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Quiz

Potential Resources for Paying for Long-Term Care Expenses

A. Financing/Paying for Long-Term Care

Let's take a look first at what Long-term care costs. In retrospect, California nursing home rates have increased at an average rate of over 5% per year during the past 20 years and are likely in the future to continue to increase by at least 5% per year. The cost of care in the future will be much higher than it is today. A 5% annual increase means a year of care that costs \$85,000 today will cost twice that amount in 14 years, or \$170,000 a year!

More than half the people who go into a nursing home will spend between \$84,000 and \$98,000 (in year 2015 dollars) and one person out of every five will spend even more, perhaps much more, than that. They shouldn't forget that before most people enter a nursing home, they would have already struggled for years with the cost of long-term care in their own homes.

Median costs for nursing homes in California for a private room averaged \$268 a day in 2015 (or \$98,000 per year) Semi-private \$230 per day \$84,000 per year. Long-term care can be very expensive. Of those who enter nursing homes, 55% will have a total lifetime use of at least one year, 24% will stay between one and five years, and 21% will have a total lifetime use of five years or more. (Source: National Center for Policy Analysis, A Long-Term Solution to Medicaid Problems)

If a person needs assistance because of a degenerative mental disease, such as Alzheimer's, who will pay for care? If one requires long-term care because of a chronic physical condition such as arthritis or Parkinson's disease, who will pay for it? The answer is probably they will, unless they act to protect themselves. (Source: Genworth 2013, California - State Median: Annual Care Costs in 2013)

1. Can One Afford Long-Term Care Insurance?

LTC policy purchasers should not spend more than 7% of their total annual income on annual premium for a long-term care [insurance policy](#). Estimate your discretionary income by subtracting your fixed expenses from your annual income. Then decide how much of that discretionary income you want to spend on long-term care insurance premiums.

After retirement, income often does not keep pace with inflation. As we age we are more likely to have unexpected medical expenses, such as prescription drugs or other medical costs that may not be covered by your medical insurance. The loss of a spouse can also result in reduced income. Select a premium you can comfortably afford. Take into [consideration](#) that your premium may increase during the years you

own the policy. When talking to an agent about long-term care insurance it is important for you and your agent to understand your financial circumstances so that he or she can tailor a plan best suited to your needs. (Source: *CA Long-term care Rate Guide-A Guide to Long-Term Care*)

2. Funding Mechanisms for Long-Term Care

Savings/Private Investment/Personal Resources

Personal Savings

When care is provided by family members and friends at home, other costs such as those for skilled care, equipment, transportation, and other costs not paid by Medicare are also paid from the patient's personal income or savings. Generally speaking, people pay long-term care expenses from their own income and resources. People who use up their assets paying for long-term care are "spending down" and may become eligible for Medi-Cal as a result.

Home Equity

Equity in a home is the asset value within the market value of a home that would be realized by an owner upon sale of that home after the mortgage and all expenses are paid. It can be viewed as an asset that might be available to a person in need of funds for long-term care. While a person might not actually sell the home to access the net money or equity, many banks will lend a person a portion of the amount of the equity in their home if the equity amount is pledged to the bank if the home were to be ultimately sold. Payments must be made back to the bank each month and would include amortization of the interest being charged.

Home Equity Conversion

Some Home Equity Conversions require full-time residency, a variety of types of home equity loans are also available: repayment schedules, and **conditions** for loan continuance, renting, etc. These are ways to raise the cash needed for care and are options for **consideration** based on the needs and situations of individuals. A qualified agent with great knowledge in this area, an accountant, banker, attorney, etc. should be consulted as all or part of one's needs when looking at reverse mortgages and other forms of home equity loans. Interested parties can contact the Senior Information & Assistant Program, available in different counties, for information.

Reverse Mortgages

The most commonly referred to methodology in this area of using the equity in one's home to provide funds for the costs associated with long-term care are Reverse mortgages. The amount of money one receives depends on their age, the value of their home and the cost of the loan. It is generally used for providing long-term home care as some require that the mortgagee be full time in residence in the home. Some require the reverse mortgage to be paid if they have to move out of the home to a nursing home and are going to be there an extended period of time. They were developed to help older people tap into the value of their homes without having to sell the home or get a second mortgage or equity loan against their home that requires a monthly repayment. A reverse mortgage allows one to remain in their home and receive payments for the equity much like a line of credit to be used when and as needed.

Residential Reverse Mortgages Insured by HUD

Reverse Annuity Mortgage (RAM) or also called the Home Equity Conversion Mortgage (HECM) is the oldest and most popular reverse mortgage product. Available since 1989 to homeowners 62 or older, HECMs are insured by the federal government through the Federal Housing Administration (FHA), a part of the U.S. Department of Housing and Urban Development. Eligible home types include single-family homes, manufactured homes built after June 1976, condominiums, and town homes.

The size of a HECM varies with

- The borrower's age;
- The value of the home; and
- Current interest rates.

The location of your home also affects the loan size. The maximum size of a HECM depends on the FHA one's limit, which varies from area to area and is usually adjusted annually. The 2013 loan limit for a particular area may be found at HUD's Web site. FHA provides free software to lenders to help compute the applicable loan amount for each borrower.

Borrowers can choose to receive the proceeds from a HECM as

- A lump sum payment;
- Fixed monthly payments;
- A line of credit; or
- A combination of these.

The origination fee cannot exceed \$2,000 or 2% of the maximum [claim](#) amount (the FHA loan limit), whichever is greater. The entire amount of the origination fee may be financed as part of the mortgage, and certain other closing costs. The fee charged to a borrower is limited for a HECM. FHA Mortgagee Letter 00-10 spells out the size of the origination fee that may be charged to borrowers and what the fee cap covers. Typically the only cost that a borrower must pay for upfront out of pocket is for an [appraisal](#) fee.

The remaining closing costs and fees generally can be financed as part of the reverse mortgage. HECM borrowers must also pay an FHA insurance premium, equal to 2% of the loan amount up-front, plus an annual premium thereafter equal to 0.5% of the loan amount.

The HECM interest rate that is charged adjusts either monthly or annually, depending on which option the borrower chooses. However, these adjustments don't alter the monthly payments that borrowers can receive (if they have chosen the monthly payment option). Instead, the adjustment affects the total interest that is charged on the loan, which is added to the loan balance while the loan is outstanding and is paid when the loan becomes due. A borrower is not required to make any mortgage payments to the lender during the life of the HECM. The HECM becomes repayable, in full, when the sole remaining borrower dies or no longer occupies the home as his or her principal residence (e.g., through a sale of the home or a permanent move out of the home).

The repayment obligation is equal to the sum of the total funds received by the borrower, interest, and any closing costs and other charges financed as part of the loan. The borrower or borrower's heirs/estate may pay off the loan and keep the home. If not, the lender is repaid when the home is sold. If the proceeds are less than the amount owed, FHA absorbs the shortfall and makes an insurance claim payment to

the lender. If the sales proceeds exceed the amount owed, excess proceeds go to the borrower or borrower's heirs/estate.

A variety of types of home equity loans exists. These are ways to raise the cash needed for care and are options for **consideration** based on the needs and situations of individuals. Some require full-time residency, repayment schedules, and **conditions** for loan continuance, renting, etc. A qualified agent with great knowledge in this area, an accountant, banker, attorney, etc. should be consulted when looking at reverse mortgages and other forms of home equity loans as all or part of one's needs.

Life Settlements

What is it? A life settlement is the sale of an existing life **insurance policy** to a third party for more than its cash surrender value, but less than its net **death benefit**.

Viatical Settlements

There are companies that will offer to "buy" a life policyholder's existing life **insurance policy** at a discount if they have a terminal life-threatening illness. They must be licensed with the California DOI. If one is seriously considering a viatical agreement, an agent should advise them to contact their insurance company to see if the medical information is kept confidential and if there may be tax/benefit consequences from entering into such a settlement. (Source: Taking Care of Tomorrow, California Department of Aging)

Viatical Life and Medical Settlements

Relative to Viatical insurance settlements, a person who is within 24 months of death can have a portion of their **death benefit** of a life **insurance policy** prepaid by the issuing insurance company tax free. Viatical settlement is the purchase of a life insurance policy from a terminally ill person (viator) for a reduction of the face value of the policy. The purchase price is based on the life expectancy of the viator - the shorter the life expectancy, the greater the offer for the policy.

California law requires that anyone entering into or soliciting a viatical settlement be licensed by the Insurance Commissioner. This licensure requirement applies to

- Purchasers of the policy;
- Those who are assigned an ownership interest in the policy, including a collateral ownership interest;
- Brokers who assist the terminally ill in securing the best offer for their policy;
- Brokers who secure investors or purchasers for the policy; and
- Those who purchase the policy after it has been purchased from the policyholder.

Generally speaking, the difference between a viatical settlement and a life or senior settlement is that a viatical settlement involves the sale of a policy from a person with a life-threatening or catastrophic illness or condition.

Although the words "life-threatening" and "catastrophic" have not yet been defined by regulations, it seems clear that a person who has been diagnosed with a terminal illness by a medical doctor would have a life-threatening illness or condition, and thus would be considered a viator if they were to sell their life insurance policy. Currently, other settlements are not regulated by the Insurance Department.

For example, if one has a terminal life-threatening illness, some companies will offer to "buy" their life policyholder's existing life insurance policy at a discount. They must be licensed with the California DOI. If one is seriously considering a viatical agreement, an agent should advise them to contact their insurance company to see if the medical

information is kept confidential and if there may be tax/benefit consequences from entering into such a settlement. (Source: Taking Care of Tomorrow, California Department of Aging)

3. Insurance Products That Contain Long-Term Care Benefit Options

Standalone Long-Term Care Insurance Products

If you have sufficient available income to pay the premiums for the rest of your life, LTC insurance may be cost-effective for you. LTC Insurance is designed to pay a portion of long-term care costs. It is available from private insurance companies selling in California.

4. Policies and Annuities With Long-Term Care Benefits

Life Insurance Policies with Long-Term Care Benefits

For dollars for long-term care cost should they be needed in the future after the policy is purchased primarily for dollars at death, some life insurance policies have been developed with provisions available or included that speak in part to the need. Long-term care benefits are occasionally sold as an additional [rider](#) to a life [insurance policy](#). If so, this rider provides “advances” and “living benefits” on the policy’s [death benefit](#) that can be used to pay for specified long-term care costs. The amount of the policy’s death benefit generally is reduced by the amount of any payments that are paid out in advance of death. In these cases, there are many varied ways that benefits are determined and paid out. Some have specific waiting periods, limited benefit pay-outs, varying pay-out periods, and specific amounts available for long-term care. Agents should be aware of the many different approaches as there is no particular standard followed industry-wide on this issue. (Source: Taking Care of Tomorrow, California Department of Aging)

Life Insurance and Annuities with Long-Term Care Benefits

Occasionally, long-term care benefits are sold as an additional [rider](#) to a life [insurance policy](#) or an annuity. Provisions available or included that speak in part to the need for dollars for long-term care cost should they be needed in the future after the policy is purchased primarily for dollars at death or retirement have been developed and are included in some life insurance policies and annuities. This rider provides “advances” and “living benefits” on the policy’s [death benefit](#) or annuity that can be used to pay for specified long-term care costs. The amount of the subsequent policy’s death benefit or annuity value generally is reduced by the amount of any payments that are paid out in advance of death or annuitization. There are many varied ways that benefits are determined and paid out. Some variations include specific waiting periods, limited benefit pay-outs, varying pay-out periods, and specific amounts available for long-term care. As there is no particular standard followed industry-wide on this issue, agents should be aware of the many different approaches.

Accelerated Death Benefits, Riders and Annuities

There are some companies that offer “accelerated” benefits in their policies. These may be a part of the policy itself, or an attached [rider](#). For a 2 to 10% increase in premium, the insurance will pay a portion of the [death benefit](#) to the policyholder periodically until the benefit is depleted or a specific maximum is reached. If the policy-owner dies before the maximum benefit is paid out, the balance of the benefits will go to the named beneficiaries.

In general, accelerated benefits or riders, may not take effect immediately with the onset of illness. Sometimes a limit is placed on how much can be collected. Some insurers require hospitalization or a nursing home stay as a condition prior to the collecting of any benefits.

Because there might be tax consequences and possible benefit consequences or eligibility issues for receiving Medicare, Medi-Cal, Social Security, Supplemental Security Income, etc., consumers, must be advised about this. It must be included in [disclosure](#) statements, as well. The disclosure statement must contain a statement that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor.

This option allows one to ask their insurance company to pay a reduced amount of value on their [insurance policy](#) before their death, if they are diagnosed with a terminal illness or have a major organ transplant. Certain criteria must be met, but the proceeds may be used for any purpose, not just long-term care. If their current life insurance does not have this rider, they may wish to contact their insurance company to see if their policy can be modified. (Source: Taking Care of Tomorrow, California Department of Aging)

While LTC riders can vary greatly, they do to have common components. They may include such things as elimination periods, benefit periods of 3 years or more, benefits triggered by impaired activities necessary to caring for themselves, and benefits for all levels of care, including custodial. Some riders may cover home health care to some degree.

Other Catastrophic Benefits

There are other types of health insurances that cover health care claims, especially larger claims, such as major medical, high [deductible](#) health care policies, hospital [indemnity](#), cancer policies, critical illness policies, and disability protection policies that do not pay for costs or losses incurred due to the triggering of and the inability to perform the activities of daily living requiring custodial long-term care.

LTCI and Health Insurance

Lots of people know about the kind of health insurance that pays doctor and hospital bills. But the kind that pays for long-term care in a nursing home or at home is not as familiar. More than half of nursing home bills are paid out-of-pocket by individuals and their families, and somewhat less than half are paid by state Medicaid programs. Insurance, and that includes Medicare, Medicare supplemental coverage and health insurance provided by employers, does not pay for most long-term care expenses. It's common for a husband and wife age 65 to spend approximately \$9,500 a year for health insurance coverage. A policy with a large daily benefit that lasts for several years, is more expensive. Inflation protection can add 25% to 40% to the benefits and nonforfeiture rights can add 10% to 100% to the bill.

The United States faces a considerable challenge in providing health care for its elderly and disabled residents in the coming years. With the looming retirement of the baby boom generation, the number of Medicare beneficiaries will increase substantially. The percentage of the population covered by Medicare could increase from about 14% today to 20.6% by 2025.

Nearly one out of every two persons age 65 and older will probably spend some time in a nursing home, which costs on average \$30,000 annually across the United States and in major metropolitan areas the average escalates to \$60,000 and as much as

\$100,000 per year. With an average nursing home stay of 19 months, seniors living in major metropolitan areas will spend \$100,000 on long-term care in addition to medical bills and prescriptions. Fearful of losing economic independence, older Americans are looking for security in long-term care insurance.

Even though for seniors over 65 premiums can range from \$2,000 to over \$10,000 per year, long-term care insurance is “the fastest-growing type of health insurance sold in recent years.” Still, only 5% of those over 65 have purchased private long-term care insurance. Uninsured seniors constitute a lucrative market and as a result over 100 insurance companies now offer long-term care policies.

5. Medi-Cal

Medi-Cal Eligibility

Medi-Cal (called Medicaid outside California) is long-term care for the poor. It pays for necessary health care that is not covered by Medicare, but only if one meets federal and state poverty guidelines.

Income and Asset Limits

A single person over 65 in 2015 would qualify for Medi-Cal if he/she had \$2,000 or less in non-housing assets. A married spouse, living in the community, however, can keep up to \$119,220 (2015) in non-housing assets and \$2,981 (2015) in joint monthly income, when his or her spouse is in a nursing home and applies for Medi-Cal. These guidelines and the amount of assets and income a person can have change annually.

Hardship Exception

Medi-Cal will not file a [claim](#) against their estate if a client dies leaving a "dependent." As illustrated above, a dependent is a surviving spouse, a child under the age of 21, or a child who is blind or permanently or totally disabled.

An individual's estate can be protected if Medi-Cal's actions will create an "undue hardship" on someone who survives him or her. Medi-Cal will look at the following circumstances to decide whether undue hardship exists for the survivor.

Look-Back Periods

In California, the value of a person's house is not counted as an asset when applying for Medi-Cal. The state “recovers” the costs paid by Medi-Cal from a person's estate, including the house. Recovery will not occur while there is a surviving spouse or dependent child.

If a person does not buy a long-term care policy, they should not feel that they will have to spend down all their money and go on Medi-Cal or have to do this to qualify for Medi-Cal. People can provide for their care, if needed in many ways before they might need to rely on Medi-Cal. This section has addressed many of the alternate funding methods which can be used individually or in combination.

Those who do not have enough current income, do not have the prospects of having significant enough future income, do not have very much assets outside their home, and do not have long-term care insurance may well be the right candidates for and should plan to rely on Medi-Cal. It may be unwise for many to buy long-term care insurance. It is all based on their unique situation.

Purchase of a Long-Term Care Policy Will Not Ensure That Someone Will Avoid Medi-Cal

Agents and financial professionals, whether it is to their advantage or not, should be aware of and communicate to clients that the purchase of long-term care policy will not necessarily ensure that someone will avoid Medi-Cal when they need long-term care. It depends upon the each person's particular circumstances. People who are unlikely to be able to afford premiums, unable to absorb even a moderate increase are not appropriate purchasers, and the safety net of Medi-Cal may be their only option.

While Medi-Cal has been addressed only briefly here, for an extended look see the California require attachment located in the attachment section of this course as Appendix A.

B. How Medicare Interrelates with Paying for Long-Term Care Expenses

1. Medicare

Brief Overview

Medicare may pay for skilled care in a nursing home for a very short period, but no longer than 100 days, and only when the patient meets all the Medicare requirements for daily skilled care. For Medicare to pay for any days in a nursing facility, one will have had to spend at least three days in the hospital for the condition requiring admittance into the nursing facility.

LTC Provisions of Medicare

Before Medicare will pay anything for a nursing home, certain **conditions** must be met. When those conditions are met, only skilled care will be covered, neither intermediate nor custodial care is ever covered by Medicare. The criteria include the following:

- The individual must have been hospitalized for a minimum of 3 consecutive days prior to the nursing home admittance;
- Admittance to the nursing home must occur within 30 days after discharge from the hospital for the same condition;
- Skilled care is required every day in the nursing home. Only skilled care is covered, so if some days only intermediate or custodial care is required, Medicare would disallow the claim;
- A doctor has prescribed the skilled nursing home care; and
- If these four conditions have been met adequately, Medicare Part A will pay for a semiprivate room (not private), rehabilitation therapy, the regular nursing staff in the nursing home (not private nursing), and medications administered in the nursing home. Part B of Medicare would cover the visits of a doctor, although the number of those visits is limited under Medicare's guidelines. Those who are enrolled in an HMO (Health Maintenance Organization) may have additional benefits. The **contract** must be checked to find out.

When Medicare pays for nursing facility care, it only pays the full costs for the first 20 days. For the next 80 days, one's **deductible** is \$167 per day (based on the **co-pay** amount for Calendar Year 2016, which tends to increase annually). Your Medicare supplement plan will pay this copayment for you, but will not pay for additional days in the nursing facility beyond what Medicare will pay for. Most Medicare HMOs will cover nursing facility care or care at home for 100 days, if skilled care is required.

Levels of Care Requirements and Implications to LTC

While people do get personal care services while receiving skilled care in a nursing facility, Medicare will not pay unless there is also a need for daily skilled services that only a nurse or therapist can provide. Medicare may pay for some personal care

services at home but again, only if you also need skilled care on a daily basis that only a licensed person can provide.

Medicare will not cover assisted living, retirement complexes, continuing care communities, adult day care, Meals on Wheels, or other services. Only those facilities that meet Medicare's requirements will qualify. Long-term nursing home policies may cover many of the things, besides nursing home care, that Medicare denies. For example, assisted living is now commonly covered by nursing home policies, as long as certain requirements are met.

For more details, see the Medicare benefits book available from your Social Security office or by calling the Social Security Administration, toll-free at 800-772-1213.

2. Medicare Supplements

Traditional Medicare Supplements (A-N)

A Medigap policy is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn't cover. If you are in the Original Medicare Plan and have a Medigap policy, then Medicare and your Medigap policy will pay both their shares of covered health care costs.

Insurance companies can only sell you a “standardized” Medigap policy. These Medigap policies must all have specific benefits so you can compare them easily.

You may be able to choose up to 10 different standardized Medigap policies (Medigap Plans A, B, C, D, F, G, K, L, M, N). Medigap policies must follow Federal and State laws. These laws protect you. A Medigap policy must be clearly identified on the cover as “Medicare Supplement Insurance.” Each plan, A through N, has a different set of basic and extra benefits.

It's important to compare Medigap policies because costs can vary. The benefits in any Medigap Plan A through N are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Generally, when you buy a Medigap policy you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium. In addition, you will have to pay a premium to the Medigap insurance company.

You and your spouse must each buy separate Medigap policies. Your Medigap policy won't cover any health care costs for your spouse. Few Medigap policies cover anything other than skilled care.

Since these are designed to fill in the shortfalls of Medicare and apply to similar care as Medicare does, they do not cover costs typically associated with long-term care. In one sense, however, the fact that they provide benefits for medical care, they allow more assets to be retained with the individual that may be available for long-term care needs that they will have down the road or following a medical incident that causes them to go beyond Medicare coverage limits where they have to acquire long-term care outside the hospital and outside the skilled care facility when Medicare benefit cease in that regard.

Medicare Advantage

Like traditional Medicare, Medicare Advantage plans cover doctors and hospital costs much like individual's health insurance while they were working for an employer before retiring and going on Medicare. Long-term care benefits are similarly covered for

skilled nursing care for rehabilitation following a hospital stay for a limited number of days per incident.

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