waivers of premium apply only when you are using the nursing facility benefit or other institutional benefit, but some policies will also waive premiums while you are using the home care benefits.

Nonforfeiture Benefits

Nonforfeiture benefits allow you to retain some benefit of long-term care insurance policy if you have to drop your policy. For example:

- **Reduced paid-up** pays some percentage of the daily benefit, such as 30 percent, after you have paid the premium for 10 years.
- **Shortened benefit period** pays the full benefit, but for a shorter period of time. (For instance, a policy that might have paid $100 each day for five years might pay $100 per day for a much shorter period of time.) Generally, you must have paid premiums for a certain number of years before dropping the policy to get this benefit.
- **Return of premium** refund a percentage of the total premiums paid, minus any claims paid, based on the number of years you paid the premiums. (For instance, if premiums had been paid for 20 years, the company might refund 100 percent of the premiums.)

Forgetfulness Feature

Companies are required to allow you to reinstate your policy if it lapses because you forgot to pay premiums. You must have missed those payments because of an impairment in your cognitive or functional abilities. Companies will ask when you apply for coverage to designate someone to receive the premium notices if you miss a payment. They will also give you the opportunity every two years to designate someone else if you choose.

Substitute or Alternative Benefits or Services

If you are eligible for benefits and you want the policy to pay for a benefit or services that is not listed in your policy, you can request that benefit from the insurance company. Although the company has absolute discretion to grant or deny your request, it may agree to your request. Some policies offer an alternative benefit in their contracts, other do not. You can always submit a request for payment of alternative services, whether or not your policy has this feature.

What Consumer Protections Do I Have If I Buy Long-Term Care Coverage?

All long-term care policies sold in the State of California include the following protections

Guaranteed Renewable or Non cancelable Protection

Every long-term care policy sold to an individual must be either guaranteed renewable or non ccancelable Guaranteed renewable means that the company cannot cancel your policy or change any of the benefits, unless you fail to pay the premiums. Insurance companies are allowed to increase premiums for a "class" of policies, but not for you individually. Non cancelablemeans that your coverage cannot be canceled or the benefits changed, and the premium cannot increase as long as you continue to pay on time.

Continuation or Conversion Coverage

If you purchase a long-term care certificate through a group, you can continue or convert your coverage if the group cancels the master policy or terminates coverage. Continuation means you keep the same coverage if you pay the premiums on time. Conversion means you get an individual policy of insurance with identical or equivalent coverage without health screening. In each case, your premium can change when you are no longer in the group.

30-Day Free Look

Every applicant (except purchasers in employer or trade groups) has the right to return any policy or certificate within 30 days or receipt, for any reason, and have all premiums or fees refunded. The 30 days begin on the day that you get the policy or certificate.

Forbidden Requirements

Policies sold after 1990 cannot require you to be in a hospital before benefits will be paid in a nursing home, or to get skilled nursing care before personal care services are covered. COmpanies may not refused to pay you benefits because you weren't in a hospital or nursing home before you needed covered home or community services. Companies also may not refuse to pay covered benefits to people who are diagnosed with a cognitive impairment, including Alzheimer's disease.

Outline of Coverage

An Outline of Coverage is a summary of the terms of a policy or certificate. Agents are required to give you an Outline of Coverage. If you are purchasing insurance through the mail, companies must give you the Outline with the application or enrollment form.

Duties of Agents and Companies

California law requires agents to comply with certain standards when selling insurance and to give consumers certain information at the time they make a sales presentation.

Agents are required to give you a fair an accurate comparison of any policies you may already have, with one you are considering to purchase. You must also be given a "Long-term Care Insurance Personal Worksheet". This form gives you important information about any rate increases the company has had, and ask you to consider certain other issues related to buying long-term care insurance. If you do not complete this form, the company is required to contact you before issuing coverage to make sure the agent showed it to you, and that you met their standards for income and assets to purchase this product.

Agents selling tax qualified policies must show you a standardized side-by-side comparison of both the tax qualified policy and policies using the California eligibility standards. Bot the side-by-side comparison and the Personal

Worksheet are intended to help you purchase the right type of policy and an appropriate amount of coverage for your particular circumstances.

Insurance agents have a duty of honest, good faith, and fair dealing to all consumers. They are prohibited from using high pressure tactics to sell you insurance and are not allowed to sell inappropriate coverage or excessive amount of insurance. Advertisements and other marketing materials used by agents and by companies cannot be misleading.

Violations of these standards should be reported to the California Department of Insurance at 1-800-927-HELP (4357).

Agent Training

All agents and other financial consultants selling long-term care insurance must be licensed by the California Department of Insurance. Agents must receive special training before they can sell long-term care insurance and complete a certain number of continuing education hours before they can renew their license. Insurance companies have to keep a list of the agents authorized to sell their long-term insurance policies and must send that list to the Department of Insurance. ***Note:*** You can call the California Department of Insurance to verify whether an agent is authorized to sell long-term care insurance by calling 1-800-927-HELP (4357).

Where Can I Get Help Understanding Long-Term Care Insurance?

You can get more information or individual counseling on long-term care insurance from your local HICAP office. Call 1-800-510-2020 to find the HICAP office nearest you.

HICAP is the Health Insurance Counseling and Advocacy Program, a free statewide program through the California Department of Aging. HICAP uses trained, impartial volunteers who will meet with you, discuss your long-term care needs and help you with the questions you may have about long-term care insurance.

California Partnership for Long-Term Care

What Is The Partnership for Long-Term Care?

The "Partnership" is an innovative alliance between the State of California and a select number of private insurance companies. The California Department of Health Services designed the Partnership program to help you maintain your financial independence by creating a special type of long-term care insurance policy. It provides a way to obtain high quality, affordable, private insurance and receive guaranteed lifetime asset protection. The Partnership has three major goals:

- To help all consumers understand the risk and costs of long-term care;
- To offer private insurance protection that help you avoid wiping out a lifetime of savings, or losing your financial independence paying for long-term care; and
- To offer private insurance policies that meet stringent state standards, and give you a lifetime of protection for you assets.

How Are These Policies Different From Other Long-Term Care Insurance Policies?

Partnership-approved long-term care insurance policies are sold by private insurance companies. These state approved policies must meet certain requirements established by the California Department of Health Services. These policies also have many features that are not required in other long-term care insurance policies. Some of the most important are:

- Each policy has standardized terms and a core set of benefits that make it easier to compare policies from different companies;
- Automatic inflation protection is built into every policy to help your benefits keep up with some of the rising costs of care;
- The premium is waived from the first day you receive care in a nursing home or assisted living facility;
- Care for assisted living is a required benefit in each type of policy;

- Premium increases are limited by how much and how frequently increases can occur; and
- Asset protection is guaranteed in each type of policy.

Insurance companies participating in the Partnership program must have their policies approved by both the Department of Insurance and the Partnership program. (You can call 1-800-227-3445 for a list of participating companies.)

What Is Asset Protection?

Partnership approved policies have a unique asset protection feature. This feature is only available when you buy a Partnership-approved policy. It ensures that every dollar paid out in benefits by one of these policies will protect an equal amount of your assets.

These policies pay for you care in the same way other long-term care policies would, until you've used up all the benefits of the policy. Then if you still need long-term care you can keep more of your assets than if you had used up the benefits of an ordinary long-term care policy. Here's a how it works:

Each dollar your Partnership policy pays in benefits can protect one dollar of your assets. You can keep each dollar of those protected assets for your own use, for your spouse, or to pass on to your loved ones.

For Example: Suppose you had $42,000 in lifetime saving and bought a Partnership policy covering the same amount of long-term care services. ($42,000 in benefits is the approximate cost of one year of nursing home care or two years of part-time home care.) Later, you need long-term care services and you use up all the benefits of your policy.

If you still need long-term care after you run out of insurance benefits, you may have to apply for Medi-Cal to pay for your care. If you do apply for Medi-Cal, you can keep the entire $42,000 of your assets, not just the $2,000 limit that would apply otherwise. Each dollar your policy paid (a total of $42,000) equals one dollar of asset protection ($42,000 of your lifetime savings in this case).

Because inflation protection is built into every Partnership policy the amount of assets you can protect increases each year if you keep the policy. For instance, if you did buy the $42,000 in benefits, those benefits will grow by 5 percent compounded each year you keep the policy. Both the daily benefit that pays for care, and the amount of your protected assets will grow at the same rate. While other policies may include inflation protection, no other policy gives you this important asset protection.

How Will The Asset Protection Work When I Need Care?

Most people will recover or die before they use up all the benefits of their policy, but a few will live longer than their benefits. If you buy a Partnership approved policy and you later need care, you will use your insurance benefits to pay for care first. As you use those benefits you will receive a quarterly report from the insurance company. The report will tell you how much your policy has paid in total benefits, and the amount paid in the quarter.

Then, if you continue to need care after your benefits are used up, you may apply for Medi-Cal. If you qualify for Medi-Cal you will be allowed to keep the amount of your assets equal to the benefits paid by your policy. Without the assets protection of the Partnership program you would have to spend your saving until you had only $2,000 remaining. This is called "spending down." The Partnership protection allows you to keep the assets you would otherwise have to spend for your care.

If your total assets are more than the amount protected by the Partnership you will have to spend those unprotected assets before you will qualify for Medi-Cal. If your income is higher than what Medi-Cal allows at the time you apply, you may have to use some of it to pay for your care.

If Medi-Cal Pays For My Care Will Medi-Cal Collect From My Estate?

The Partnership asset protection guarantee continues even after your death. Medi-Cal can only collect from your estate when your assets are more than the amounts protected by the Partnership-approved policy you bought. Even

then Medi-Cal can only collect the amounts paid by the Medi-Cal for covered services. Asset protection applies to the value of any asset you own, including equity you may have in your house.

How Do I Know How Much Asset Protection To Buy?

You can purchase coverage equal to all your assets. The amount you buy is up to you. Remember, if you buy less coverage than than the assets you currently have, the inflation protection feature of the policy will increase your asset protection each year. After you own the policy for thirteen years, and have filed no claims, the amount of asset protection you bought will have doubled. You will have twice as much asset protection as you purchased originally.

What Kind Of Policies Can I Buy Through The Partnership?

There are two kinds of Partnership-approved policies. One is a facility only policy that covers care in a nursing home or a residential care facility, often called an assisted living facility. The other is comprehensive policy that also covers care in a nursing home or residential care facility, but includes a full range of benefits for home and community services. Home and community services include home health care, personal care, homemaker services, adult day care, hospice, and respite care. Both kinds of policies have built in inflation protection. The daily benefit and the lifetime benefit maximum automatically increase by 5 percent compounded each year.

When you buy one of these policies you can choose the daily benefit that will be paid for benefits covered by the policy. You also choose the number of years you want the policy to pay benefits once you need care. Every participating insurance company offers one and two year policy with a 30-day waiting period. These companies can also sell policies that pay longer than two years and include other benefits.

The benefits in each policy are interchangeable. The lifetime policy maximum is available to pay for any benefit covered by the policy. All Partnership-approved policies calculate home and community benefits as a monthly pool of funds that can be used to pay for any of the services covered by the policy. This gives you the flexibility to arrange services at the times and in the amounts needed. You are not limited to a set amount of care each day, regardless of how many or how few services you need.

You can select the amount of coverage closest to the amount of assets you want to protect. Participating insurance companies offer benefit amounts ranging from coverage for one year up to coverage for the rest of your life. You can protect as little as $30,000 in assets up to $300,000 or more. The asset protection feature means you only need to buy the amount of insurance that is equal to the assets you want to protect.

Note: A Partnership option is offered by the California Public Employees Retirement System (CALPERS). Call 1-800-338-2244 or visit their web site at http://www.calpers.ca.gov to find out more about long-term care benefits offered to their members.

How Much Do Partnership Policies Cost?

The cost of a policy will depend on your age, your health, the amount of daily benefit you select, and the features you choose. The more years you want the policy to pay if you need care also adds to the premium cost. Lifetime coverage is the most expensive, and few people can afford to buy it. Most people buy a policy that will pay for two or three years. In addition, the older you are when you buy a policy, the higher the premium will be.

When Does A Partnership Policy Pay Benefits?

There are two ways to qualify for benefits. One is if you are unable to perform at least two of the six basic activities of daily living (ADLs), and are expected to need care for at least 90 days. Those six ADLs including bathing, dressing, toileting, transferring, continence, and eating. The other way to qualify is if you have a severe cognitive impairment like Alzheimer's disease. In either case you must need human assistance or supervision.

Note: Partnership policies use the same benefit eligibility standards required by federal law to be considered a tax qualified policy. Premiums paid for policies labeled as tax qualified may be deductible as a medical expense if you itemize your federal (and state) income tax returns. Consult your tax advisor for more information on how the tax changes affect you.

How Is The Need For Care Determined?

When you need care, an independent care management agency will assess your physical, mental, and social needs. The care manager will develop a Plan of Care that describes the services you need. The cost of these services will not be deducted from your benefits. Some policies will even pay the care manager to arrange for the delivery and coordination of your services, and monitor the quality of care at your request.

What If I Am Denied Benefits?

You have the right to appeal any denial of benefits, the Plan of Care or the amount of any claims paid. The care management agency must give you an explanation of your right to appeal, and the procedures you must follow.

Who Is Eligible To Purchase A Partnership Policy?

There are no special eligibility rules, except that you must be a resident of California at the time you buy a policy. The insurance benefits of your policy can be used anywhere, even if you move to another state. The benefits paid for your care will count towards your asset protection, even when you live in another state. However, you must live in California to claim the asset protection. If you returned to California and still needed care, your assets would be protected when you applied for Medi-Cal.

Can I Get A Partnership Policy If I Already Have A Long-Term Care Policy?

If you already have a policy from one of the companies participating in the Partnership you may be able to replace your current policy with a Partnership policy. If you do have a policy from one of these participating companies, you may want to consider replacing your old policy with a Partnership policy. You will be charged a higher premium based on your current age, but you will also get some premium credit towards the premium for the new policy. This may make it possible to upgrade an older policy purchased before many of the new improvements in newer policies. While companies can require you to pass new health screening, it cannot be stricter than it is for other people applying for new policies.

How can I Find Out More About Partnership Programs?

Partnership policies are sold by private insurance companies participating in the Partnership program, and specially trained insurance agents. You should ask your agent, or any agent selling long-term care insurance, if they have taken the required training and can sell you a Partnership policy. You can get a list of the companies that are currently selling these policies by calling 1-800-227-3445.

Note: The State does not endorse any particular policy or company selling Partnership-approved policies.