Long Term Care Insurance:
How to Choose the Best LTC Insurance

By BizMove Management Training Institute

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1. The Single Most Critical Factor in Choosing Long Term Care Insurance

The number one mistake made by Long Term Care insurance seekers is approaching only the companies that are most heavily advertised. The first long term care insurance company that comes to mind is not necessarily the one that will offer you the best rates.

The single most critical factor in getting the deal that is best for you is shopping around for as many quotes as you can. Why? because different LTC insurance companies charge different rates for the same coverage. In addition, insurance companies' competitiveness differ tremendously by customer location.

Only by obtaining several quotes that are specific to your situation and location you will be really able to discover the best plan that is available to you. How many quotes? go for at least 3 quotes from different insurers, less than that will not do the job.

Now, usually shopping around for three quotes can be a tedious and time consuming task, however, you can make it easier and more effective by using a free online quoting service such as Insurance-Me (If the link doesn't work, copy and paste the following URL into a browser: **www.liraz.com/insureme)**.

Insurance-Me will provide you with several competing offers from reliable LTC insurance providers that offer good plans in your area thus enabling you to compare and pinpoint on the best plan that is available for your location.

What is long-term care insurance

Unlike traditional health insurance, long-term care insurance is designed to cover long-term services and supports, including personal and custodial care in a variety of settings such as your home, a community organization, or other facility.

Long-term care insurance policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living such as bathing, dressing, or eating. You can select a range of care options and benefits that allow you to get the services you need, where you need them.

The cost of your long-term care policy is based on:

How old you are when you buy the policy

The maximum amount that a policy will pay per day

The maximum number of days (years) that a policy will pay

The maximum amount per day times the number of days determines the lifetime maximum amount that the policy will pay.

Any optional benefits you choose, such as benefits that increase with inflation

If you are in poor health or already receiving long-term care services, you may not qualify for long-term care insurance as most individual policies require medical underwriting. In some cases, you may be able to buy a limited amount of coverage, or coverage at a higher “non-standard” rate. Some group policies do not require underwriting.

What Long-term Care Insurance Covers

Most policies sold today are comprehensive. They typically allow you to use your daily benefit in a variety of settings, including:

Your home

Adult day service centers

Hospice care

Respite care

Assisted living facilities (also called residential care facilities or alternate care facilities)

Alzheimer’s special care facilities

Nursing homes

In the home setting, comprehensive polices generally cover these services:

Skilled nursing care

Occupational, speech, physical, and rehabilitation therapy

Help with personal care, such as bathing and dressing

Receiving Long-Term Care Insurance Benefits

In order to receive benefits from your long-term care insurance policy you meet two criteria: the Benefit Trigger and the Elimination Period.

Benefit triggers are the criteria that an insurance company will use to determine if you are eligible for benefits. Most companies use a specific assessment form that will be filled out by a nurse/social worker team. Benefit triggers:

Are the criteria insurance policies use to determine if you are eligible for long-term care benefits

Are determined through a company sponsored nurse/social worker assessment of your condition.

Usually are defined in terms of Activities of Daily Living (ADLs) or cognitive impairments

Most policies pay benefits when you need help with two or more of six ADLs or when you have a cognitive impairment

Once you have been assessed, your care manager from the insurance company will approve a Plan of Care that outlines the benefits for which you are eligible.

The “elimination period” is the amount of time that must pass after a benefit trigger occurs but before you start receiving payment for services. An elimination period:

Is like the deductible you have on car insurance, except it is measured in time rather than by dollar amount

Most policies allow you to choose an elimination period of 30, 60, or 90 days at the time you purchased your policy

During the period, you must cover the cost of any services you receive

Some policies specify that in order to satisfy an elimination period, you must receive paid care or pay for services during that time

Once your benefits begin:

Most policies pay your costs up to a pre-set daily limit until the lifetime maximum is reached

Other policies pay a pre-set cash amount for each day that you meet the benefit trigger, whether you receive paid long-term care services on those days or not

These “cash disability” policies offer more flexibility but are potentially more expensive

Using Life Insurance to Pay for Long-term Care

You can use your life insurance policy to help pay for long-term care services through the following options:

Combination (Life/Long-Term Care) Products

Accelerated Death Benefits (ADBs)

Life settlements

Viatical settlements

Combination Products

Many consumers are reluctant to buy long-term care insurance because they fear that their investment will be wasted if they do not use it. Some insurance companies have attempted to solve this problem by combining life insurance with long-term care insurance. The idea is that policy benefits will always be paid, in one form or another. These products are relatively new and the features are changing as the product evolves. The amount of the long-term care benefit if often expressed in terms of a percentage of the life insurance benefit.

Accelerated Death Benefits (ADBs)

A feature included in some life insurance policies that allows you to receive a tax-free advance on your life insurance death benefit while you are still alive. Sometimes you must pay an extra premium to add this feature to your life insurance policy. Sometimes the insurance company includes it in the policy for little or no cost.

There are different types of ADBs each of which serves a different purpose. Depending on the type of policy you have, you may be able to receive a cash advance on your life insurance policy's death benefit if:

You are terminally ill

You have a life-threatening diagnosis, such as AIDS

You need long-term care services for an extended amount of time

You are permanently confined to a nursing home and incapable of performing Activities of Daily Living (ADL), such as bathing or dressing

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2. Essential Long Term Care information

Last year over 10 million people needed some form of long-term care in the United States. Of this population, 3.6 million (37%) were under age 65 and 6 million (63%) were over age 65. Almost 70% of people turning age 65 will need long-term care at some point in their lives. This section of the website provides basic information so you can begin to think about how you will handle the need for long-term care. Your path will be unique to you, and based on your preferences and circumstances. Let's look at the basic questions covered in this section:

Long-term care is a range of services and supports you may need to meet your personal care needs. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called Activities of Daily Living (ADLs), such as:

Bathing

Dressing

Using the toilet

Transferring (to or from bed or chair)

Caring for incontinence

Eating

Other common long-term care services and supports are assistance with everyday tasks, sometimes called Instrumental Activities of Daily Living (IADLs) including:

Housework

Managing money

Taking medication

Preparing and cleaning up after meals

Shopping for groceries or clothes

Using the telephone or other communication devices

Caring for pets

Responding to emergency alerts such as fire alarms

Location matters.

Consider where you live and whether some of these tasks could be made easier by modifying your home. You can learn more in our housing considerations section.

70% of people turning age 65 can expect to use some form of long-term care during their lives. There are a number of factors that affect the possibility that you will need care:

Age - The older you are, the more likely you will need long-term care

Gender - Women outlive men by about five years on average, so they are more likely to live at home alone when they are older

Disability

Having an accident or chronic illness that causes a disability is another reason for needing long-term care

Between ages 40 and 50, on average, eight percent of people have a disability that could require long-term care services

69 percent of people age 90 or more have a disability

Health Status

Chronic conditions such as diabetes and high blood pressure make you more likely to need care

Your family history such as whether your parents or grandparents had chronic conditions, may increase your likelihood

Poor diet and exercise habits increase your chances of needing long-term care

Living Arrangements

If you live alone, you're more likely to need paid care than if you're married, or single, and living with a partner

The duration and level of long-term care will vary from person to person and often change over time. Here are some statistics (all are "on average") you should consider:

Someone turning age 65 today has almost a 70% chance of needing some type of long-term care services and supports in their remaining years

Women need care longer (3.7 years) than men (2.2 years)

One-third of today's 65 year-olds may never need long-term care support, but 20 percent will need it for longer than 5 years

Long-term care services and support typically come from:

An unpaid caregiver who may be a family member or friend

A nurse, home health or home care aide, and/or therapist who comes to the home

Adult day services in the area

A variety of long-term care facilities

A caregiver can be your family member, partner, friend or neighbor who helps care for you while you live at home. About 80 percent of care at home is provided by unpaid caregivers and may include an array of emotional, financial, nursing, social, homemaking, and other services. On average, caregivers spend 20 hours a week giving care. More than half (58 percent) have intensive caregiving responsibilities that may include assisting with a personal care activity, such as bathing or feeding.

Information on caregivers show that:

About 65.7 million people in the US (one in four adults) were unpaid family caregivers to an adult or child in 2009

About two-thirds are women

Fourteen percent who care for older adults are themselves age 65 or more

Most people can live at home for many years with help from unpaid family and friends, and from other paid community support

Most long-term care is provided at home. Other kinds of long-term care services and supports are provided by community service organizations and in long-term care facilities.

Examples of home care services include:

An unpaid caregiver who may be a family member or friend

A nurse, home health or home care aide, and/or therapist who comes to the home

Community support services include:

Adult day care service centers

Transportation services

Home care agencies that provide services on a daily basis or as needed

Often these services supplement the care you receive at home or provide time off for your family caregivers.

Outside the home, a variety of facility-based programs offer more options:

Nursing homes provide the most comprehensive range of services, including nursing care and 24-hour supervision

Other facility-based choices include assisted living, board and care homes, and continuing care retirement communities. With these providers, the level of choice over who delivers your care varies by the type of facility. You may not get to choose who will deliver services, and you may have limited say in when they arrive.

The facts may surprise you.

Consumer surveys reveal common misunderstandings about which public programs pay for long-term care services. It is important to clearly understand what is and isn't covered.

Medicare:

Only pays for long-term care if you require skilled services or rehabilitative care:

In a nursing home for a maximum of 100 days, however, the average Medicare covered stay is much shorter (22 days).

At home if you are also receiving skilled home health or other skilled in-home services. Generally, long-term care services are provided only for a short period of time.

Does not pay for non-skilled assistance with Activities of Daily Living (ADL), which make up the majority of long-term care services

You will have to pay for long-term care services that are not covered by a public or private insurance program

Medicaid:

Does pay for the largest share of long-term care services, but to qualify, your income must be below a certain level and you must meet minimum state eligibility requirements

Such requirements are based on the amount of assistance you need with ADL

Other federal programs such as the Older Americans Act and the Department of Veterans Affairs pay for long-term care services, but only for specific populations and in certain circumstances

In general, planning for long-term care is like planning for dementias like Alzheimer's disease. While many of the same planning steps apply, certain steps take on added importance. The loss of executive function associated with dementia can create hardships for caregivers in arranging or paying for care. The ability to comprehend finances and care choices is often among the first signs of dementia. To avoid problems in planning, the following steps can be taken:

Advanced Care Directive — to make sure care choices reflect preferences

Medical Power of Attorney — to make sure decisions can be made for persons no longer able to communicate their wishes

Power of Attorney — to make sure financial and estate decisions can be made to pay for care, apply for assistance (i.e. Medicaid, state based programs) or for the ongoing management of an estate.

Once symptoms appear, dementia makes the long-term care planning process more complex. It causes a specific set of challenges that also must be considered when deciding what your next steps will be. Among these are:

Safety issues specific to people with Alzheimer's

Working with caregivers that understand the symptoms of dementia and how to respond effectively

Medical specialists and products that may add to the cost of care, especially in regards to drugs specifically tailored to your loved one's needs

Adult day services that provide socialization and activities in a safe environment to both provide a break to the caregiver as well as giving the people with Alzheimer's positive stimulus

While people with dementia can stay in the home for some time, for most there will come a time when professional help, or living in a facility, becomes necessary. Today's options for facility care may include assisted-living arrangements that specialize in care for people with dementia. Here are just a few of the possibilities commonly available:

To learn more about general assisted-living facilities follow the link here

Specialized dementia care facilities, also known as "memory care" assisted living, generally offer supports and protections that go beyond traditional assisted living communities. For example, having specialized staff training, secured exits, and enhanced visual cues to help residents feel more at ease in unfamiliar surroundings can be part of one of these facilities*

Nursing homes include all the services of an assisted living facility with the added service of full-time nursing care, 24-hours a day. Some are designed specifically for people with Alzheimer's*

Did you know that one in three older Americans falls every year? Falls are the leading cause of both fatal and nonfatal injuries for people aged 65+.

Falls can result in hip fractures, broken bones, and head injuries and significant loss of independence. Falls often trigger the onset of a series of growing needs. For those over age 75, fallers are more than four times more likely to be admitted to a skilled nursing facility. (Donald and Bullpitt, 1999)

And falls, even without a major injury, can cause an older adult to become fearful or depressed, making it difficult for them to stay active.

The good news about falls is that most of them can be prevented. The key is to know where to look. Here are some steps developed by the National Council on Aging (NCOA) to help your older loved one reduce their risk of a fall:

6 Steps to Reducing Falls (Source: National Council on Aging)

1. Enlist their support in taking simple steps to stay safe. For example:

Ask your older loved one if they're concerned about falling

Many older adults recognize that falling is a risk, but they believe it won't happen to them or they won't get hurt—even if they've already fallen in the past

A good place to start is by sharing NCOA's Debunking the Myths of Older Adult Falls. If they're concerned about falling, dizziness, or balance, suggest that they discuss it with their health care provider who can assess their risk and suggest programs or services that could help

2. Discuss their current health conditions:

Find out if your older loved one is experiencing any problems with managing their own health

Ask whether they are having trouble remembering to take their medications—or are they experiencing side effects?

Ask if it is getting more difficult for them to do things they used to do easily?

Also make sure they're taking advantage of all the preventive benefits now offered under Medicare, such as the Annual Wellness visit. Encourage them to speak openly with their health care provider about all of their concerns

3. Ask about their last eye checkup:

If your older loved one wears glasses or contact lenses, make sure they have a current prescription and they're using the glasses/contacts as advised by their eye doctor

Remember that using tint-changing lenses can be hazardous when going from bright sun into darkened buildings and homes. A simple strategy is to change glasses upon entry or stop until their lenses adjust

Bifocals also can be problematic on stairs, so it's important to be cautious. For those already struggling with low vision, consult with a low-vision specialist for ways to make the most of their eyesight

4. Notice if they're holding onto walls, furniture, or someone else when walking or if they appear to have difficulty walking or arising from a chair, because:

These are all signs that it might be time to see a physical therapist

A trained physical therapist can help your older loved one improve their balance, strength, and gait through exercise

They might also suggest a cane or walker—and provide guidance on how to use these aids. Make sure to follow their advice.

Poorly fit aids actually can increase the risk of falling

5. Talk about their medications:

If your older loved one is having a hard time keeping track of medicines or is experiencing side effects, encourage them to discuss their concerns with their doctor and pharmacist

Suggest that they have their medications reviewed each time they get a new prescription

Some find it useful to use a spreadsheet to keep track of medications and schedules. Adding a timed medication dispenser that can be refilled each month by a family member can also promote peace of mind and ensure adherence to the prescribed regime

Beware of non-prescription medications that contain sleep aids—including painkillers with "PM" in their names. These can lead to balance issues and dizziness. If your older loved one is having sleeping problems, encourage them to talk to their doctor or pharmacist about safer alternatives.

6. Do a walk-through safety assessment of their home.

There are many simple and inexpensive ways to make a home safer. For professional assistance, consult an Occupational Therapist. Here are some examples:

Lighting: Increase lighting throughout the house, especially at the top and bottom of stairs. Ensure that lighting is readily available when getting up in the middle of the night

Stairs: Make sure there are two secure rails on all stairs

Bathrooms: Install grab bars in the tub/shower and near the toilet. Make sure they're installed where your older loved one would actually use them. For even greater safety, consider using a shower chair and hand-held shower

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3. Does Medicare and Medicaid Cover Long Term Care?

A number of public programs, including Medicare and Medicaid, may help pay for some long-term care services under certain circumstances. However, each program has specific rules about what services are covered, how long you can receive benefits, whether or not you qualify for benefits, and how much you have to pay in out-of-pocket costs. To accurately plan for your long-term care needs, it is very important to know the facts about what may or may not be covered, and to stay current on program changes.

Medicare only covers medically necessary care and focuses on medical acute care, such as doctor visits, drugs, and hospital stays. Medicare coverage also focuses on short-term services for conditions that are expected to improve, such as physical therapy to help you regain your function after a fall or stroke. (In January of 2013 a lawsuit (Jimmo v. Sebelius) regarding the Medicare Improvement Standard was settled. The Settlement may result in changes to this requirement.)

Eligibility

Medicare pays for health care for people age 65 years and older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure that requires dialysis or a kidney transplant).

Long-term Care Services – Skilled Nursing

Medicare does not pay the largest part of long-term care services or personal care—such as help with bathing, or for supervision often called custodial care. Medicare will help pay for a short stay in a skilled nursing facility, for hospice care, or for home health care if you meet the following conditions:

You have had a recent prior hospital stay of at least three days

You are admitted to a Medicare-certified nursing facility within 30 days of your prior hospital stay

You need skilled care, such as skilled nursing services, physical therapy, or other types of therapy

If you meet all these conditions, Medicare will pay for some of your costs for up to 100 days. For the first 20 days, Medicare pays 100 percent of your costs. For days 21 through 100, you pay your own expenses up to $140.00 per day (as of 2013), and Medicare pays any balance. You pay 100 percent of costs for each day you stay in a skilled nursing facility after day 100.

Long-term Care Services – Home and Other Care Services

In addition to skilled nursing facility services, Medicare pays for the following services for a limited time when your doctor says they are medically necessary to treat an illness or injury:

Part-time or intermittent skilled nursing care

Physical therapy, occupational therapy, and speech-language pathology that your doctor orders that a Medicare-certified home health agency provides for a limited number of days only

Medical social services to help cope with the social, psychological, cultural, and medical issues that result from an illness. This may include help accessing services and follow-up care, explaining how to use health care and other resources, and help understanding your disease

Medical supplies and durable medical equipment such as wheelchairs, hospital beds, oxygen, and walkers. For durable medical equipment, you pay 20 percent of the Medicare approved amount

There is no limit on how long you can receive any of these services as long as they remain medically necessary and your doctor reorders them every 60 days.

Hospice care

Medicare covers hospice care if you have a terminal illness and are not expected to live more than six months. If you qualify for hospice services, Medicare covers drugs to control symptoms of the illness and pain relief, medical and support services from a Medicare-approved hospice provider, and other services that Medicare does not otherwise cover, such as grief counseling. You may receive hospice care in your home, in a nursing home (if that is where you live), or in a hospice care facility. Medicare also pays for some short-term hospital stays and inpatient care for caregiver respite

Medicaid is a joint federal and state government program that helps people with low income and assets pay for some or all of their health care bills. It covers medical care, like doctor visits and hospital costs, long-term care services in nursing homes, and long-term care services provided at home, such as visiting nurses and assistance with personal care. Unlike Medicare, Medicaid does pay for custodial care in nursing homes and at home.

Overall program rules for who can be eligible for Medicaid and what services are covered are based on federal requirements, but states have considerable leeway in how they operate their programs,. States are required to cover certain groups of individuals, but have the option to cover additional groups. Similarly, states are required to cover certain services, but have the option of covering additional services if they wish to do so. As a result, eligibility rules and services that are covered vary from state to state.

To be eligible for Medicaid you must meet certain requirements, including having income and assets that do not exceed the levels used by your state. The section on "Medicaid Eligibility", which you can go to by clicking on the link below, provides more detailed information about how to become eligible for Medicaid.

Once your state determines that you are eligible for Medicaid, the state will make an additional determination of whether you qualify for long-term care services. When determining whether you qualify for long-term care services, most states use a specific number of personal care and other service needs to qualify for nursing home care or home and community-based services. There may be different eligibility requirements for different types of home and community-based services.

Your State Medical Assistance office is the best source for information about how to qualify for Medicaid in your state and if you qualify for long-term care services.

Medicaid covers nursing home services for all eligible people age 21 and older. Medicaid also covers home and community-based services for people who would need to be in a nursing home if they did not receive the home care services. In most states, Medicaid will also cover services that will help you remain in your home, such as personal care services, case management, and help with laundry and cleaning. Medicaid will not pay for your rent, mortgage, utilities, or food. Check to see whether your state Medicaid program offers alternatives to nursing home care services.

It is important to understand that Medicaid programs and eligibility for services vary from state to state. Services that may be available to you in one state may not be available in another. For example, some states cover assisted living services, while others do not. Contact your state Medicaid office to learn more about your state's programs and eligibility requirements.

To be eligible for Medicaid, you must meet the requirements for an eligibility group that your state covers under its Medicaid program. We can define an "eligibility group" as people who have certain common characteristics, such as being aged or disabled, and who meet certain common requirements, such as having income and assets below certain levels. There are many different eligibility groups in the Medicaid program, and each one has its own set of requirements. States are required to cover some groups, but have the option to cover or not cover others.

Regardless of the specific eligibility group, though, you must meet two types of requirements to qualify for Medicaid.

1. General requirements

2. Financial requirements

Once you qualify for Medicaid, you will have to meet additional functional requirements to qualify for long-term care services.

There are many pathways to being eligible for Medicaid. For example, most states provide Medicaid to anyone who is receiving benefits under the Supplemental Security

Income (SSI) program. A number of states provide Medicaid to aged or disabled persons with income that is below 100 percent of the federal poverty level ($931 a month for an individual in 2012).

For the most part, to be eligible for Medicaid you must be one of the following:

Be age 65 or older

Have a permanent disability as that term is defined by the Social Security Administration

Be blind

Be a pregnant woman

Be a child, or the parent or caretaker of a child

In addition you must meet certain other requirements, such as:

Be a U.S. citizen or meet certain immigration rules

Be a resident of the state where you apply

Have a Social Security number

There are two particular pathways, or groups, that you should be aware of because they are the ones most commonly used to make people eligible for Medicaid long-term care services. These groups are the special income level group, and the medically needy.

To be eligible for Medicaid, you must have limited income and assets.

Income

The amount of income you can have varies by state, and also varies depending on which eligibility groups each state covers. When the state determines your financial eligibility for Medicaid, the state will count some of your income, but not all of it. Your income includes these sources:

Regular benefit payments such as Social Security retirement or disability payments

Veterans benefits

Pensions

Salaries

Wages

Interest from bank accounts and certificates of deposit

Dividends from stocks and bonds

However, Medicaid generally does not count such things as:

Nutritional assistance such as food stamps

Housing assistance provided by the federal government

Home energy assistance

Some of your earnings if you have earned income from work you do

Medicaid will count payments to which you are entitled even if you don't receive all of the payment. For example, if you have earnings from which income taxes are withheld, Medicaid will count the entire amount of your earnings, including the amount that is withheld for taxes. If you and your spouse receive joint payments, such as rental income, the state allocates half to you and half to your spouse.

Special Income Level Group

The special income level group is an optional group for states, meaning that states can choose to cover or not cover this group. Over 40 states have chosen to cover this group, though, so it is widely available as a pathway to receiving long-term care services under Medicaid. This is an important group for you to know about because it is aimed specifically at people who need long-term care services.

To be eligible under this group a person must meet the general eligibility requirements, such as being aged, blind or disabled. The person must also be in an institution such as a nursing home for at least 30 consecutive days.

The amount of income a person can have is quite high, up to $2,130 a month in 2013. That is three times higher than the amount of income a person can have ($710 a month in 2013) and be eligible for Medicaid because he or she is receiving SSI benefits. The amount of countable assets a person can have is similar to other pathways, about $2,000 for an individual.

Once a state has determined that someone is eligible under the special income level group, eligibility starts at the beginning of the 30 days the person must be in an institution. That means that Medicaid can pay for all of the care you receive from the beginning of your stay in the nursing home.

Although the special income level group is aimed at people who are in institutions such as nursing homes, states can use the same rules to make people eligible for home and community-based services. This means that people with higher incomes can get long-term care services while still living in their own homes.

Because the amount of income you can have under the special income level group is higher than other pathways to Medicaid eligibility, you may be required to pay for part of your long-term care services out of your own income. See the section titled "Share of Cost" for more information about this.

Medically Needy

Like the special income level group, coverage of the medically needy is an option for states. Thirty-three states choose to cover the medically needy, which is not as many as cover the special income level group. But, this is still an important group for you to know about because in states which cover the medically needy, people with high incomes and high medical expenses can still be eligible for Medicaid long-term care services.

As with other pathways to eligibility to be eligible as medically needy a person must meet the general eligibility requirements, such as being aged, blind or disabled.

People who are eligible as medically needy have too much income to qualify for Medicaid through any other pathway. But, they can still qualify for Medicaid as medically needy by "spending down" the income that is above their state's income limit.

Spending Down to Become Eligible as Medically Needy

A person spends down his or her excess income to the state's medically needy limit by incurring medical expenses, such as doctor visits, prescription drugs, or anything else the state considers to be medical or remedial care. It is important to understand that the person does not actually have to pay an expense for it to count as an incurred expense. The person only has to incur the obligation to pay the expense.

The medical expenses the person has incurred are then subtracted from his or her income. If the remaining income does not exceed the state's income limit, the person is eligible as medically needy.

The medically needy income limit varies considerably from state to state. In most of the states that cover the medically needy, the income limit for an individual is less than $500 a month.

As an example of how this works, Mr. George has income of $1,000, which is too high to qualify for Medicaid in his state unless he can qualify as medically needy. His state has a medically needy income limit of $400 a month. That means Mr. George has a spenddown liability, or spenddown amount, of $600, which is the difference between his income and the state's income limit.

But, Mr. George also has incurred medical expenses of $600. The state will subtract that $600 in medical bills from his $1,000 in income, leaving him with $400 in countable income for the month. Since his countable income is no higher than the state's income limit of $400, Mr. George can be eligible for Medicaid as medically needy.

For a person with high income, the spenddown liability can be considerable. But, a person receiving long-term care services, particularly as an inpatient in a nursing home, can incur enough expenses very quickly because nursing home care is very expensive.

It is important to understand that even though Mr. George is now eligible for Medicaid, the program will only pay for the medical care he receives after he has met his spenddown liability. In our example, Mr. George's spenddown liability is $600. Medicaid

cannot pay that $600 on behalf of Mr. George. However, Medicaid will pay for medical care beyond that $600.

Income-Only or Miller Trusts

In states that do not have an Medically Needy Program, Medicaid applicants often use a trust to effectively lower their countable income below the state limit. Income-only trusts, often called Miller trusts, are trusts that can be established by or for a person of any age, regardless of whether the person is disabled. The trust can be funded only with the person's income, such as Social Security benefits, pensions, etc. It cannot be funded with assets such as money from a bank account or the sale of stocks or bonds. And, like a special needs trust or pooled trust, a Miller trust must contain a clause that says that upon the death of the person for whom the trust is established, any funds remaining in the trust must be paid to the state Medicaid program, up to the amount the program paid for services on behalf of the person.

Not all states recognize Miller trusts. If your state covers nursing home care for the medically needy, the state will not recognize a Miller trust. However, the other two trusts we described are recognized in all states.

When the state determines your financial eligibility for Medicaid some of your assets are counted, while others are excluded. During the Medicaid application process, you will have to provide documentation of what assets you have. While Medicaid's assessment of your income is relatively straightforward, the assessment of your assets can be fairly complex, depending on how much and what kind of assets you have.

Assets that are usually counted for eligibility include:

Checking and savings accounts

Stocks and bonds

Certificates of deposit

Real property other than your primary residence

Additional motor vehicles if you have more than one.

Assets that do not get counted for eligibility include the following:

Your primary residence

Personal property and household belongings

One motor vehicle

Life insurance with a face value under $1,500

Up to $1,500 in funds set aside for burial

Certain burial arrangements such as pre-need burial agreements

Assets held in specific kinds of trusts. See “Trusts” for more information about how a trust can affect your eligibility for Medicaid.

Limits on Home Equity

When determining eligibility for Medicaid your home, regardless of its value, is exempt from being counted as a resource as long as it is your principal place of residence. But, your home can affect whether Medicaid will pay for your long-term care services, including nursing home care and home and community-based waiver services.

If your equity interest in the home exceeds a certain level, Medicaid cannot pay for your long-term care. The equity value of your home is the fair market value (that is, what you could sell it for on the open market) minus any debts secured by the home, such as a mortgage or a home equity loan. For example, if your home has a fair market value of $300,000 and an outstanding mortgage of $100,000, the equity value is $200,000.

But your equity interest, which is what is important, depends on whether you own the home by yourself or with someone else. In our example, if you own the home by yourself, your equity interest is the entire equity value of $200,000. If you own your home jointly with your spouse or someone else, though, your equity interest is only half of the home’s equity value, or $100,000.

In 2013, the minimum home equity limit is $536,000. In other words, your must have more than $536,000 in equity interest in your home before Medicaid must deny payment for your long-term care services. However, states have the option of using a higher limit, which can be as high as $802,000 in 2013. Most states have chosen to use the lower limit but some states, especially in parts of the country where housing is expensive, use the higher amount. These limits are adjusted each year to account for inflation.

There are some exceptions to this rule. If your spouse or your child who is under 21 or blind or disabled lives in the home, this rule does not apply. Also, the state can choose not to apply this rule if it determines that applying the rule would be an undue hardship.

Other Important Considerations:

Unless specifically excluded any other real property, such as a vacation home, that you and your spouse own is counted as an asset in the Medicaid eligibility determination

The full value of an asset that you own jointly with someone else may be counted as belonging entirely to you when the state determines your Medicaid eligibility. For example, a jointly owned checking or savings account would be considered to be entirely your asset since either you or the other owner can withdraw all of the funds in the account.

The amount of countable assets you can have and still qualify for Medicaid varies from state to state. In most states you can retain about $2,000 in countable assets, and married couples who are still living in the same household can retain about $3,000 in

countable assets. This may not sound like much, but remember that many assets are not counted at all when determining your eligibility.

If one spouse lives in an institution and the other lives in the community, the community spouse is allowed to keep more of the couple's assets without disqualifying the spouse in the institution from Medicaid coverage. In addition, the community spouse may be able to have some of the institutionalized spouse's income set aside for his or her use. See "Considerations for Married People" for more information about how income and assets can be protected for a community spouse.

As we mentioned in the section on assets the asset limit in most states is about $2,000 for an individual, and $3,000 for a couple when both spouses are living together. But, if one spouse is in an institution such as a nursing home and the other spouse is still living on the community, different rules apply. These rules are commonly known as the spousal impoverishment rules.

The spousal impoverishment rules are designed to keep the spouse living in the community from becoming impoverished when the other spouse enters a nursing home. Without the spousal impoverishment rules, the state would consider a couple's jointly owned assets to belong entirely to the institutionalized spouse when the state determines that spouse's eligibility for Medicaid. And, most of the couple's income might have to be used to help pay for the cost of the institutionalized spouse's nursing home care, leaving little or nothing for the spouse in the community to live on.

Under the spousal impoverishment rules, though, the community spouse is allowed to keep a portion of the couple's assets. That portion is usually one-half of the couple's combined assets, up to a maximum of $115,920 in 2013. In about half of the states, if the couple has less than that in total assets the community spouse can keep all of the couple's assets.

In addition to assets, the spousal impoverishment rules provide that at least some of the institutionalized spouse's income can be protected for the community spouse to use. This helps ensure that the community spouse will have income to pay for living expenses. In 2013, the maximum amount of the institutionalized spouse's income that can be protected for the community spouse is $2,898 a month. However, in deciding how much income to protect, the state will take into consideration any other income the community spouse has.

Depending on how much income they have, people in nursing homes and even some receiving home and community-based services may have to pay part of the cost of the care they receive themselves. This is known as share of cost, or by the more complicated name of post-eligibility treatment of income. To keep this as simple as possible we will use the term "share of cost".

There are two reasons why you may be required to pay for part of the cost of your care.

One is that when you are in a nursing home, almost everything you need is provided for you. In addition to medical care you receive food and shelter, and if you are eligible for Medicaid the program pays for that through its reimbursement to the nursing home. In

other words, you have very little in the way of living expenses because Medicaid is paying for everything in the nursing home.

The second reason is that in most states a person with high income can still be eligible for Medicaid if the person is in a nursing home. As we explain in the section on the special income level group, the income limit for that group can be as high as $2,130 a month in 2013. If you are living in the community you must spend much of your income on things like shelter, food, and utilities. But, if you are in a nursing home, you do not have to pay for these things because the nursing home provides them and they are paid for by Medicaid. This means that if you are in a nursing home and have high income, you may have "extra" income that you are not using for anything.

Medicaid deals with this extra income by requiring you to help pay for part of the cost of your care in the nursing home. The state determines how much extra income you have by starting with your total income and then deducting certain items and expenses. Some things that are deducted are a small allowance for personal needs, an amount to take care of the needs of a spouse or children who may still be living at home, and an allowance to maintain your home if you have one. Whatever is left after all of the deductions is considered to be extra income, and that is your share of cost, or the amount you are expected to pay for your care. If nothing is left after all of the deductions, you do not have any share of cost.

The state takes your share of cost into account when it pays the nursing home. It does this by subtracting your share of cost from the nursing home payment. For example, if your share of cost is $300, the state reduces its payment to the nursing home by that amount. The nursing home will then ask you or your family for payment of your $300 share of cost.

Share of cost can also apply if you have high income and receive home and community-based services. But, instead of a small allowance for personal needs, you would have a much larger maintenance needs allowance. That is because a person receiving home and community-based services has the same expenses as anyone else living in the community. A number of states do not require people receiving home and community-based services to pay any share of cost. Instead, they allow those people to keep all of their income to pay for their living expenses in the community.

A medical specialist (nurse/social worker) in your state must evaluate your needs and decide if you need long-term care services. Usually, the specialist will make the decision based in part on whether you need assistance performing certain activities of daily living (ADL), such as:

Bathing

Dressing

Using the toilet

Transferring to or from a bed or chair

Caring for incontinence

Eating

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4. Choosing Where to Live

In thinking about long-term care it is important to consider where you will live as you age and how your place of residence can best support your needs should you become unable to fully care for yourself. The following questions will be answered in this section:

Most people prefer to stay in their own home for as long as possible. When planning to receive long-term care in your home there are many things to consider including:

The condition of your home

Whether it can be modified, if necessary, to accommodate a wheelchair or other devices/equipment

The availability of long-term care services in your area, such as adult day care or nearby medical facilities

How “aging-friendly” your community is—does it offer public transportation, home delivered meals and other needed services?

Tax and legal issues

It’s wise to think now about how your current residence and community will support your needs as you age and require long-term care services.

Support Services

In-home and community services can help you live at home longer. The following are some of the services and supports that may be available in your area:

Convenient and affordable public transportation

Someone to drive you on errands and to appointments

Help with housing and yard chores

Help with personal care

Home Delivered Meals

Senior Center where you can socialize and exercise

Adult Day Care centers

Contact your Area Agency on Aging to see what services are available in your community. Visit the Eldercare Locator or call 1-800-677-1116.

Typical Home Modifications

Modifications can make your home or apartment safer and allow you to stay there longer. An important component to staying at home is avoiding falls. One of the goals of home modification is to increase your chances of avoiding a fall, especially in the bathroom. Typical changes needed as you age include:

Entryway ramps to accommodate wheelchairs or walkers

Bathroom safety grip bars and walk-in or roll-in showers

Medical alert system

Lever style door and sink handles

Improved lighting and night lighting

Handrails

Wider doorways for wheelchair access

Stairway chair lifts

Costlier modifications

Bathroom and bedroom on the first floor of a multi-story home to accommodate someone unable to climb stairs

A separate apartment for a relative or renter in exchange for assistance when you need it

Do you qualify for financial help?

There may be state and local programs that provide low-interest loans or grants to help you pay for home modifications or home repairs. If you are age 60 or older, check with your local Area Agency on Aging to see whether you qualify for home modification and repair funds from Title III of the Older Americans Act.

Modifying your rented residence

You may need to talk with your landlord about the types of modifications you can make and whether you, or your landlord, will be responsible for the costs. Landlords are required to allow you to make reasonable modifications to accommodate your needs. If you have questions, consult your local Area Agency on Aging for more information.

Assistive Technology

Assistive devices are tools, products, or equipment that can help you perform daily tasks and activities independently in your home and community. Some of the simplest

assistive devices are kitchen and self-care tools such as a reacher (a tool that helps you get objects that are out of your reach).

Other devices are designed to help you communicate, such as:

Voice amplification tools

Voice recognition tools

Cueing and memory aids

Software such as word prediction programs

Tools that help you move or walk are called mobility assistive devices and include walkers, wheelchairs, and scooters.

Housing with Services

If it becomes necessary, several types of housing come with support services. Primarily, these are:

Public Housing for low-to-moderate income elderly and persons with disabilities. Typically assistance with services is provided by a staff person called a Service Coordinator

Assisted Living or “board and care” homes are group living settings that offer housing in addition to assistance with personal care and other services, such as meals. Generally, they do not provide medical care

Continuing Care Retirement Communities (CCRCs) provide a range of housing options, including independent living units, assisted living and nursing homes, all on the same campus. Nursing facilities, or nursing homes, are the most service-intensive housing option, providing skilled nursing services and therapies as needed.

Housing for Aging and Disabled Individuals

The Federal Government and most states have programs that help pay for housing for older people with low or moderate incomes, less than $46,000 if single or $53,000 if married.

Usually you have to fill out an application, and there may be a waiting list. Some of these housing programs also offer help with:

Meals

Housekeeping

Shopping

Laundry

Residents typically live in their own apartments within the complex. Usually a Federal or State agency will review your monthly income and expenses to see if you are eligible for this type of housing. Rent payments are usually a percentage of your income.

Assisted Living facilities come in many forms and variations. In 2011, there were 6,921 professionally managed assisted living facilities in the United States. In general, they provide room and board, social and recreational activities, and help with personal care and other activities of daily living. Residents pay for the cost of medical and nursing services separately. The following services are generally available: :

Some help with Activities of Daily Living (ADLs) such as eating, bathing, and using the bathroom, taking medicine, and getting to appointments as needed (varies by facility).

Residents often live in their own room or apartment within a building or group of buildings and have some or all of their meals together.

Social and recreational activities are usually provided. Some assisted living facilities have health services on site.

Residents usually pay a monthly rent and then pay additional fees for extra services they receive.

Costs for assisted living facilities can vary widely depending on the size of the living areas, services provided, type of help needed, and geographic location.

A continuing care retirement community (CCRC) is a community living arrangement, typically on a single campus, that provides housing, health care, and social services. CCRCs offer different levels of services ranging from independent housing to nursing home care.

Joining a CCRC is a way of obtaining long-term care services more easily. You move into a CCRC as a resident of an independent housing unit where you can usually purchase and receive support services. When you need more care or are unable to live independently, you can move to the assisted living facility on campus. Should you need the next level of care, you can move into the on-site nursing home.

The fee arrangements for CCRCs vary and generally include both a monthly fee and an entrance fee. CCRCs charge a monthly fee based on the size of your independent living unit. Most CCRCs also charge a sizeable one-time entrance fee. In some cases the entrance fee is not refundable. In other cases the fee may be refundable under certain circumstances. If the fee is refundable it will be held by the CCRC. It is important for you to understand that if the fee you pay to the CCRC is refundable it will be counted as an available asset if you need to apply for Medicaid, even if you cannot get access to the money yourself.

More things to consider:

Some allow you to hire your own home health care services while you live in an independent living unit. Others require you to be fully independent to remain in an independent living unit.

They may require that you have a health screening before you can move into the independent living unit

Some allow married couples to move into an independent living unit even if one spouse requires some care

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5. How to Decide on a Long Term Care

As you age, you can feel better knowing there are steps you can take to ensure that your wishes, both medical and financial, are carried out the way that you want them. Advance care planning entails discussing your wishes, completing legal documents, and appointing a health care decision maker.

Having your decisions squared away and clear, so that there are no misunderstandings or second-guessing, can be the greatest gift you can give to your loved ones, and yourself. In this section we will answer the following questions:

You should consider these questions as you plan:

What are your values and beliefs? When developing an advance care plan, consider your concerns, values, spiritual beliefs, or your ideas about what makes life worth living. A variety of user friendly publications and guides on advance health care are available at the American Bar Association.

What do you want for yourself? Most people think about the way they wish to face death or disability but may be uncomfortable discussing these topics. Sometimes sharing your own ideas, if you are helping someone, or reviewing the situations of other family members or friends who have been in similar situations, can help

Who do you want as your decision maker? Decide who should make decisions for you if you cannot. Choose someone who will understand and be able to carry out your wishes even if they include stopping life-sustaining treatment. You should also name a back-up agent to make decisions, in case the first person is not able to do so.

Most people are unable to handle the complexity of planning their medical and financial futures on their own. Consulting an elder law attorney, who deals daily with the issues surrounding old age, can be the first step in the advance care planning process. Elder law attorneys can help you create a legal framework to ensure that your medical and financial wishes are fulfilled. Some general functions they perform are:

Preparing Advance Medical Directives or “living wills” that clearly state what medical treatments you wish, or do not wish to receive if you can’t answer for yourself

Preparing power of attorney documents, identifying the person you trust to make your decisions when you cannot

Estate planning in the form of last wills and testaments and/ or “living trusts” that direct where your assets will go after your death

Exploring your qualifications for Medicaid, and if appropriate, applying on your behalf

Advocating, on your behalf, on disputes from insurance companies either for health insurance, long-term care insurance, or life insurance

Help your loved ones seek legal guardianship or conservatorship, if prior planning proves insufficient and you have lost capacity

Employment and retirement matters

General advice and counsel on issues surrounding aging

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6. Costs of Long Term Care

Just as there are many kinds of long-term care services and supports, so is there a wide range of costs for them. And while some people may qualify for a public program to help pay for these expenses, most people use a variety of options, including long-term care insurance, personal income and savings, life insurance, annuities and reverse mortgages to ensure they can pay for the care they require. As our population ages, new financial products are offering yet more options.

Some average costs for long-term care in the United States (in 2010) were:

$205 per day or $6,235 per month for a semi-private room in a nursing home

$229 per day or $6,965 per month for a private room in a nursing home

$3,293 per month for care in an assisted living facility (for a one-bedroom unit)

$21 per hour for a home health aide

$19 per hour for homemaker services

$67 per day for services in an adult day health care center

The cost of long-term care depends on the type and duration of care you need, the provider you use, and where you live. Costs can be affected by certain factors, such as:

Time of day. Home health and home care services, provided in two-to-four-hour blocks of time referred to as “visits,” are generally more expensive in the evening, on weekends, and on holidays

Extra charges for services provided beyond the basic room, food and housekeeping charges at facilities, although some may have “all inclusive” fees.

Variable rates in some community programs, such as adult day service, are provided at a per-day rate, but can be more based on extra events and activities

Many people believe that the medical insurance they currently have will pay for all or much of their long-term care. In general, health insurance covers only very limited and specific types of long-term care, and disability policies don’t cover any at all.

Health Insurance

Most forms of insurance, such as the private health insurance or HMO you may have on your own or through your employer, follow the same general rules as Medicare with regard to paying for long-term care services. If they do cover long-term care services, it is typically only for skilled, short-term, medically necessary care.

Like Medicare, the skilled nursing stay must follow a recent hospitalization for the same or related condition and is limited to 100 days

Coverage of home care is also limited to medically necessary skilled care

Most forms of private insurance do not cover custodial or personal care services at all

Your plan may help you pay for some of the copayments or deductibles that Medicare imposes. For example, your plan may help cover the $137.50 per day for Medicare covered nursing home care for days 21 through 100

Medigap

Medicare Supplemental Insurance, also known as “Medigap,” are private policies designed to fill in some of the gaps in Medicare coverage. Specifically, these policies help to:

Cover Medicare copayments and deductibles

Enhance your hospital and doctor coverage, but does not extend to long-term care coverage

Cover the daily Medicare copayment of $148.00 per day for days 21 through 100 for the small portion of nursing home stays that qualify for Medicare coverage

Medigap insurance is not intended to meet long-term care needs and provides no coverage for the vast majority of long-term care expenses like care in a nursing home, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

There are 12 standardized Medigap plans defined by federal law. Find out more about Medigap and see what is covered at the official government website for Medicare.

Disability Insurance

Disability insurance is intended to replace some of a working person’s income when a disability prevents them from working. It does not:

Cover medical care or long-term care services

Provide benefits once you are over age 65—when you are most likely to need long-term care services

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7. Long Term Care Glossary

Accelerated Death Benefit

A life insurance policy feature that lets you use some of the policy's death benefit prior to death.

Activities of Daily Living (ADLs)

Basic actions that independently functioning individuals perform on a daily basis:

Bathing

Dressing

Transferring (moving to and from a bed or a chair)

Eating

Caring for incontinence

Many public programs determine eligibility for services according to a person's need for help with ADLs. Many long-term care insurance policies use the inability to do a certain number of ADLs (such as 2 of 6) as criteria for paying benefits.

Acute Care

Recovery is the primary goal of acute care. Physician, nurse, or other skilled professional services are typically required and usually provided in a doctor's office or hospital. Acute care is usually short term.

Adult Day Services

Services provided during the day at a community-based center. Programs address the individual needs of functionally or cognitively impaired adults. These structured, comprehensive programs provide social and support services in a protective setting during any part of a day, but not 24-hour care. Many adult day service programs include health-related services.

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Services provided during the day at a community-based center. Programs address the individual needs of functionally or cognitively impaired adults. These structured, comprehensive programs provide social and support services in a protective setting during any part of a day, but not 24-hour care. Many adult day service programs include health-related services.

Advanced Directive

(also called Health Care Directive, Advanced Health Care Directive, Living Will, or Health Care Directive) Legal document that specifies whether you would like to be kept on artificial life support if you become permanently unconscious or are otherwise dying and unable to speak for yourself. It also specifies other aspects of health care you would like under those circumstances.

Aging and Disability Resource Centers (ADRCs)

ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, advice, counseling and assistance, empower people to make informed decisions about their long term supports, and help people more easily access public and private long term supports and services programs.

Alzheimer’s Disease

Progressive, degenerative form of dementia that causes severe intellectual deterioration. First symptoms are impaired memory, followed by impaired thought and speech, and finally complete helplessness.

Annuity

A contract in which an individual gives an insurance company money that is later distributed back to the person over time. Annuity contracts traditionally provide a guaranteed distribution of income over time, until the death of the person or persons named in the contract or until a final date, whichever comes first.

Arthritis

Disease involving inflammation of a joint or joints in the body.

Assisted Living Facility

Residential living arrangement that provides individualized personal care, assistance with Activities of Daily Living, help with medications, and services such as laundry and housekeeping. Facilities may also provide health and medical care, but care is not as intensive as care offered at a nursing home. Types and sizes of facilities vary, ranging from small homes to large apartment-style complexes. Levels of care and services also vary. Assisted living facilities allow people to remain relatively independent.

Bathing

Washing oneself by sponge bath or in the bathtub or shower. One of the six Activities of Daily Living (ADLs)

Benefit Triggers (Triggers)

Insurance companies use benefit triggers as criteria to determine when you are eligible to receive benefits. The most common benefit triggers for long-term care insurance are:

1. Needing help with two or more Activities of Daily Living

2. Having a Cognitive Impairment such as Alzheimer's Disease

Benefits

Monetary sum paid by an insurance company to a recipient or to a care provider for services that the insurance policy covers.

Board and Care Home

(also called Group Home) Residential private homes designed to provide housing, meals, housekeeping, personal care services, and supports to frail or disabled residents. At least one caregiver is on the premises at all times. In many states, Board and Care Homes are licensed or certified and must meet criteria for facility safety, types of services provided, and the number and type of residents they can care for. Board and Care Homes are often owned and managed by an individual or family involved in their everyday operation.

Caregiver

A caregiver is anyone who helps care for an elderly individual or person with a disability who lives at home. Caregivers usually provide assistance with activities of daily living and other essential activities like shopping, meal preparation, and housework.

Charitable Remainder Trust

Special tax-exempt irrevocable trust written to comply with federal tax laws and regulations. You transfer cash or assets into the trust and may receive some income from it for life or a specified number of years (not to exceed 20). The minimum payout rate is 5 percent and the maximum is 50 percent. At your death, the remaining amount in the trust goes to the charity that you designated as part of the trust arrangement.

Chronically Ill

Having a long-lasting or recurrent illness or condition that causes you to need help with Activities of Daily Living and often other health and support services. The condition is expected to last for at least 90 consecutive days. The term used in tax-qualified long-term care insurance policies to describe a person who needs long-term care because of an inability to do a certain number of Activities of Daily Living without help, or because of a severe cognitive impairment such as Alzheimer's Disease.

Cognitive Impairment

Deficiency in short or long-term memory, orientation to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. Alzheimer's Disease is an example of a cognitive impairment.

Community Spouse

Spouse of a nursing home resident applying for or receiving Medicaid long-term care services.

Community-Based Services

Services and service settings in the community, such as adult day services, home delivered meals, or transportation services. Often referred to as home- and community-based services, they are designed to help older people and people with disabilities stay in their homes as independently as possible.

Continence

Ability to maintain control of bowel and bladder functions, or when unable to maintain control of these functions, the ability to perform associated personal hygiene such as caring for a catheter or colostomy bag. This is one of the six Activities of Daily Living.

Continuing Care Retirement Communities (CCRC)

Retirement complex that offers a range of services and levels of care. Residents may move first into an independent living unit, a private apartment, or a house on the campus. The CCRC provides social and housing-related services and often also has an assisted living unit and an on-site or affiliated nursing home. If and when residents can no longer live independently in their apartment or home, they move into assisted living or the CCRC's nursing home.

Countable Assets

Assets whose value is counted in determining financial eligibility for Medicaid. They include:

Vehicles other than the one used primarily for transportation

Life insurance with a face value over $1,500

Bank accounts and trusts

Your home provided that your spouse or child does not live there and its equity value is greater than $500,000 ($750,000 in some states)

CPR (Cardiopulmonary Resuscitation)

Combination of rescue breathing (mouth-to-mouth resuscitation) and chest compressions used if someone isn't breathing or circulating blood adequately. CPR can restore circulation of oxygen-rich blood to the brain.

Custodial Care

(also called personal care) Non-skilled service or care, such as help with bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom.

Dementia

Deterioration of mental faculties due to a disorder of the brain.

Disabled

For Medicaid eligibility purposes, a disabled person is someone whose physical or mental condition prevents him or her from doing enough work or the type of work needed for self-support. The condition must be expected to last for at least a year or be expected to result in death. Persons receiving disability benefits through Supplemental Security Income (SSI), Social Security, or Medicare automatically meet this criterion.

Do Not Resuscitate Order (DNR)

Written order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. A DNR order may be instituted on the basis of an Advance Directive from a person, or from someone entitled to make decisions on the person's behalf, such as a health care proxy. In some jurisdictions, such orders can also be instituted on the basis of a physician's own initiative, usually when resuscitation would not alter the ultimate outcome of a disease. Any person who does not wish to undergo lifesaving treatment in the event of cardiac or respiratory arrest can get a DNR order, although DNR orders are more common when a person with a fatal illness wishes to die without painful or invasive medical procedures.

Dressing

Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. This is one of the six Activities of Daily Living.

Durable Power of Attorney

Legal document that gives someone else the authority to act on your behalf on matters that you specify. The power can be specific to a certain task or broad to cover many financial duties. You can specify if you want the power to start immediately or upon mental incapacity. For the document to be valid, you must sign it before you become disabled.

Eating

Feeding oneself by getting food into the body from a receptacle or by a feeding tube or intravenously. It is one of the six Activities of Daily Living.

Elimination Period

(also known as a Deductible Period or Benefit Waiting Period) Specified amount of time at the beginning of a disability during which you receive covered services, but the policy does not pay benefits. A Service Day Deductible Period is satisfied by each day of the period on which you receive covered services. A Calendar Day or Disability Day Deductible Period doesn't require that you receive covered services during the entire deductible period, but only requires that you meet the policy's benefit triggers during that time period.

Equity Value

Fair market value of property minus any liabilities on the property such as mortgages or loans.

Estate Recovery

Process by which Medicaid recovers an amount of money from the estate of a person who received Medicaid. The amount Medicaid recovers cannot be greater than the amount it contributed to the person's medical care.

Exempt Assets

(also called Non-countable Assets) Assets whose value is not counted in determining financial eligibility for Medicaid. They include:

Personal belongings

One vehicle

Life insurance with a face value under $1,500

Your home provided that your spouse or child lives there and its equity value is less than $500,000 ($750,000 in some states)

Federal Poverty Level

Income standard that the federal government issues annually that reflects increases in prices, measured by the Consumer Price Index.

Financial Eligibility

Assessment of a person's available income and assets to determine if he or she meets Medicaid eligibility requirements.

Functional Eligibility

Assessment of a person's care needs to determine if he or she meets Medicaid eligibility requirements for payment of long-term care services. The assessment may include a person's ability to perform Activities of Daily Living or the need for skilled care.

General Medicaid Eligibility Requirements

You must be:

A resident of the state in which you are applying

Either a United States citizen or a legally admitted alien

Age 65 or over

Or meet Medicaid's rules for disability, or blind

Group Home

(also called Board and Care Home) Residential private homes designed to provide housing, meals, housekeeping, personal care services, and supports to frail or disabled residents. At least one caregiver is onsite at all times. In many states, group homes are licensed or certified and must meet criteria for facility safety, types of services provided, and the number and type of residents they can care for. Group homes are often owned and managed by an individual or family involved in their everyday operation.

Health Care Proxy

Legal document in which you name someone to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions for yourself.

High Blood Pressure

Blood pressure is the force of blood pushing against your blood vessel walls. High blood pressure is when that force, as measured by a blood pressure cuff, is elevated above normal limits.

Homemaker

Licensed Homemaker Services provides "hands-off" care such as helping with cooking and running errands. Often referred to as "Personal Care Assistants" or "Companions." This is the rate charged by a non-Medicare certified, licensed agency.

Homemaker or Chore Services

Help with general household activities such as meal preparation, routine household care, and heavy household chores such as washing floors or windows or shoveling snow.

Hospice Care

Short-term, supportive care for individuals who are terminally ill (have a life expectancy of six months or less). Hospice care focuses on pain management and emotional, physical, and spiritual support for the patient and family. It can be provided at home or in a hospital, nursing home, or hospice facility. Medicare typically pays for hospice care. Hospice care is not usually considered long-term care.

Incontinence

Inability to maintain control of bowel and bladder functions as well as the inability to perform associated personal hygiene such as caring for a catheter or colostomy bag. Continence is one of the six Activities of Daily Living.

Informal Caregiver

Any person who provides long-term care services without pay.

Instrumental Activities of Daily Living

Activities that are not necessary for basic functioning, but are necessary in order to live independently. These activities may include:

Doing light housework

Preparing and cleaning up after meals

Taking medication

Shopping for groceries or clothes

Using the telephone

Managing money

Taking care of pets

Using communication devices

Getting around the community

Responding to emergency alerts such as fire alarms

Living Will

(also called Health Care Directive, Advanced Health Care Directive, Living Will, or Health Care Directive) Legal document that specifies whether you would like to be kept on artificial life support if you become permanently unconscious or are otherwise dying and unable to speak for yourself. It also specifies other aspects of health care you would like under those circumstances.

Long-Term Care

Services and supports necessary to meet health or personal care needs over an extended period of time.

Long-Term Care Facility

(also called Long Nursing Home or Convalescent Care Facility) Licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.

Long-Term Care Insurance

Insurance policy designed to offer financial support to pay for long-term care services.

Long-Term Care Services

Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care services assists people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility. For purposes of Medicaid eligibility and payment, long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility.

Look Back Period

Five-year period prior to a person's application for Medicaid payment of long-term care services. The Medicaid agency determines if any transfers of assets have taken place during that period that would disqualify the applicant from receiving Medicaid benefits for a period of time called the penalty period.

Medicaid

Joint federal and state public assistance program for financing health care for low-income people. It pays for health care services for those with low incomes or very high medical bills relative to income and assets. It is the largest public payer of long-term care services.

Medical Power of Attorney

Legal document that allows you to name someone to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions for yourself.

Medicare

Federal program that provides hospital and medical expense benefits for people over age 65, or those meeting specific disability standards. Benefits for nursing home and home health services are limited.

Medicare Supplement Insurance

(also called Medigap coverage) Private insurance policy that covers gaps in Medicare coverage.

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(also called Medicare Supplement Insurance) Private insurance policy that covers gaps in Medicare coverage.

National Association of Insurance Commissioners (NAIC)

Membership organization of state insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

Non-countable Assets

(also called exempt assets) Assets whose value is not counted in determining financial eligibility for Medicaid. They include:

Personal belongings

One vehicle

Life insurance with a face value under $1,500

Your home provided that your spouse or child lives there and its equity value is less than $500,000 ($750,000 in some states)

Nursing Home

(also called Long-Term Care Facility or Convalescent Care Facility) Licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.

Osteoporosis

Bone disease characterized by a reduction in bone density. Bones become porous and brittle as a result of calcium loss. People with osteoporosis are more vulnerable to breaking bones.

Partnership Long Term Care Insurance Policy

Private long-term care insurance policy that allows you to keep some or all of your assets if you apply for Medicaid after using up your policy's benefits. The Deficit Reduction Act of 2005 allows any state to establish a Partnership Program. Under a Partnership policy, the amount of Medicaid spend-down protection you receive is generally equal to the amount of benefits you received under your private Partnership policy. (State-specific program designs vary.)

Personal Care

(also called custodial care) Non-skilled service or care, such as help with bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom.

Respite Care

Temporary care which is intended to provide time off for those who care for someone on a regular basis. Respite care is typically 14 to 21 days of care per year and can be provided in a nursing home, adult day service center, or at home by a private party.

Reverse Mortgage

Type of loan based on home equity that enables older homeowners (age 62 or older) to convert part of their equity in their homes into tax-free income without having to sell the home, give up title, or take on a new monthly mortgage payment. Instead of making monthly payments to a lender, as you do with a regular mortgage, a lender makes payments to you. The loan, along with financing costs and interest on the loan, does not need to be repaid until the homeowner dies or no longer lives in the home.

Skilled Care

Nursing care such as help with medications and caring for wounds, and therapies such as occupational, speech, respiratory, and physical therapy. Skilled care usually requires the services of a licensed professional such as a nurse, doctor, or therapist.

Skilled Care Needs

Services requiring the supervision and care of a nurse or physician, such as assistance with oxygen, maintenance of a feeding tube, or frequent injections.

Spend Down

Requirement that an individual spend most of his or her income and assets to pay for care before he or she can satisfy Medicaid's financial eligibility criteria.

Supervisory Care

Long-term care service for people with memory or orientation problems. Supervision ensures that people don't harm themselves or others because their memory, reasoning, and orientation to person, place, or time are impaired.

Supplemental Security Income (SSI)

Program administered by the Social Security Administration that provides financial assistance to needy persons who are disabled or aged 65 or older. Many states provide Medicaid without further application to persons who are eligible for SSI.

Transfer of Assets

Giving away property for less than it is worth or for the sole purpose of becoming eligible for Medicaid. Transferring assets during the look back period results in disqualification for Medicaid payment of long-term care services for a penalty period.

Transferring

Moving into and out of a bed, chair, or wheelchair. Transferring is one of the six Activities of Daily Living.

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Special Bonus:

8. Sixty One Ways to Save Money

Here is a list of tips and ideas that will help you save money in various areas of your life:

Airline Fares

1.You may lower the price of a round trip air fare by as much as two-thirds by making certain your trip includes a Saturday evening stay over, and by purchasing the ticket in advance.

2.To make certain you have a cheap fare, even if you use a travel agent, contact all the airlines that fly where you want to go and ask what the lowest fare to your destination is.

3.Be flexible, if possible. Consider using low fare carriers or alternative airports and keep an eye out for fare wars.

Car Rental

1.Since car rental rates can vary greatly, shop around for the best basic rates. Ask about any additional charges (extra driver, gas, drop-off fees) and special offers.

2.Rental car companies offer various insurance and waiver options. Check with your automobile insurance agent and credit card company in advance to avoid duplicating any coverage you may already have.

New Cars

1.You can save thousands of dollars over the lifetime of a car by selecting a model that combines a low purchase price with low financing, insurance, gasoline, maintenance, and repair costs. Ask your local librarian for new car guides that contain this information.

2.Having selected a model, you can save hundreds of dollars by comparison shopping. Call at least five dealers for price quotes and let each know that you are calling others.

3.Remember there is no "cooling off" period on new car sales. Once you have signed a contract, you are obligated to buy the car.

Used Cars

1.Before buying any used car:

- Compare the seller's asking price with the average retail price in a "bluebook" or other guide to car prices found at many libraries, banks, and credit unions.

- Have a mechanic you trust check the car, especially if the car is sold "as is."

2.Consider purchasing a used car from an individual you know and trust. They are more likely than other sellers to charge a lower price and point out any problems with the car.

Auto Leasing

1.Don't decide to lease a car just because the payments are lower than on a traditional auto loan. The leasing payments may be lower because you don't own the car at the end of the lease.

2.Leasing a car is very complicated. When shopping, consider the price of the car (known as the capitalized cost), your trade-in allowance, any down payment, monthly payments, various fees (excess mileage, excess "wear and tear," end-of- lease), and the cost of buying the car at the end of the lease. Keys to Vehicle Leasing: A Consumer Guide, published by the Federal Reserve Board and Federal Trade Commission, is a valuable source of information about auto leasing.

Gasoline

1.You can save hundreds of dollars a year by comparing prices at different stations, pumping gas yourself, and using the lowest-octane called for in your owner's manual.

2.You can save up to $100 a year on gas by keeping your engine tuned and your tires inflated to their proper pressure.

Car Repairs

1.Consumers lose billions of dollars each year on unneeded or poorly done car repairs. The most important step that you can take to save money on these repairs is to find a skilled, honest mechanic. Before you need repairs, look for a mechanic who:

- is certified and well established;

- has done good work for someone you know; and

- communicates well about repair options and costs.

Auto Insurance

1.You can save several hundred dollars a year by purchasing auto insurance from a licensed, low-price insurer. Call your state insurance department for a publication showing typical prices charged by different companies. Then call at least four of the lowest-priced, licensed insurers to learn what they would charge you for the same coverage.

2.Talk to your agent or insurer about raising your deductibles on collision and comprehensive coverages to at least $500 or, if you have an old car, dropping these coverages altogether. Taking these steps can save you hundreds of dollars a year.

3.Make certain that your new policy is in effect before dropping your old one.

Homeowner/Renter Insurance

1.You can save several hundred dollars a year on homeowner insurance and up to $50 a year on renter insurance by purchasing insurance from a low-price, licensed insurer. Ask your state insurance department for a publication showing typical prices charged by different licensed companies. Then call at least four of the lowest priced insurers to learn what they would charge you. If such a publication is not available, it is even more important to call at least four insurers for price quotes.

2.Make certain you purchase enough coverage to replace the house and its contents. "Replacement" on the house means rebuilding to its current condition.

3.Make certain your new policy is in effect before dropping your old one.

Life Insurance

1.If you want insurance protection only, and not a savings and investment product, buy a term life insurance policy.

2.If you want to buy a whole life, universal life, or other cash value policy, plan to hold it for at least 15 years. Canceling these policies after only a few years can more than double your life insurance costs.

3.Check your public library for information about the financial soundness of insurance companies and the prices they charge. The July 1998 issue of Consumer Reports is a valuable source of information about a number of insurers.

Checking

1.You can save more than $100 a year in fees by selecting a checking account with a low (or no) minimum balance requirement that you can, and do, meet. Request a list of these and other fees that are charged on these accounts.

2.Banking institutions often will drop or lower checking fees if paychecks are directly deposited by your employer. Direct deposit offers the additional advantages of convenience, security, and immediate access to your money.

Savings and Investment Products

1.Before opening a savings or investment account with a bank or other financial institution, find out whether the account is insured by the federal government (FDIC or NCUA). An increasing number of products offered by these institutions, including mutual stock funds and annuities, are not insured.

2.To earn the highest return on savings (annual percentage yield) with little or no risk, consider certificates of deposit (CDs) and treasury bills or notes.

3.Once you select a type of savings or investment product, compare rates and fees offered by different institutions. These rates can vary a lot and, over time, can significantly affect interest earnings.

Credit Cards

1.You can save as much as a thousand dollars or more each year in lower credit card interest charges by paying off your entire bill each month.

2.If you are unable to pay off a large balance, pay as much as you can and switch to a credit card with a low annual percentage rate (APR). For a modest fee, RAM Research Corp. (800-344-7714) will send you a list of low-rate cards. You can obtain a list of low-rate cards by accessing "www.ramresearch.com.cardtrack" on the Internet.

3.You can reduce credit card fees, which may add up to more than $100 a year, by getting rid of all but one or two cards, and by avoiding late payment and over-the-credit limit fees.

Auto Loans

1.If you have significant savings earning a low interest rate, consider making a large down payment or even paying for the car in cash. This could save you as much as several thousand dollars in finance charges.

2.You can save as much as hundreds of dollars in finance charges by shopping for the cheapest loan. Contact several banks, your credit union, and the auto manufacturer's own finance company.

First Mortgage Loans

1.Although your monthly payment may be higher, you can save tens of thousands of dollars in interest charges by shopping for the shortest-term mortgage you can afford. On a $100,000 fixed-rate loan at 8% annual percentage rate (APR), for example, you will pay $90,000 less in interest on a l 5-year mortgage than on a 30-year mortgage.

2.You can save thousands of dollars in interest charges by shopping for the lowest-rate mortgage with the fewest points. On a 15-year, $100,000 fixed-rate mortgage, just lowering the APR from 8.5% to 8.0% can save you more than $5,000 in interest charges. On this mortgage, paying two points instead of three would save you an additional $1,000.

3.If your local newspaper does not periodically run mortgage rate surveys, call at least six lenders for information about their rates (APRs), points, and fees. Then ask an accountant to compute precisely how much each mortgage option will cost and its tax implications.

4.Be aware that the interest rate on most adjustable rate mortgage loans (ARMs) can vary a great deal over the lifetime of the mortgage. An increase of several percentage points might raise payments by hundreds of dollars per month.

Mortgage Refinancing

1.Consider refinancing your mortgage if you can get a rate that is at least one percentage point lower than your existing mortgage rate and plan to keep the new mortgage for several years or more. Ask an accountant to calculate precisely how much your new mortgage (including up-front fees) will cost and whether, in the long run, it will cost less than your current mortgage.

Home Equity Loans

1.Be cautious in taking out home equity loans. These loans reduce the equity that you have built up in your home. If you are unable to make payments, you could lose your home.

2.Compare home equity loans offered by at least four banking institutions. In comparing these loans, consider not only the annual percentage rate (APR) but also points, closing costs, other fees, and the index for any variable rate changes.

Home Purchase

1.You can often negotiate a lower sale price by employing a buyer broker who works for you not the seller. If the buyer broker or the broker's firm also lists properties, there may be a conflict of interest, so ask them to tell you if they are showing you a property that they have listed.

2.Do not purchase any house until it has been examined by a home inspector that you selected.

Renting a Place to Live

1.Do not limit your rental housing search to classified ads or referrals from friends and acquaintances. Select buildings where you would like to live and contact their building manager or owner to see if anything is available.

2.Remember that signing a lease probably obligates you to make all monthly payments for the term of the agreement.

Home Improvement

1.Home repairs often cost thousands of dollars and are the subject of frequent complaints. Select from among several well established, licensed contractors who have submitted written, fixed-price bids for the work.

2.Do not sign any contract that requires full payment before satisfactory completion of the work.

Major Appliances

1.Consult Consumer Reports, available in most public libraries, for information about specific brands and how to evaluate them, including energy use. There are often great price and quality differences among brands.

2.Once you've selected a brand, check the phone book to learn what stores carry this brand, then call at least four of these stores for the prices of specific models. After each store has given you a quote, ask if that's the lowest price they can offer you. This comparison shopping can save you as much as $100 or more.

Electricity

1.To save as much as hundreds of dollars a year on electricity, make certain that any new appliances you purchase, especially air conditioners and furnaces, are energy-efficient. Information on the energy efficiency of major appliances is found on Energy Guide Labels required by federal law.

2.Enrolling in load management programs and off-hour rate programs offered by your electric utility may save you up to $100 a year in electricity costs. Call your electric utility for information about these cost-saving programs.

Home Heating

1.A home energy audit can identify ways to save up to hundreds of dollars a year on home heating (and air conditioning). Ask your electric or gas utility if they can do this audit for free or for a reasonable charge. If they cannot, ask them to refer you to a qualified professional.

Local Telephone Service

1.Check with your phone company to see whether a flat rate or measured service plan will save you the most money.

2.You will usually save money by buying your phones instead of leasing them.

3.Check your local phone bill to see if you have optional services that you don't really need or use. Each option you drop could save you $40 or more each year.

Long Distance Telephone Service

1.Long distance calls made during evenings, at night, or on weekends can cost significantly less than weekday calls.

2.If you make more than a few long distance calls each month, consider subscribing to a calling plan. Call several long distance companies to see which one has the least expensive plan for the calls you make.

3.Whenever possible, dial your long distance calls directly. Using the operator to complete a call can cost you an extra $6.

Food Purchased at Markets

1.You can save hundreds of dollars a year by shopping at the lower-priced food stores. Convenience stores often charge the highest prices.

2.You will spend less on food if you shop with a list.

3.You can save hundreds of dollars a year by comparing price-per-ounce or other unit prices on shelf labels. Stock up on those items with low per-unit costs.

Prescription Drugs

1.Since brand name drugs are usually much more expensive than their generic equivalents, ask your physician and pharmacist for generic drugs whenever appropriate.

2.Since pharmacies may charge widely different prices for the same medicine, call several. When taking a drug for a long time, also consider calling mail-order pharmacies, which often charge lower prices.

Funeral Arrangements

1.Make your wishes known about your funeral, memorial, or burial arrangements in writing. Be cautious about prepaying because there may be risks involved.

2.For information about the least costly options, which could save you several thousand dollars, contact a local memorial society, which is usually listed in the Yellow Pages under funeral services.

3.Before selecting a funeral home, call several and ask for prices of specific goods and services, or visit them to obtain an itemized price list. You are entitled to this information by law and, by using it to comparison shop, you can save hundreds of dollars.

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