Chapter 2 Financing for Long-Term Care

Public Financing for Long-Term Care

Estimations of present and future costs of long-term care vary. Regardless of the assumptions, only a limited number of sources exist to fund this care. Government programs and services supported by taxes are the most apparent source. Private resources, which include personal savings and investments, can be very limiting if not planned for in advance. Long-term care insurance, of course, is a very viable source for funding, but only when it is a suitable option for the potential policy holder.

The aging baby boom generation will lead to a sharp growth in federal entitlement spending. In the absence of significant reform, it will impose what may be an unsustainable burden on future generations. As the estimated 76 million baby boomers—those born between 1946 and 1964—continue to age, Medicare, Medicaid, and Social Security expenditures will nearly double as a share of the economy by 2035.7 Lacking any meaningful reform of these entitlement programs, an escalation of federal spending for Social Security, Medicare, and Medicaid may overwhelm the federal budget. A significant challenge for policymakers is to reconcile the concerns about the costs of long-term care with the public and private sectors.

Public and Private Payors of Long-Term Care

In the broadest of terms, there are essentially two sources available for the funding and payment of long-term care services: public and private.

Public financing for LTC services and support comes primarily from the Medicaid program. Although the federal and state governments jointly finance Medicaid, Medicaid is primarily a state-administered program. Of course, other public sources help provide payment for long-term care services. Each program is different and imposes specific rules for eligibility, the types of services it covers, how long it will pay for services, and in some cases, cost-sharing. Some programs focus on home and/or community-based services, while others—such as Medicare—only pay for some short-term nursing home stays or home health care. However, no public source of LTC funding compares to the magnitude of Medicaid and the dollars this program expends on long-term care.

Private funding for long-term care comes from individuals and their families and LTC insurance. In addition to insurance, private resources take the form of available savings and cash, investments, retirement accounts, and home equity. When the need arises, people tap into all available resources. (Private LTC funding options is the topic of the next unit.)

Medicare and Long-Term Care

Many people believe that Medicare covers long-term care services. This is not the case. Medicare was never intended nor was it designed to support long-term care.

Medicare was implemented in 1965 as an amendment (Title XVIII) to the Social Security Act. Then and now, it is a federal health insurance program that provides hospital and medical expense coverage, primarily for those age 65 and older. At the time Medicare was enacted, the senior segment of the population was the most likely to be living in poverty, and only about half had

insurance.8 since its introduction; many changes have been made to the Medicare program. Coverage now extends to include the legally blind, people with end stage kidney disease, and younger people who are disabled and who meet the criteria to collect Social Security disability benefits.

As wide-spread and encompassing as the program may be, however, Medicare does not contain a comprehensive long-term care component. It does not pay for ongoing assisted living or custodial care costs, which constitute the most common of long-term care services and needs. It does cover the cost of short-term services—physical and other therapies, for example—contracted through a home health care agency provided to the resident at home or at an assisted living facility. With regard to nursing home care, Medicare covers only those skilled nursing facility services rendered to help a patient recover from an acute illness or injury. Payment for skilled nursing care by Medicare requires that the patient must have first been hospitalized.

Medicare is administered by the federal government's Centers for Medicare and Medicaid Services. Original Medicare consists of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare Part C (Medicare Advantage) combines these two parts into a single program, typically available as and delivered through a managed care plan. Part D Prescription Drug Coverage provides for prescription drugs. Individuals who are covered by Original Medicare can enroll in a separate Part D plan; those who are covered by a Medicare Advantage plan may find that Part D is included in the plan, or its coverage may be available for purchase separately.

Broadly speaking, Medicare's coverage for any ongoing care services is restricted to skilled nursing care and home health care. However, this coverage is limited and cannot be considered (or relied on) for long-term needs.

Eligibility for Medicare Skilled Nursing Care

Nursing facility coverage under Medicare is very limited. If certain conditions are met, Medicare will fully cover the first 20 days of care in a skilled nursing facility (SNF) during each benefit period. (A Medicare benefit period starts when an individual enters the hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or SNF care was provided.)

For days 21 through 100 of each benefit period, the patient must share, or co-pay, the cost of SNF care by paying a daily coinsurance rate, which changes yearly. (In 2009, the coinsurance payment was $133.50 per day for each benefit period). After 100 days, all costs for each day in an SNF are borne by the patient.

Medicare pays for nursing facility care only when all of the following conditions have been met:

-The nursing home must be a Medicare-certified SNF providing 24-hour nursing care to convalescent patients.

-The patient must require daily continuous skilled nursing care or skilled rehabilitation services, as defined by the federal law.

-The patient must have spent at least three consecutive days in a hospital, and admission to the SNF must occur within 30 days after discharge from the hospital.

-A physician must certify that SNF services are needed for the same or related illness for which the person was hospitalized.

Skilled Nursing Services Covered by Medicare
Assuming the conditions just described have been met, the following nursing home services will be paid by Medicare:

-a semi-private room
-custodial care
-meals, including special diets
-regular physician and nursing services
-rehabilitation services
-laboratory tests
-drugs furnished by the facility
-medical supplies

Medicare does not cover personal convenience items, private duty nurses, or the additional cost for a private room.

Home Health Care Services Covered by Medicare
Medicare covers home health care, but services are limited to people with skilled care needs. To be eligible for home health services, beneficiaries must be homebound, require only intermittent skilled nursing or therapy services, and must be under the care of a physician who prescribes their plan of care. Home health aide services for assistance with ADLs can be provided during this time, but people who have no skilled care needs—that is, those who require assistance with ADLs only—are not eligible to receive home health care benefits.

Medicare's home health benefit is less restrictive than its SNF benefit. For example, eligibility for home health care is not linked to a recent hospitalization; there is no limit on the number of days of care or the number of home care visits a beneficiary may receive; and there is no required beneficiary cost-sharing. However, the condition that often gives rise to needing long-term care—ongoing assistance with ADLs—does not qualify for Medicare coverage.

Medicare Supplement Insurance
Citizens who elect to enroll in Original Medicare may augment their coverage with a private Medicare supplement (Medigap) policy. However, as the name implies, Medicare supplement policies are designed only to supplement Medicare benefits by covering the many and varied deductible, cost-sharing, and co-payment provisions that characterize the program. For example, a Medicare supplement may cover the coinsurance amount that applies to days 21 through 100 of skilled nursing facility care under Medicare Part A. However, Medicare supplement policies do not cover conditions that are not covered by Medicare; thus, Medicare supplement policies do not cover long-term care.

Medicaid and Long-Term Care
Serving a much more significant role than Medicare in the LTC arena is Medicaid. Medicaid is a cooperative program between the federal and state governments to pay for health care and medical services for certain needy, low-income individuals. The federal and the state governments share responsibilities in designing, administering, and funding the program. Although the federal government sets general guidelines for the program, the Medicaid program requirements are actually established by each state. At the federal level, the Centers for Medicare and Medicaid Services (CMS) is the agency charged with administering Medicaid. At the state level, the program is administered by the state's health and human services department or a family service agency.

Medicaid covers a range of services, including those needed by people to live independently in the community, such as home health care and personal care, as well as services provided in institutional settings. Most of these very essential services are not covered by Medicare or by traditional health insurance policies. As such, Medicaid has become the primary single payor of long-term care services, far surpassing any other public or private funding source.

The hard costs associated with long-term care are beyond the reach of most Americans, especially those who are retired or who, for health reasons, are no longer active in the workforce. Because Medicare does not cover extended long-term care services and despite the availability of LTC insurance policies, Medicaid remains the dominant payment resource for the millions who require long-term care services. In fact, Medicaid today pays for almost one-half of the costs associated with paid delivery of long-term care—approximately $100 billion. By 2017, Medicaid expenditures for LTC services are expected to reach $225 billion.

Medicaid dollars are spent as follows for each service type for long-term care:

-4% Home Health Services
-10% Personal Care Services
-13% Intermediate Care Facilities
-26% Home & Community Based Waiver Services
-47% Nursing Facility Services

Eligibility for Medicaid Payment of LTC Costs
Medicaid was designed to provide health care to needy low-income individuals and their dependents. As such, it is not available to everyone who needs LTC services. Though the federal government establishes general program rules and guidelines, each individual state creates its own program within these guidelines; for this reason, eligibility and covered services vary from state to state. However, all states incorporate into their general eligibility criteria certain limits on income and personal assets. Coverage specifically for long-term care services requires that an individual also meet certain functional criteria in addition to financial criteria.

To qualify for the payment of long-term care expenses by Medicaid, an individual must meet three categories of requirements: general, functional, and financial.

Medicaid General Requirements
Medicaid's general eligibility requirements stipulate that an individual must be 65 or older, or

permanently disabled or blind. He or she must also be a U.S. citizen (or hold qualified immigrant status) and be a resident of the state in which application for Medicaid is made.

Medicaid Functional Requirements
Medicaid applicants must undergo a functional assessment and, as a result, be determined to need long-term care. The assessment, performed by a medical specialist, is also used to determine where the care should be delivered: in a skilled nursing facility, or in the home or community. The functional assessment is generally based on whether an individual needs assistance with ADLs. Meeting Medicaid's functional eligibility requirements for home and community-based services may or may not be the same as the requirements for skilled nursing home care, depending on the state. In 2007, federal law changed to allow states to impose less stringent functional requirements for those who are able to receive care outside a nursing home.

Medicaid Financial Requirements
The individual must have levels of assets and income that are at or below certain levels. These levels are determined by the state in accordance with federal guidelines. Medicaid's financial requirements are explained in more detail later in this unit.

Medicaid Benefits
Medicaid does not pay benefits directly to beneficiaries. Instead, it makes payment to the providers furnishing services. The individual states establish eligibility standards, determine which benefits to cover, and establish provider payment rates. All state Medicaid programs must cover the following basic services:

-inpatient and outpatient hospital services
-laboratory and X-ray services
-skilled nursing and home health services
-physician and certified nurse practitioner visits
-family planning
-periodic health check-ups
-diagnosis and treatment for children

Medicaid may also pay for things such as prescription drugs, clinic visits, prosthetic devices, hearing aids, some dental care, eye exams and glasses, transportation to and from treatment, and services not covered by Medicare.

All states provide long-term care services for people who are Medicaid-eligible and qualify for institutional care. Though the federal Medicare program does not cover the costs of assisted living facilities, Medicaid may pay for some level of the care component of assisted living. In 2007, states were granted the authority to pay for assisted living under Medicaid state plan amendments. Even so, benefits are limited.

Even when Medicaid does pay for long-term care, the conditions are not always the most favorable. Assisted living facilities, which allow residents some privacy and independence, often do not accept Medicaid patients, nor do all nursing homes. Most nursing facilities do accept Medicaid but limit the number of Medicaid beds they make available. Applicants can face long waits for the

facility they prefer. Many times, they must settle for a facility far away from home and inconvenient for family. The placement process differs from state to state, but in some states, patients must take the first bed that becomes available no matter where in the state it is located. The available facility may not be as satisfactory as the patient's and family's first choice in terms of cleanliness, staffing, or quality standards.

Home and Community-Based Waivers

Though a few state Medicaid programs still require that long-term care be delivered only in nursing homes or skilled nursing facilities, most allow for covered care to be received in the home or in a community-based setting as well, under what is known as a waiver program. A waiver program enables a state to provide a variety of home and community-based services as alternatives to institutionalization for qualifying individuals or targeted groups. In this way, Medicaid waiver programs provide individualized support that helps people live in their homes or in community settings instead of institutional settings. Waiver programs essentially permit states to "waive" some of Medicaid's provisions and allow individuals to seek and receive Medicaid-covered care and services through means other than nursing homes.

Potential services that may be delivered under a waiver program include day services, respite care, home modifications, personal emergency response systems, non-medical transportation, and other services that keep beneficiaries at home and out of institutions for as long as possible. Waivers can also be used to provide Medicaid services for waiver participants that are not offered to other adult Medicaid beneficiaries, such as case management and personal assistance services.

Today the proliferation of community-based programs has captured a significant portion of the Medicaid funding that at one time went entirely to nursing home care.

Medicaid's Financial Requirements

Eligibility for payment by Medicaid for long-term care requires that a recipient have a low income and very few assets. In most states, LTC Medicaid recipients are limited to no more than $2,000 or $3,000 in assets. For many who need long-term care and who do not have any means other than Medicaid to cover the cost, this means that they will first have to "spend down" their assets to a level that qualifies them for benefits. Consequently, most private resources must be exhausted before Medicaid will pay for long-term care, essentially a process of self-impoverishment.

Unfortunately, those who must spend down their assets to qualify for Medicaid-paid long-term care lose not only their financial security but their independence and freedom of choice as well. Furthermore, once a person has been forced to deplete resources to qualify for LTC, he or she is so impoverished that returning to a pre-Medicaid financial position will never be an option.

Medicaid Treatment of Assets

Individual states establish their own eligibility rules and determine the level of assets that may be retained to receive long-term care under Medicaid. To this end, assets are deemed countable or non-countable. Countable assets are those whose values are counted in determining eligibility; non-countable assets are not considered.

Countable Assets
As a general rule, applicants for Medicaid-paid LTC may retain only about $2,000 to $3,000 in countable assets. Countable assets, also called non-exempt assets, include:

-cash
-checking and savings accounts
-certificates of deposit and money market accounts
-stocks, mutual funds, bonds, and other investment holdings
-IRAs and other retirement investments
-nonresident property

Generally, all money and property that can be valued and turned into cash are considered countable assets, unless it is specifically exempt. If the value of total countable assets exceeds the Medicaid eligibility limit, the applicant must then spend down these assets to the state-prescribed limit before qualifying. Certain allowances are made for married couples that enable the at-home, community spouse, to retain some countable assets and, therefore, remain living at home. (This is explained in the section "Avoiding Spousal Impoverishment.")

Non-countable Assets
Certain assets are not considered in the Medicaid eligibility determination. These are termed non-countable (or "exempt") assets and include:

-primary residence—A primary residence is not countable as long as the home's equity is less than $500,000 (up to $750,000 at state option). The exempt value is unlimited if a spouse, a child under the age of 21, or a blind or permanently disabled child is living in the home.

-automobile—One automobile of any value is exempt if one spouse is institutionalized. One auto of any value is exempt if the spouse needs the auto for employment or if the vehicle has been modified to be handicap accessible.

-household belongings—Household belongings, including furniture, appliances, and similar items, are not countable.

-personal possessions—Personal possessions such as jewelry, clothing, and similar items, are not countable.

-business property essential to self-support—A business property is exempt if it produces income sufficient to justify possession of the business assets (equipment and supplies, inventory, cash on hand).

-burial contracts—Burial contracts are exempt, though limits on the amount of the exemption may be imposed. The value of the burial contract must be reduced by the cash value of any life insurance policies

-burial plot—This exemption is for the applicant and his or her immediate family. It includes the purchase or prepayment of a gravesite, the opening and closing of a gravesite, a cremation urn, a casket, an outer burial container, and a headstone or marker.

-cash surrender value of life insurance—The cash value of any life insurance owned is exempt, up to a total of $1,500 for all such policies.

Medicaid Treatment of Income

States assess a Medicaid applicant's income level as well as the sources of his or her income. Like assets, income is deemed either countable or not countable. Most states define countable income as income from:

-Salaries and wages
-Pensions
-Social Security
-Veterans' benefits
-Interest earnings and dividends

Non-countable income includes:

-Temporary Aid to Needy Families (TANF) payments
-Supplemental security income (SSI)
-Food stamps
-Low Income Home Energy Assistance Program (LIHEAP) benefits
-Ffoster care payments/certain housing subsidies

Some states impose a cap on the amount of income one can qualify for and receive from Medicaid; other states do not have an income limit. However, once individuals are deemed eligible for Medicaid long-term care, they will be required to contribute a substantial portion of their income to the cost of care. This amount varies from state to state; it also varies depending on whether the individual is in a nursing facility or is receiving care at home or in the community, and whether a spouse is living in the home.

Generally speaking, those who receive care in a nursing facility must contribute virtually all of their income toward the cost of their care; Medicaid picks up the remainder. (The income of an institutionalized person's spouse is not affected and does not have to be directed to paying for the institutionalized spouse's care.) An institutionalized beneficiary is permitted to retain only a nominal amount of monthly income, such as $30 or $50. Generally, Medicaid recipients that receive care in their homes or through a waiver program are allowed to retain a larger amount of their income then recipients living in a nursing facility.

All states provide that greater income amounts may be retained if the Medicaid recipient is married and his or her spouse remains in the community.

Transferring Assets

In years past, given the Medicaid eligibility rules, applicants were tempted to simply transfer their assets to family members to meet eligibility criteria. Not surprisingly, the law now imposes certain requirements to curb this practice.

If an asset is improperly transferred, a state can consider the asset countable. States can "look back" for 60 months, called the look-back period, to find improper transfers of assets. If a transfer of assets for less than fair market value is found to have been made during the look-back period, the state will withhold payment for nursing facility care and other long-term care services for a specific period. This period is called the penalty period.

The penalty period begins when the individual enters a nursing home and otherwise meets Medicaid's eligibility requirements. The length of the penalty period is based on two factors:

-The market value of the property transferred.
-The average monthly rate for nursing facility care in the applicant's area.

The value of the transferred property is divided by the average monthly nursing facility rate in the applicant's area. The result is the penalty period: the number of months that Medicaid will not pay for care.

For example, suppose Gene transferred his $30,000 investment holdings to his son, Jake, on March 1, 2010. On August 1 of that year, Gene enters a nursing home and applies for Medicaid. The state will look back 60 months from the date Gene entered the nursing home and applied for Medicaid and bring into its asset assessment all transfers Gene made during this time—from July 31, 2005, through August 1, 2010. The $30,000 transfer to his son will be included in Gene's asset assessment. If the average monthly rate for nursing facility care in Gene's area is $4,000, Medicaid payments for Gene's care will be withheld for seven and a half months ($30,000 ÷ $4,000). The effect is that Gene will have to pay out-of-pocket toward the cost of his care an amount equal to the value of the asset he transferred.

Allowable Transfers

Certain transfers are permitted. For example, a transfer to a spouse, a transfer to a third party for the benefit of a spouse, a transfer to a child over age 21 living in the home for at least two years before the applicant's institutionalization and who provided care to delay institutionalization, and transfers to disabled children are allowed and will not result in a Medicaid penalty period, even if made during the look-back period.

Avoiding Spousal Impoverishment

Before 1997, requiring applicants for Medicaid LTC benefits to spend themselves into near poverty had the unintended consequence of also impoverishing the community spouse. Today, spouses of nursing facility residents are protected from what is termed spousal impoverishment. States are required to permit the community spouse to retain income sufficient for support. This is termed a minimum monthly maintenance needs allowance (MMMNA).

The allowable income amount that may be kept to support a community spouse varies from state to state, but it is generally in the range of 200 to 300 percent of the federal poverty level. If the

community spouse's own income is below the allowed MMMNA, the shortfall is made up from the nursing home spouse's income.

Any income the community spouse receives in his or her own name may be retained fully by the community spouse. In all circumstances, the income of the community spouse will continue undisturbed. That is, no portion of the community spouse's personal income may be used to cover the cost of care for the institutionalized spouse. In addition, a community spouse is allowed to retain without modification his or her share of income that is payable to the couple jointly.

With respect to assets, a community spouse may retain half or more of the couple's combined countable assets, subject to state and federal minimum and maximum limits. All states must allow the community spouse to keep all countable assets up to a certain minimum ($21,912 in 2009) and up to half of assets above this amount, up to a maximum amount ($109,560 in 2009). A state may impose a limit less than the maximum, but not more. (Minimum and maximum amounts are subject to change every year.)

The following simplified example illustrates how the asset rules for spouses work. It assumes a couple has combined countable assets of $78,000. The state in which the couple resides has set the asset limit for an institutionalized spouse at $2,000, and the community spouse is allowed to retain one-half of the couple's assets, up to a maximum of $100,000. This year, the husband enters a nursing home and applies for Medicaid.

Total countable assets: $78,000
Maximum allowance for nursing home spouse: – 2,000
Maximum allowance for community spouse (half of assets): –39,000
Amount exceeding maximum asset allowance: $37,000

The maximum allowance for the nursing home spouse ($2,000) plus the maximum allowance for the community spouse ($39,000) results in a total asset allowance for the couple of $41,000. To qualify for Medicaid assistance, this couple must spend down $37,000 of their joint countable assets.

Estate Recovery
Federal laws require states to recover Medicaid-paid expenses for long-term care from the estates of individuals who were institutionalized. This is known as estate recovery and occurs after the individual's death. If the decedent, as the Medicaid recipient, was 55 years old or older at the time of death and received Medicaid benefits on or after October 1, 1993, the state must initiate a recovery claim for expenses it paid for nursing facility services and home and community-based services. States also have the option of seeking recovery for payments for other Medicaid services. Estate recovery cannot be initiated if the Medicaid recipient leaves a surviving spouse or a child under the age of 21 (or a child of any age who is blind or disabled).

Estate Recovery Rules
Assets subject to recovery include both real and personal property. Real property includes homes and land. Personal property includes vehicles, furniture, bank accounts, and similar assets. The state may claim a portion of personal property owned jointly with another person. Property that

was deemed not countable for purposes of qualifying for Medicaid can be subject to estate recovery upon the Medicaid recipient's death.

Recovery of assets from an estate may be made:

-After the death of an unmarried Medicaid recipient.
-After the death of a surviving spouse.
-When the Medicaid recipient has no surviving child under age 21.
-When the Medicaid recipient has no surviving child of any age who is blind or totally disabled.

In cases where estate recovery would create an undue hardship for surviving family members, the right to immediate recovery may be waived by the state. The administrator of a Medicaid recipient's estate must apply for a hardship waiver within six months of the decedent's death or within 30 days of receiving notice of a claim against the estate, whichever is later. The request for a hardship waiver must be in writing.

Medicaid and Long-Term Care Insurance

In recognition of the growing need for long-term care and the additional burden that will inevitably fall on hard-pressed state Medicaid programs as the ranks of the elderly continue to expand, the federal government affected a number of far-reaching reforms with the passage of the Deficit Reduction Act (DRA) in 2005. Among the many provisions of this act were changes to Medicaid rules that now allow for the expansion of state long-term care partnership plans—plans that link state Medicaid programs with private long-term care insurance policies. Partnership plans are intended to encourage citizens to purchase affordable long-term care insurance policies and thus reduce the burden on state Medicaid programs. Partnership plans and the types of LTC policies that may be used for such plans are the topics of later chapters.

Private Funding for Long-Term Care

In the last unit, we examined the major sources of public funding for long-term care. The most significant government programs—Medicare and Medicaid—are, at best, very limited. Private funding for this need entails the use of personal resources: savings and investments, annuities and life insurance, and the equity in one's home. Also included in the scope of private funding resources is long-term care insurance, a product that is specifically designed for this need. For some, self-funding the long-term care risk can be accomplished without an LTC policy; however, for many, it represents the best way to address a risk that is very likely to materialize.

Self-Funding for Long-Term Care

As the term is used here, self-funding refers to paying for long-term care costs out-of-pocket with personal or family income, savings, pension benefits, stocks, bonds, and other investments. Contributions from children or other relatives may also come into play. Any financial product designed to grow and accumulate funds can be used as a way to save for future long-term care needs. However, most people find that, even when done in advance, saving a sufficient amount every month or every year for long-term care expenses is extremely difficult. Those who are older may not have enough time to ensure funding is complete.

When considering the best options to fund the costs of long-term care, the focus should be on what the cost of care will likely be in the future. The cost of all aspects of health care continues to increase; long-term care is no exception. The following chart projects today's costs into the future, using an assumed annual increase of 5 percent. The significant sums that will likely be needed are considerable; for many citizens, they may be unattainable.

The risks of self-funding long-term care costs for even the most prosperous individuals are significant. They include:

-Not being able to define future long-term health-care needs.

-Not knowing when long-term care may be needed.

-Not wanting to "sacrifice" money toward care that is intended to be passed on to family members and dependents.-Losing the ability, through dementia or similar cognitive failure, to understand on what type of care the money should be spent.

Generally, self-funding is possible only for individuals with above-average wealth. Those whose disposable incomes exceed the cost of care are the best candidates for self-funding. For most others, attempts at self-funding could exhaust assets, eventually leading to reliance on Medicaid or other public resources. Self-funding can also take the form of relying on or expecting family members or loved ones to provide needed care. Depending on family and loved ones is certainly possible, but it ignores the realities of long-term care: that it can affect the quality of life of the caregiver, that the need for care will likely be ongoing and sustained, and that the caregiver may not be able to deliver the level or kind of care needed.

Long-Term Care Insurance

Though the means to self-fund the cost of long-term care are many and virtually any financial instrument or personal asset can be used for this purpose, the reality of long-term care presents significant challenges:

-The cost of the care is extremely high. Funding the need adequately requires thousands upon thousands of dollars. For high levels of care necessary over an extended period, the cost can be measured in hundreds of thousands of dollars.

-The likelihood of needing care is fairly high. It is estimated that about 70 percent of individuals over age 65 will require at least some type of long-term care services during their lifetimes.

-It is very difficult to predict when the need for care—and thus, the need for the funds—will materialize. It could be years into the future or it could be next month. Likewise, it is difficult to predict the level of care that may be required.

For these reasons, and for individuals other than the very wealthy, none of the private resources described so far in this unit can be relied on to fully meet the LTC funding need. None can ensure that necessary money will be available in adequate amounts when it is needed. Fortunately, there

is another private resource available for LTC funding—one that is designed specifically to meet the risk and cover the need: long-term care insurance.

Long-term care insurance covers the risk of long-term care and pays benefits for policy holders that need care services and support. Though it will be discussed in detail in the next units, an overview is appropriate here. There are many types and forms of long-term care insurance, with many combinations of benefits and coverage. For example:

-A policy may cover the cost of care in all kinds of settings (a comprehensive policy) or only care that is delivered in the home or in a nursing facility a non-comprehensive policy).

-The policy holder may select from a range of daily benefit amounts the benefit the policy will provide (such as $100, $150, or $250) and the period that the policy will cover (such as one year, three years, five years, or a lifetime).

-A policy may provide benefits on an indemnity (specified amount) basis or on a reimbursement basis (actual costs incurred), up to the daily amount.

-A policy may be tax-qualified (in which case the premiums are deductible) or non-tax-qualified (in which case the premiums are not deductible).

-If it conforms to certain state and federal guidelines, a policy may be a partnership policy, which would make the policy holder eligible to participate in the state's long-term care partnership program and allow him or her to retain a greater level of assets than otherwise allowed should he or she ever need to apply for Medicaid assistance.

Both individual and group LTC policies are available. Coverage considerations include the benefit amount, the elimination period, inflation protection, non-forfeiture protection, and other features. Underwriting requirements vary depending on the insurance company. Most insurers are unwilling to accept applicants who already have serious medical problems or who are already receiving care. The younger the applicant, the more likely coverage will be granted and the lower the premium. Like all insurance products, cost is also determined based on the features and options chosen.

Summary

Private funding for long-term care makes use of the income, assets, and personal resources an individual may have. Virtually any type of savings or investment product can be used for this purpose, as can the equity in a home. However, the cost of long-term care can be extraordinarily high; for other than the very wealthy, relying on personal income and assets may fall short of adequately covering the need. For many, long-term care insurance may be the best option. The many different types and forms of LTCI enable citizens to customize the type and level of coverage that is best for them and, to some degree, to control the premium.

The Basics of Long-Term Care Insurance

Most long-term care services begin at home with the help of family or friends until the burden of care giving becomes too much of an emotional and financial hardship. The next step is generally

to hire a paid caregiver to help with ADLs and IADLs. Unfortunately, many people cannot afford to pay for such care even when it is delivered by the unskilled, unlicensed, or unsupervised, and more costly care by paid professionals is simply out of the question for most. Given the extraordinarily high cost of long-term care services, it is not surprising that few people are able to amass these sums. Fortunately, there is an option: long-term care insurance.

In exchange for the payment of premiums, long-term care insurance (LTCI) policies promise to pay benefits for custodial, intermediate, and/or skilled care. Like other types of insurance coverage's, LTCI contracts can be very complex. Even though policies have become more standardized in recent years, options, riders, elimination periods, benefit amounts, and other aspects of coverage can make the long-term care insurance picture difficult to fully comprehend.

Today's Long-Term Care Policies

Today's LTCI policies present many options to fulfill the care needs of seniors as well as those of any age with a chronic condition, disease, and/or disability. Choosing a benefit amount, benefit period, and the length of the elimination period are straightforward considerations, but today's policies contain a myriad of inflation protection, non-forfeiture benefits, elimination periods, pre-existing condition exclusions, premium payment options, and other provisions that make the selection of a suitable, appropriate policy a challenging task.

While today's LTCI policies may be complicated, it is important to recognize that they are a relatively new form of insurance. They are still in their early stages of development and are still evolving. New systems or delivery methods for care available in the future might not be covered by today's policies. For example, LTCI policies offered in the mid-1980s did not pay for care in assisted living facilities, because these types of facilities were not common at that time. Those who purchased early generations of LTC policies may not have the coverage they need as the evolution continues.

Standardizing various elements of LTCI policies would significantly reduce citizen uncertainty about the product and make regulation easier for the states and the federal government. Although some standardization of policies has occurred, especially with respect to LTC partnership policies (discussed in the next chapter), policies still vary among insurers.

In an attempt to define minimum standards for long-term care insurance and to provide a measure of citizen protection for those who purchase these policies, the National Association of Insurance Commissioners (NAIC) created the Long-Term Care Insurance Model Act and Regulations. Many states have adopted this model as the foundation for the design and regulation of policies issued in their jurisdictions, another factor that is helping to standardize policies. However, currently, states can pick and choose the provisions of the model they incorporate into their state law and the extent to which they apply them.

The following describes the major forms of LTCI policies and the common features that most contain or offer.

Tax-Qualified and Non-Tax-Qualified Policies

Today's long-term care policies may be issued as either tax-qualified or non-tax-qualified. These

two classes of LTC policies came about with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with the addition of Section 7702B to the Internal Revenue Code.

Before HIPAA, LTC insurance was not given the same tax treatment as other forms of health insurance. For example, some LTC services did not qualify as "medical care"; consequently, benefits an LTC policy paid for such services were potentially outside the scope of the income tax exclusion for reimbursements from accident and health insurance and were potentially taxable. Premiums employers pay for health and accident insurance for their employees are generally deductible by the employer and are not taxable to the employee; however, whether this treatment also applied to long-term care insurance was not clear. HIPAA clarified these questions by declaring that "qualified" long-term care contracts would be treated for tax purposes as accident and health insurance, and added Section 7702B to the Internal Revenue Code. Among other things, Section 7702B establishes standard requirements for qualified LTC contracts, subject to certain rules and restrictions. Policies that meet these requirements are known as tax-qualified policies. Policies that do not meet these requirements are non-tax-qualified policies.

Required Provisions for Tax-Qualified Policies

The defining standards HIPAA established for a LTC policy to be considered "tax-qualified" address the services such a policy must cover, the features it must contain, and the conditions that trigger the payment of benefits. These include the following:

-The policy must provide insurance only for long-term care services. These services are diagnostic, preventive, therapeutic, or rehabilitative treatments relating to curing, treating, or mitigating a chronic condition or disease, or services related to maintenance and personal care.

-The policy cannot provide for a cash surrender value.

-The policy must be guaranteed renewable.

-The policy must use standard benefit triggers and pay its benefits if the policy holder is certified as chronically ill due to:

-The inability to perform two of six activities of daily living (eating, bathing, dressing, continence, toileting, and transferring) and the need for assistance is expected to last at least 90 days; or

-A severe cognitive impairment.

-The policy must specify that once the policy holder qualifies for benefits—under either the ADL trigger or the cognitive impairment trigger—an approved plan of care developed by a licensed health care practitioner must be in place.

By meeting the definition of tax-qualified, a long-term care policy is given advantageous tax treatment with respect to premiums and benefits.

Treatment of Premiums

Premiums an individual pays for qualified LTC insurance policies are tax deductible as an itemized deduction on Schedule A of Form 1040. When these amounts, added to other non-reimbursed

qualifying medical expenses (including those for long-term care), exceed 7.5 percent of the individual's adjusted gross income (AGI), the excess may be deducted. However, a cap is placed on the deductible amount of these premiums, which varies by age and is subject to change every year.

Treatment of Benefits

Benefit dollars paid out from qualified LTC policies, subject to certain limitations, are not considered taxable income. If the contract is a reimbursement contract and pays for the actual costs incurred as a reimbursement for the cost of care, no portion of the benefit is taxable. If the benefit is paid as a flat indemnity amount regardless of the cost of care, there is a per day limitation on the amount that may be received tax-free. (In 2009, this daily limit was $280. It is subject to change every year.)

It should be noted that the tax treatment of benefits paid under a non-tax-qualified long-term care policy is not clear. The IRS has not definitely stated whether these benefits are taxable or not taxable.

Contracts Issued Before and After 1997

A contract issued after 1996 is a qualified long-term care insurance contract if it meets the requirements of IRC Section 7702B(b). A contract issued before 1997 is generally treated as a qualified LTCI contract if it met state law requirements for long-term care insurance contracts at the time and it has not been materially changed.

Any rider providing long-term care coverage that is attached to a life insurance policy or, with some exceptions, to an annuity (after 2009) will be treated as a separate contract.

Most LTCI policies sold today are tax-qualified contracts. Though some companies continue to issue non-tax-qualified policies, and some of these policies impose fewer restrictions on how an policy holder can qualify for benefits, non-tax-qualified policy forms are becoming less and less common. Furthermore, as noted, the IRS has not yet issued a definitive decision as to the tax treatment of benefits paid under non-tax-qualified policies, which also lessens their appeal. The following chart compares the features and treatment of tax-qualified and non-tax-qualified policies.

Comprehensive and Non-comprehensive Policies

As discussed previously, LTC policies are either comprehensive or non-comprehensive. The more common comprehensive policies cover care at all levels, home health care and nursing home care, as well as care in community-based settings such as assisted living. These are the most expensive policies, but they provide the greatest coverage.

Non-comprehensive policies are those that cover either home health care or nursing home care. Home health-care-only policies cover care provided in the home by nurses and therapists as well as personal care from home health aides and housekeepers. Nursing home-only policies pay for only the cost of a stay in a skilled nursing facility.

Reimbursement, Indemnity, and Disability Policies

Today’s long-term care policies can pay benefits on a reimbursement (expense incurred) or a set-dollar (indemnity) basis. Under a reimbursement, or expense incurred policy, the insurer will pay no more than the actual charge for LTC services, covering all or a portion of the actual expenses incurred daily or monthly up to the daily or monthly maximum stated in the policy. Benefits may be paid to the provider or directly to the policy holder.

Unlike a reimbursement policy, benefits paid by an indemnity policy are a set dollar amount. Under this type of policy, the insurer will pay the amount specified in the policy, regardless of the cost of service. Provider bills are not necessary, and the insurer will often pay out monthly the fixed amount selected, regardless of whether services have been received that month, to the provider of those services.

A third type of LTC contract is the disability (cash) policy. Under these policies, benefits are paid when the policy holder qualifies for benefits (i.e., meets the policy’s benefit trigger), regardless of whether the policy holder is actually receiving care or incurring expenses.