CALIFORNIA DEPARTMENT *of* AGING

Taking Care *of* Tomorrow

A Consumer's Guide to Long-Term Care

2018 EDITION

This guide is made available through the Health Insurance Counseling and Advocacy Program (HICAP) of the California Department of Aging. HICAP assists individuals and families with concerns regarding Medicare and other related health insurance, including long-term care insurance.

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Phone numbers, web addresses, and contact information for resource organizations contained in this guide are accurate as of July 2018. Please note that contact information may be subject to change by the individual organizations without the knowledge of the California Department of Aging.

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Table of Contents

Introduction: About This Guide 4

Understanding Long-Term Care 5

What If I Need Long-Term Care 13

Paying for Long-Term Care 21

Stand-Alone Long-Term Care Insurance 27

Consumer Questionnaires 45

Other Types of Insurance and Benefits for Long-Term Care 49

California Partnership for Long-Term Care 56

California Public Employees' Retirement System (CalPERS) 62

Federal Long Term Care Insurance Program 65

Reference and Data Chart Citations 71

Glossary of Terms 76

Index 80

Suggestions for Further Reading 82

Resource Guide 83

Contributors 85

Introduction: About This Guide

Everyone's situation is unique. Your decisions and those of your family members about what type of retirement you want or where you will live when you are older depend on your individual values, desires, and financial circumstances. The best long-term care option for you, and how you pay for that option, may be different from the one chosen by another family member or friend.

The Consumer's Guide to Long-Term Care was developed for people concerned about how to plan, provide, and pay for long-term care for themselves, a spouse, parent, or loved one. It contains information to help you make decisions now and in the years to come that will allow you to retain more control of your life if you need long-term care. We suggest that you share this guide with your family and friends, using the information to begin discussing your future long-term care needs and financial options before a crisis arises.

The information in this guide was prepared to:

1. Provide you with an overview of long-term care issues;
2. Answer basic questions about long-term care;
3. Provide information about long-term care services; and
4. Explain options for paying for long-term care.

We hope you will take the time to read this guide carefully and discuss it with your family. You may want to keep it in a convenient place for future reference. As you get older, changes may occur in your life and make a difference in what is important to you and your family. Depending on your situation a review of certain chapters may be helpful in the future.

Throughout this guide, you will find the names, websites, and telephone numbers of agencies that can provide you with additional information on specific topics concerning long-term care. This information is also listed in the Resource Guide on page 83. We recommend that you consult a tax professional, attorney, financial advisor, and/or insurance agent before making any final decisions about planning or paying for your long-term care.

In addition to the general information in this guide, a list of questions is included on pages 45–48 to assist you if you decide to purchase insurance to help pay for long-term care. On page 82 there are Suggestions for Further Reading, and on pages 76–79 there is a Glossary of Terms used throughout this guide. Words in bold print are included in the glossary. There is also an Index on pages 80–81 to help you quickly locate information on specific topics.

Understanding Long-Term Care

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

*Martha has always been a saver. She planned for emergencies. She thought **Medicare** would pay for most of her medical costs. She even purchased a **Medicare** supplemental policy to protect her from unexpected health care costs that exceed what **Medicare** will pay. Now, she has learned that in her case, **Medicare** may only pay for about 28 days of her stay in the **nursing home** following the hospital care for her broken hip. There is a **Medicare** rule about needing to receive skilled care or skilled supervision of her care for every day she is in the **nursing home.** If she continues to need skilled care or supervision, Martha will have a **Medicare co-payment** beginning on the 21st day of her **nursing home** stay. When she no longer needs skilled care she will have to pay the **nursing home** expenses herself. If she can't go home her savings will be used up very quickly, and then what will she do?*

Most of us would like to be able to look into a crystal ball to see what our lives will be like ten, twenty, or thirty years from now. Will we be healthy or will we need care and assistance from others? If we need help to stay at home, will we be able to get that kind of care? Will we spend time in a **nursing home,** like Martha? How will we pay for our care?

Medicare only pays for **nursing home care** if there is a prior qualified hospital **inpatient** stay of at least three days and skilled nursing, skilled supervision, or rehabilitative care is needed on a daily basis. In some cases a **Medicare Advantage** Plan enrollee may not have to meet the three-day hospital requirement, but will have to meet the need for skilled supervision, skilled nursing, or rehabilitative care for coverage and payment from the plan to continue. Even in extreme cases, the **Medicare**

benefit for **nursing home** care will only last for a maximum of 100 days, and in most cases for a far fewer number of days.

IMPORTANT! It is also important to know if you are in a hospital as an **outpatient** under **"observation"** because different rules apply if you need **nursing home care** after you leave the hospital. Information about hospital **observation** care can be found starting on page 23 of this guide.

What Is Long-Term Care?

Long-term care is the kind of **personal care** needed for tasks like bathing, dressing, eating, continence, toileting, and transferring (getting in or out of a bed or chair). These six basic needs are commonly referred to as **Activities of Daily Living** or **ADLs.** You might need help with one or more of these tasks because of a chronic medical or physical condition, or for an injury like Martha had. Frequently, people with **Alzheimer's disease** or other **dementias,** also referred to as a **cognitive impairment,** need ongoing supervision. People who can no longer drive, manage their medications, or their finances need help with these tasks, which are referred to as **Instrumental Activities of Daily Living** or **IADLs.** These needs often occur first, before someone needs formal long-term care services.

Long-term care covers a broad range of needs and related services people receive in several types of places. Services may include care at home or in a community program like adult day care, as well as care in an **Assisted Living Facility** (also known as a **Residential Care Facility**) or in a **nursing home** (also known as a **Skilled Nursing Facility).** Because long-term care is provided through a wide variety of services, it is also known as **long-term services and supports,** or **LTSS.**

IMPORTANT! Assisted Living Facilities (ALF) or **Residential Care Facilities (RCF)** are generally licensed in California as "Adult Residential Facilities" (ARF), which typically provide care for people age 18–59, or **"Residential Care Facilities for the Elderly" (RCFE),** which usually provide care for people age 60 and older.

*If Martha gets well enough to go home she might be able to get care in her home – such as a nurse's aide to help her with ADLs, **homemaker services** to help her with housework and, perhaps, physical therapy to help her recover from her broken hip. This care might be covered by the **Medicare** Home Health benefit, but only if she meets **Medicare**'s requirements for skilled care. Otherwise she will have to use her own funds to pay for any care she might need.*

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

Anyone at any age can need long-term care. An accident or a sudden, serious illness can create a need for care, but so can the slow progression

of chronic diseases such as rheumatoid arthritis, **Alzheimer's disease** or other types of **dementia,** or any other health condition that limits the ability to perform everyday tasks. The number of older adults is increasing, and age or frailty can also be contributing factors to the need for long-term care, as shown in Charts #1 and #2 on page 8. People who live into their 80's and 90's are more likely to need long-term care than those at younger ages; and someone turning age 65 today has almost a 70 percent chance of needing some type of **long-term services and supports** in their remaining years.[1]

In addition to age and disability, there are other factors that can affect the need for long-term care.

Gender

Women are more likely to need long-term care services than men. One reason may be their longer life expectancy. In addition, women are more likely to get their care in a **nursing home** if they live alone and don't have a live-in caregiver. At age 90 and over, women outnumber men by more than two to one.[2] For example, a 2015 Centers for **Medicare** & **Medicaid** Services (CMS) report found that approximately 66 percent of **nursing home** residents were women; approximately 34 percent were men.[3] Because of her longer lifespan, the average amount a woman can expect to pay for long-term care services during her lifetime is $180,000, as compared to $90,000 for men.[4]

Marital Status

Traditionally women have married men who are older. Since women also live longer, many eventually outlive their husbands.[5] It is not unusual to find an older man being cared for by his younger wife. When a woman needs long-term care services, she is often widowed and living alone. A daughter or daughter-in-law frequently provides care to a family member who lives at home. But a widowed spouse or single elder may need more care than family members can provide and may eventually need long-term care in an **Assisted Living Facility** or a **nursing home**. And, people who live alone are more likely to need paid care than those who are married or single and living with a partner.[6]

Functional Limitations

Women develop chronic diseases such as arthritis and osteoporosis more often than men.[7, 8] These diseases limit the ability to walk without support, to get in and out of a chair, and to do other physical tasks of daily life. Both men and women are more likely to fall or have difficulty walking when their balance is impaired.[9] However, when thinking about long-term care, you should remember that these are generalizations and don't apply to everyone. Your situation may be different.

Cognitive Impairments

Cognitive impairments caused by **Alzheimer's disease**, other types of **dementia** related to strokes and other health conditions, often lead to the need for long-term care.[10]

CHART 1:
MORE FRAIL ELDERLY, MORE CARE NEEDED

Projected Number of Californians, Age 85 and Older, 2010–2050

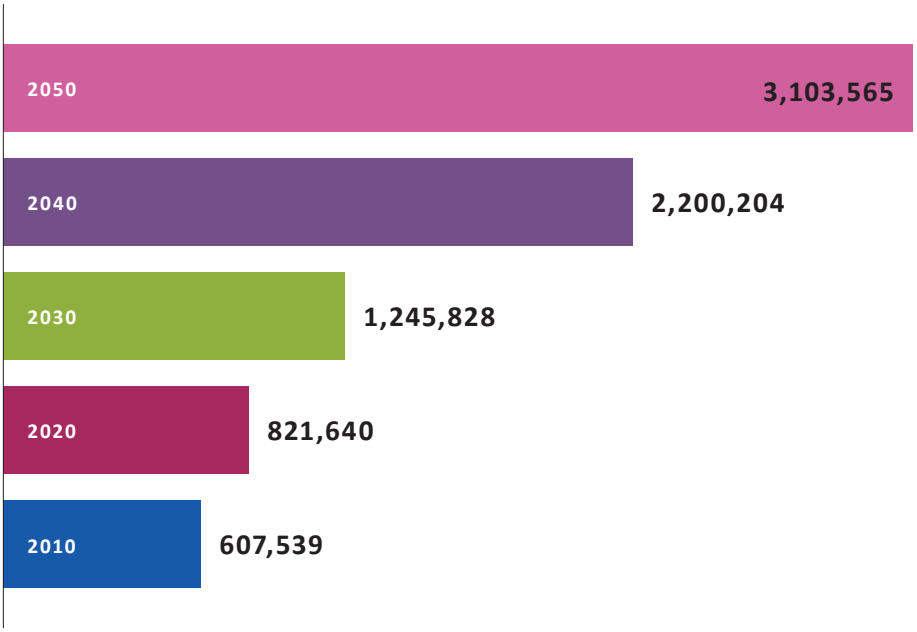


CHART 2:
AGES OF RESIDENTS OF CALIFORNIA NURSING HOMES, 2014

Percentage of Nursing Home Residents by Sex and Age: United States 2014

Note: Does not include persons aged 30 years and younger.

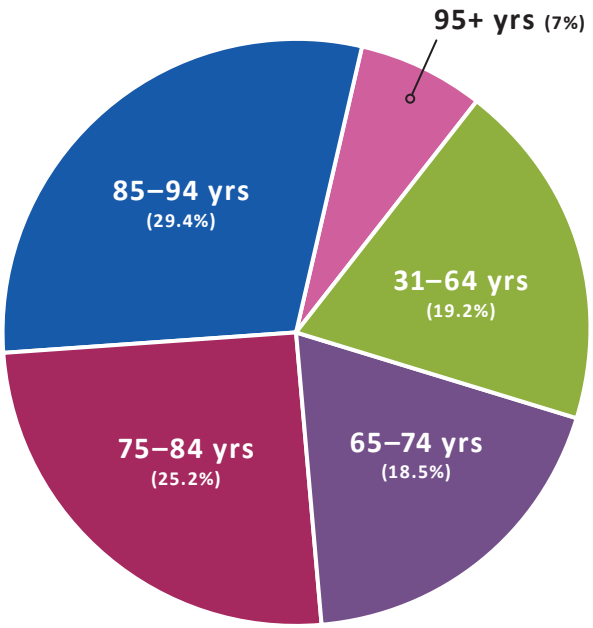
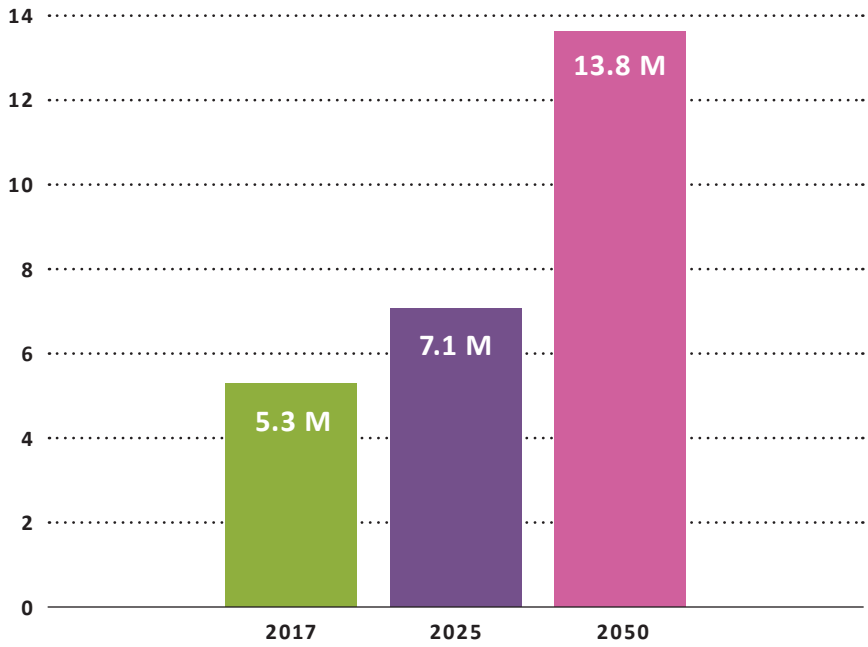


CHART 3:
ESTIMATED NUMBER OF AMERICANS AGE 65+ WITH ALZHEIMER'S DISEASE FROM 2017 THROUGH 2050

In Millions



People with these disorders go into **nursing homes** more frequently, for their own safety or that of their caregivers, than those who are physically impaired. Advanced age is one risk factor for **Alzheimer's disease**, with approximately one-third of those over age 85 affected by the disease.[11] Some families may also have a genetic predisposition toward **Alzheimer's disease**, strokes, or other mentally or physically disabling conditions and be at a higher risk of needing care. The prevalence of **Alzheimer's disease** and other types of **dementia** is expected to increase as more Americans live to an older age.[12] Chart #3 shows the estimates for future increases in **Alzheimer's disease** in the United States.

Family Circumstances and Support Systems

Whether a person can remain at home once they begin to need care often depends on the available support system. Many older people do not live near their families and their support system may consist of neighbors and friends who may not always be available. If an older person does live near family, family caregivers may work full-time or be unable to offer as much help as is needed.

However, family members do provide significant amounts of informal unpaid long-term care. An AARP study of unpaid family caregivers found that over a twelve-month period more than 34 million adults in the United States provided unpaid care to an adult age 50 and older.[13] More than seven out of ten people with mild to moderate **Alzheimer's disease** and other types of **dementia** live at home where their families and friends provide most of their care.[14] Estimates of the value of informal unpaid caregiving range from $230 billion to $470 billion.[15, 16]

Care at home that is provided by unpaid caregivers may include financial, nursing, social, homemaking, emotional support, and other types of assistance. Caregivers spend an average of 20 hours a week providing care. More than half have intensive caregiving responsibilities that may include assisting with a **personal care** activity, such as bathing or feeding. An estimated two-thirds of caregivers are women.[17] Some also have a child or grandchild under the age of 18 living in the household.[18]

A significant number of caregivers are themselves older because they are caring for a spouse.[19] Many middle-aged women find themselves sandwiched between the needs of their school age children and family responsibilities, their jobs, and the needs of an older family member who has cognitive or functional limitations. A woman age 55 who leaves work to care for an older relative is estimated to lose $300,000 in wages and other financial advantages, making her more likely to fall into poverty later.[20]

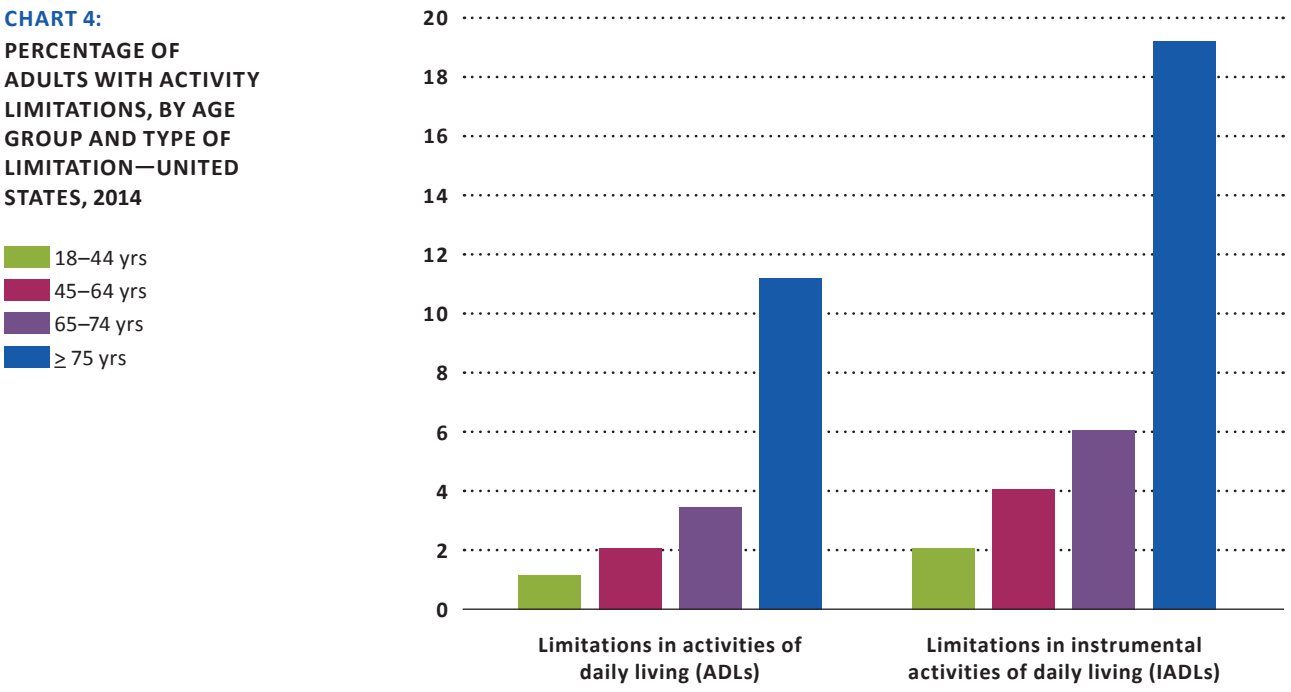
IMPORTANT! Family Caregiver Support Program: The California Department of Aging contracts with 33 Area Agencies on Aging (AAAs) to coordinate local community-service systems for assisting caregivers of seniors. Services are available to family and other unpaid caregivers supporting older individuals, as well as grandparents and older relatives caring for children. Each AAA is responsible for determining the array of services, including caregiver information, assistance in gaining access to services, counseling and training support, temporary respite, and limited supplemental services to complement the care provided by caregivers.

Where Do People Get Long-Term Care?

Home and Community Care

Only a small number of people who need long-term care services live in **nursing homes.** Most live at home and may also attend day programs, such as **Adult Day Care** or receive assistance from other community-based programs. (Turn to pages 13 and 21 for more detail on community-based services.) They may receive at least the initial part of their care from family members or other informal caregivers, who do shopping, food preparation, housekeeping, laundry, transportation, administer medications, and provide assistance with dressing, bathing, and toileting. Chart #4 shows the results of a 2014 survey that identified the percentages of adults with activity limitations who live in the community.

CHART 4:
PERCENTAGE OF ADULTS WITH ACTIVITY LIMITATIONS, BY AGE GROUP AND TYPE OF LIMITATION—UNITED STATES, 2014



Nursing Home Care

Some people may use a **nursing home** for a few days or weeks after a hospital stay to recover from an illness or injury. Others may move into a **nursing home** when they can no longer stay safely in their own home. Many people never need **nursing home** care because they get their care in an **Assisted Living Facility** or at home, and die before ever needing **nursing home** care. In 2014, there were approximately 1.4 million people receiving care in **nursing homes** nationally and about one in eight people age 85 and older (13 percent) resided in facilities.[21, 22]

What Can I Do To Reduce My Chances Of Needing Long-Term Care?

Some of us will need help as we get older no matter how well we take care of ourselves. Diseases such as arthritis and osteoporosis can affect our ability to get around and may lead to dependence on other people. Debilitating illnesses or accidents can occur at any time, and advanced age is often accompanied by increased frailty or **dementia.**

However, research demonstrates that we are more in control of our own aging than previously assumed.

Good nutrition and regular exercise have been shown to be the key ingredients to a healthy and active old age. And the earlier we get started, the better. High fiber, healthy-fat diets can decrease the incidence of cancer, heart disease, and many other "modern" ailments.[23] Exercise and physical activity may be equally as important as nutrition in helping us to remain active and safe throughout our lifetime. In 2015, the National Institutes of Health Senior Health web-publication noted that being physically active on a regular basis is one of the healthiest things we can do.[24]

Although our muscles get smaller in size as we age, weak muscles are not a normal part of aging. Older people who exercise have less deterioration in muscle tone. Walking and other aerobic exercises like swimming help build endurance. Strength exercises help build muscles. Balance training can help prevent falls, and moderate stretching exercises help us retain flexibility.[25]

Although illness or injury can affect muscles and joints, with good medical treatment even this damage can be greatly reduced. However, there is no magic ingredient that allows us to stay fit. It takes determination, discipline, belief that good nutrition and exercise are worth the effort, along with a little bit of luck!

Of course, there are some things we cannot control. For instance, falls are a major contributor to the need for long-term care services. Annually, more than 300,000 people age 65 and older are hospitalized for a broken hip resulting from a fall, and 75 percent of these are women.[26] A broken hip frequently results in the inability to live alone. **Alzheimer's disease** and similar **dementias** that affect how our brain and nervous system work often lead to the need for long-term care. Over half of **nursing home** residents have a **cognitive impairment** like **Alzheimer's disease**.[27] Not only is this a devastating condition for patients and their families, but there is also no known cure at the present time.

What If I Need Long-Term Care?

Long-term care services are available in many communities in many ways. These services consist of formal paid care and local community programs. Both paid services and community programs are designed to help older people stay in the most independent living situation possible.

What Options Are Available To Me At Home If I Need Care?

Formal paid services include:

- **Home Health Care:** services provided by a nurse or other licensed personnel;
- **Personal Care:** help with bathing, grooming, moving from a chair to a bed, and other personal assistance;
- **Homemaker Services:** housekeeping, cooking, and grocery shopping;
- **Hospice Care:** support for patients with terminal illnesses and their families;
- **Respite Care:** temporary relief for caregivers;
- **Adult Day Programs:** community-based, non-medical model of care programs for persons 18 years of age or older who need protective supervision, structured activities, health monitoring, meals, out-of-home respite, and support for the caregiver;
- **Adult Day Health Care (ADHC)/ Community-Based Adult Services (CBAS):** community-based day health programs that provide medical, rehabilitative, and social services through an individualized Plan of Care to individuals with chronic medical, cognitive, or mental health conditions, and/or disabilities who are at risk of needing institutional care; and

- **Alzheimer's Day Care Resource Centers:** individualized day care for people with moderate to late stage **Alzheimer's disease** or related **dementias.**

Many people who use **home care** services may also be receiving additional help from their family or friends. When someone needs this additional support and it isn't available, they may not be able to stay in their own home. One option is to move to a place that combines housing and the services a person needs. Some living arrangements provide room and board and **personal care** (help with **ADLs,** grooming, medications, and light housekeeping) in a supervised setting. These services may be provided in an **Assisted Living Facility** or, if a higher level of care is needed, the individual may need to move to a **Skilled Nursing Facility (nursing home).** These facilities are discussed later in this guide.

IMPORTANT! The availability and cost of **home care** services vary greatly from one community to another and from one state to another. In 2016, the median daily statewide average for **home care** in California was $144 for **homemaker services,** $150 for a home health aide, and $55 for **adult day health care.**[28]

How Do I Find Out About Long-Term Care Services?

Information about formal paid services, community programs, and services in your local community is available through the network of Information and Assistance (I&A) programs throughout California. These programs are funded through California's 33 Area Agencies on Aging (AAAs). The AAAs are responsible for the planning and delivery of services for older persons and persons with disabilities. (All states and U.S. territories have similar aging networks.) In California, you can reach local I&A services by calling 1-800-510-2020.

Local programs are designed to fit the needs of older people in each specific region. Through your local I&A program, you can find out about community services such as senior centers, senior nutrition sites, **adult day care,** Alzheimer's resource centers, home-delivered meal programs, transportation, **care management** programs and services, home health agencies, hospice programs, legal services, and health insurance counseling. To find out about services where you live, locate the listing for your local Area Agency on Aging in your telephone book, through an Internet search, or call 1-800-510-2020 for Information and Assistance services. In California, you can also locate your closest Area Agency on Aging by visiting https://www.aging.ca.gov, and search for "Area Agency on Aging." If you are looking for services for a relative who lives out of state, the Eldercare Locator, a nationwide toll-free information and referral service, can give you telephone numbers for programs in all areas of the United States. From the West Coast, this information is available Monday through Friday between 8 a.m. and 5 p.m. by calling 1-800-677-1116.

IMPORTANT! Some AAAs use another organizational name such as "Council on Aging." You can use the Eldercare Locator to find the AAA in your area if you can't find it in the phone book, through an Internet search, or by visiting https://www.aging.ca.gov.

*When Martha is ready to leave the **nursing home,** she will need to determine what services will support her to live safely in her home, as well as the cost of those services. How many and what types of services Martha will need depend not only on her health, but also on the cost of that help and the help available to her from her family or friends. Martha may need assistance locating and contracting for the services she needs and she may want to hire a case manager or geriatric care manager – providing she has the funds to do so. A geriatric care manager or case manager can assess her needs, locate and contract for her services, and monitor her care. A professional care manager can be particularly helpful in setting up and monitoring her care if Martha's family is unable to help her.*

How Can I Make My Home Safer If I Plan To Stay There?

Preventing Falls

The number of older adults who die from falling is a growing public health problem. Every year more than 2.8 million seniors are treated in emergency departments for fall-related injuries, and many of those are hospitalized. According to the Centers for Disease Control (CDC), the medical costs of treating fall-related injuries have risen to approximately $31 billion annually.[29] Throw rugs are responsible for many falls and shouldn't be used. All staircases should have non-slip surfaces and handrails that are sturdy and easy to grasp. And, if climbing stairs becomes difficult, you may want to move your bedroom to the first floor.

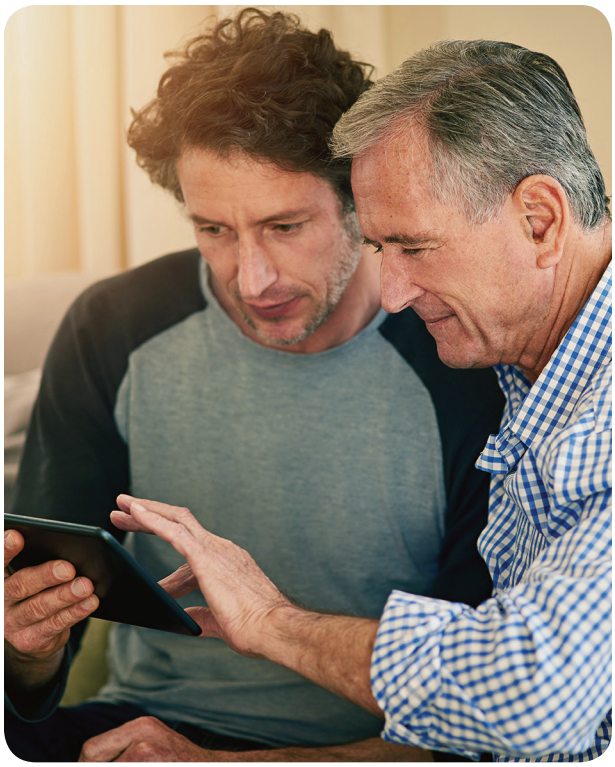
Safety is a prime concern and it is important to plan ahead before a problem occurs. Take a look around your home. Do you need to make changes in the physical environment to ensure safety as you get older? Bathtubs should have grab bars and non-skid mats. The track for sliding glass doors on the bathtub adds another inch of height that you must step over and can contribute to falls. Removing the glass doors or installing a bathtub that is much lower may make it easier for you to get in and out of the tub. Grab bars by the toilet can also be helpful. New design innovations in home safety products have made them more attractive, while still maintaining their durability and functionality. Small changes such as these can produce big results in terms of keeping you safer inside your home.

Lighting and Appliance Safety Hazards

Many older people begin to limit their activities when they develop problems with their eyesight. People 65 years of age and older are more likely to report vision loss as compared to younger people.[30] However, there are

things you can do to reduce hazards caused by changes in your eyesight. Hallways, staircases, and entryways in particular should be well lit to prevent falls. Remember that lighting should be more intense as you get older, but avoid creating glare.

Stoves are another source of concern. If you occasionally forget to turn off the burners of your stove, try using a timer as a reminder or have an electronic sensor installed to warn you when you've left them on. When you are at home alone, consider using a microwave oven instead of a stove to limit the possibility of a fire.



Telephones

Hearing loss can be minimized by installing amplifiers on telephones and by using drapes and carpets to deaden external noise. Phones should be located in areas where they are easy to reach. A cellular or cordless phone may be one solution. Anyone living alone should have a phone close by during the day and by the bedside in case of emergency! The California Telephone Access Program offered by the California Public Utilities Commission is a good resource for finding phone sets that are easy to see and use.

Emergency Response Systems

Another consideration for people who live alone is an emergency response system. An emergency response system is usually a small device that attaches to your clothing. If you fall or need help, you press the alarm and a signal shows up at a response center that follows emergency procedures to get you the help you need. Some emergency response systems are inexpensive and may be available from a local hospital; others are sold commercially and can be very expensive. Newer electronic sensors and alarms can be helpful too, as well as wearable technology devices such as armbands, clips, and watches that transmit alerts to the cell phones and computers of family members or other caregivers.

Digital Safety Monitoring

Motion sensors placed throughout a home or an apartment can monitor not only speed and frequency of movement, but also lifestyle

habits and patterns. Caregivers can be alerted to check in on you if unusual activity or lack of activity is detected. In addition, several types of electronic gadgets can remind you to take your medication or lock doors. The advances in applying technology to improve safety in the home and increase the likelihood of aging-in-place are moving at a rapid pace.

IMPORTANT! Your Area Agency on Aging (AAA) should know which hospitals have emergency response systems. Before leasing or purchasing a commercial system check with your local AAA and talk with other users to see if they are satisfied with the product and services.

Support Systems

Many older people develop a support system with their neighbors. They signal each other by raising the blinds or check in by phone by a certain time each day. Simple routines like these can alert a neighbor when there is a problem. Most postal workers are trained to report when mail has not been picked up and to notice other signs of a problem. You can find many ways to make your living area safe that will help you stay in your own home and avoid or delay the need for long-term care.

If your health remains good and your social support systems remain in place, staying in your home has many rewards. And, there are some financial advantages to continuing to live in your own home. However, the positive aspects of staying in your home can sometimes be outweighed by the responsibilities of home maintenance and repairs or social isolation. If your health begins to fail, cherished neighbors move away, or the neighborhood no longer meets your needs, you may need to consider another living situation.

What Are My Housing Options?

Though most of us want to grow old in our homes, there may come a time when it will be more practical to consider alternative living arrangements that provide some degree of support or assistance. Alternative housing arrangements are available in many communities and can be an option for some people. Housing options vary depending on where you live and the services provided. These housing arrangements are known by many different names. They may be called congregate living, retirement homes, **Assisted Living Facilities,** or **Continuing Care Retirement Communities (CCRC).**

Some of these housing arrangements require a large cash payment and a monthly fee; others use a month-to-month rental arrangement. Some are designed to allow residents to move from independent living through more intensive levels of care within the same facility as they need more care. Others provide only some of the services a resident might need, and may require them to move to a facility which provides a higher level of care at later stages of disability.

Independent Living

Independent living includes single-family homes, condos, apartments, mobile homes, "granny" or "in-law" units that can be located on family property, and independent living units in some retirement communities. Many of these independent living situations don't include onsite services such as meals and housekeeping services.

Congregate Housing

Congregate housing is a term used to describe a variety of housing arrangements with shared common space that is specially designed for older residents. Residents live independently in their own unit. Housekeeping, meals, laundry, transportation, and other non-medical amenities are included in their monthly rent. This type of housing is often provided in retirement communities and through other types of senior housing arrangements.

Residential Care Facilities for the Elderly (RCFE), commonly known as Assisted Living Facilities (ALF)

Residential Care Facilities for the Elderly provide room and board with supervision and assistance with **personal care** needs included in their monthly rental fee or available separately at a daily, weekly, or monthly rate. These facilities can range in size from small, two- to six-bed, "mom and pop" operations in a local neighborhood to facilities with over 200 units. Some larger **RCFEs** may offer a broader range of services than a small operation is able to provide. All of these facilities are licensed by the California Department of Social Services Division of Community Care Licensing.

IMPORTANT! Some of these facilities offer specialized services for people with **Alzheimer's disease** and other types of **dementia** sometimes referred to as memory care. These specialized units within an **Assisted Living Facility** are also licensed by the California Department of Social Services Division of Community Care Licensing.

Continuing Care Retirement Communities (CCRC)

Residents of **Continuing Care Retirement Communities (CCRC)** pay a large one-time entry fee plus a monthly maintenance fee in exchange for lifetime housing and access to multiple levels of living arrangements and long-term care services. Residents' monthly maintenance fees change as they move through the different levels of care within a **CCRC.** Moving into a **CCRC** requires signing a legally binding contract. Since this contract has serious financial implications, this decision should be discussed with a trusted financial advisor and the contract reviewed by an attorney before you purchase your unit. In the state of California, **CCRCs** are licensed by the California Department of Social Services and, if **nursing home** care is provided, they are also licensed by the California Department of Public Health.

Skilled Nursing Facilities (SNF), commonly known as Nursing Homes

Skilled nursing facilities provide both skilled nursing and **personal care** services. Residents

receiving skilled nursing care are often recovering from serious illness or surgery and need continuous nursing services, observation, and rehabilitation or therapy services. However, the most common type of care given in **nursing homes** is **personal care** or assistance with **activities of daily living (ADLs).** While some residents can also receive skilled services in addition to **personal care** services during the first few days of their stay, most don't qualify for skilled care for longer than a few days. Some residents with **Alzheimer's disease** or other types of **dementia** require constant supervision. In both cases these residents can no longer care for themselves safely at home. **Skilled nursing facilities** are licensed by the California Department of Public Health Licensing and Certification Division (L&C) and certified by the U.S. Department of Health and Human Services Centers for **Medicare** & **Medicaid** Services.

How Will My Family Know How I Want To Be Cared For In My Later Years Or When I Am Seriously Ill?

Advance Health Care Directives

An advance health care directive is a legal document that allows you to spell out your decisions about end-of-life care ahead of time. It gives you a way to let your family, friends, and health care professionals know your wishes and avoid confusion later on.

A living will is another legal document that tells your family, friends, and health care professionals which treatments you want if you are dying or permanently unconscious, including whether you wish to accept or refuse medical care.

A durable power of attorney for health care is yet another legal document that names the person you want to make health care decisions for you if you are unable to do so.

Living wills and durable powers of attorney for health care are the two most common types of advance directives.[31]

Physician Orders for Life-Sustaining Treatment (POLST)

The POLST Form is another type of advance health care planning tool. It is designed for people who are seriously or critically ill and can supplement an advance health care directive when needed. The POLST Form allows you to specify the medical treatment you want, or don't want, during a medical emergency or critical illness.[32]

IMPORTANT! A Do Not Resuscitate (DNR) order alerts emergency personnel when a person does not want to receive cardiopulmonary resuscitation (CPR) or life support measures. A DNR order is a different document from an advance health care directive, and is generally used only when a person has a terminal illness and has discussed a DNR with their doctor and their family.[33]

Discussing Advance Care Planning With Your Doctor

Medicare includes voluntary advance care planning as part of the yearly "Wellness" visit or, in certain circumstances, as part of your regular medical treatment. You can discuss advance directives with your health care professional/doctor and get assistance filling out the forms. This is planning for the care you would want if you become unable to speak for yourself. If your doctor or other qualified health care provider accepts the **Medicare**-approved amount as full payment for covered services, (also known as accepting assignment), you will not be billed.[34]

Estate Planning

A living trust may avoid expensive and lengthy probate proceedings and federal taxes for people with large estates. Because of the high value of real estate in California, a living trust may also benefit someone who owns his or her own home and has a modest amount of other assets. You can name yourself as the trustee of a living trust but you can also appoint a successor to make decisions for you if you become incapacitated. Even if you have a living trust you will still need to pay for your long-term care. Assets held in a living trust and all other assets will be counted in determining **Medi-Cal** eligibility.

IMPORTANT! If you are considering any of the options listed in this section, check with a free legal services program in your community, your financial advisor or an Elder Law attorney. The California Lawyers Association also provides several free publications and referral services describing trusts and other important estate planning topics as part of the Educating Seniors Project at https://calawyers.org/Sections/Trusts-Estates/Educating-Seniors

Paying For Long-Term Care

The cost of caring for an adult in their home or in another setting is not a trivial expense. A few hours of care for someone who lives alone is much less expensive than the cost of care in a facility, but both add up to significant costs over time.

How Much Does Long-Term Care Cost?

Recent data from insurance companies show the cost of this kind of care increasing about three percent annually during the last decade. Across California, in 2017: [35, 36]

- **Nursing home** costs averaged $300 per day for a private room.
- **Assisted Living Facilities** had a median cost of $141 per day depending on their size, location, and amenities.
- **Home care** costs averaged $157 per day for **homemaker services** and $150 for a home health aide.
- **Community-Based Adult Services** or **Adult Day Health Care Services** costs averaged $77 a day or more depending on where you live.

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

That depends on whether you ever need long-term care, what kind of care you will need, where you will get that kind of care, and how long you will need care. It's difficult to predict this for an individual. But the longer you live, the more likely it is that you will need at least some amount of long-term care.

The California Partnership for Long-Term Care estimates that in 2017 California **nursing home** costs averaged $109,500 for a full year. This is

a potentially devastating cost some people will incur if their stay lasts longer than a couple of months. People with very high incomes and assets are likely to have the ability to pay for the care they need, whether at home or in a **nursing home.**

If you have the time to save and you invest well, you might be able to save enough to pay for your own long-term care. But that may not be enough to pay all of your costs if you need care for an extended period of time or if you need more care than the money you've saved will cover.

Can I Deduct Any Of The Costs Of Long-Term Care On My Income Tax?

You may be able to deduct long-term care costs if you meet ***all*** of the requirements of a 1996 federal tax law ***and*** you file an itemized tax return. This law, known as the **Health Insurance Portability and Accountability Act,** or **HIPAA,** amended the federal tax code. You may be able to deduct qualified long-term care expenses, including costs for **personal care** and **homemaker services** as a medical expense if you meet all of the requirements of the federal law.

Will Medicare Pay For Long-Term Care In A Nursing Home?

Most long-term care delivered in **nursing homes** is provided to people with chronic, long-term illnesses or disabilities that are not covered by **Medicare.** They generally receive **personal care,** which is sometimes referred to as **custodial care. Medicare** does not pay for this kind of care because it is not skilled care by **Medicare**'s definitions. **Medicare** pays only a small percentage of all **nursing home** costs. **Medicaid (Medi-Cal in California)** is the primary payer for **long-term services and supports.**[37] To qualify for **Medi-Cal** coverage, your income and assets cannot exceed certain threshold amounts. Your county human services agency can help you determine if you are eligible for **Medi-Cal.**

Medicare only pays when you are receiving skilled medical and rehabilitative care, and then only for a short period of time. To qualify for the limited **Medicare nursing home** benefit in Original **Medicare,** you must first have spent three full days in a hospital within 30 days of your admission to a **nursing home.** You must also need skilled care that only a licensed professional can provide, every day of your stay, and the **nursing home** must be certified by **Medicare.**

Some **Medicare Advantage** Plans may waive the 3-day prior hospital stay requirement, but you will still have to meet all the other requirements for payment of a skilled **nursing home** stay.

If you meet these requirements **Medicare** will only pay the full cost of **nursing home** care up to the first 20 days of a covered stay. After the first 20 days, if you still require daily skilled care, **Medicare** will pay part of the **nursing home** bill. You will have to pay a **co-payment** for each day of the next 80 days if **Medicare** continues to pay for your stay, but for no more than a total of 100 days.

*Martha received only 28 days of care paid by **Medicare** (the average number of days **Medicare** pays for most **nursing home care**) because she no longer met **Medicare**'s requirement for daily skilled or rehabilitative care after the first 28 days of her stay.[38] As a result, Martha will have to pay the full cost of her care for any remaining days in the **nursing home** using other resources unless her assets and income are low enough for her to qualify for **Medi-Cal.***

IMPORTANT! If you are hospitalized and you need additional care after the hospitalization, you might be transferred to a **nursing home.** You should know about an important notice, known as the Medicare Outpatient Observation Notice (MOON).[39] This notice informs you when you are in the hospital under **"observation"** and are **not** considered an **inpatient.** This is important because if you have not spent a minimum of three days (two overnights) as an **inpatient** you will not be eligible for **Medicare** benefits in a **nursing home.** ***You or your representative should check with your doctor to make sure you are admitted as an* inpatient.**

Will Medicare Pay For Long-Term Care In My Home?

Yes, but only if you meet certain stringent requirements of the **Medicare** program and only for a short period of time. These requirements apply whether you are in a **Medicare Advantage** plan or receiving Original **Medicare** fee-for-service benefits. You must be homebound and require skilled nursing or rehabilitation services at least several times per week that only a licensed professional can provide. The services you receive must be from a **home health care** agency that participates in **Medicare.**

You may also receive some **personal care** from a home health aide to help you with **activities of daily living**, along with any skilled care you are receiving.[40] However, **Medicare** does not pay when **personal care** is ***all*** you need, and it doesn't pay for general household services such as laundry, shopping, or other services you receive in your home. Remember that **Medicare** also may not pay for all of the services that a home health agency provides, and you may need to pay for those costs yourself. Visit https://www.medicare.gov/coverage/home-health-services.html for more information.

Do Medicare Advantage (MA) Plans Pay For Long-Term Care?

Members of MA Plans generally have no more coverage for long-term care than people with Original **Medicare** fee-for-service benefits. These plans usually provide only those services that are covered by **Medicare** and meet the same requirements for skilled care. However, some plans may waive the three-day hospital stay requirement. Members of these plans may or may not have to pay the **nursing home co-payments** depending on the benefits provided by the MA Plan.

Can A Home Equity Conversion Help Pay For Long-Term Care?

For many older people, their home is their most valuable asset. **"Home equity conversion" (HEC)** or **"reverse mortgages"** were developed to help older people take advantage of the equity in their homes. A **HEC** or **reverse mortgage** might allow you to receive a lump sum, a line of credit, or monthly payments based on the equity you own in your home and your age when you apply. These payments could then be used to help pay for any care you need and allow you to remain in your own home.

There are various types of these loans. Some **HEC** loans are offered by lenders approved by the Federal Housing Administration (FHA) or by the Federal National Mortgage Association, while other loans are offered by financial services companies or insurance companies. Federally approved **HECs** will continue making payments as long as you continue to live in your home; others can be fixed term mortgages and may require that you move out of your house at the end of the contract term.

The FHA requires lenders to provide third-party counseling to help you understand how one of their federally approved loans works and how much it will cost you. As with any complex financial contract, you should discuss these arrangements with your financial advisor, accountant, or attorney before you enter into

any loan based on your home equity. You can also check with your local Better Business Bureau to make sure that you are dealing with a reputable company. Taking these steps will help you decide if the product is suitable for your needs.

IMPORTANT! Additional information on **HECs** or **"reverse mortgages"** counseling services can be found on the National Council on Aging (NCOA) website at https://www.ncoa.org/economic-security. You may also schedule an appointment for **reverse mortgage** counseling by calling 1-855-899-3778. There is an upfront fee for the service.

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

Medi-Cal

Medi-Cal is California's version of **Medicaid,** a joint federal and state program for people with low income and few assets. **Medi-Cal** provides health care services to people on public assistance and to others who cannot afford to pay for these services themselves. **Medi-Cal** pays for hospital and medical care approved by your doctor, prescription drugs if you don't have **Medicare,** and **nursing home care.** It also covers some **home care** services known as In-Home Supportive Services (IHSS).

Eligibility

Eligibility for **Medi-Cal** is based on countable income and assets. For couples, one spouse can be eligible for **Medi-Cal** benefits separately from the other spouse. The value of an individual's or a couple's home is generally excluded from the calculation of countable assets when applying for **Medi-Cal.** However, if the home is still in the name of the individual who is receiving **Medi-Cal** benefits when they die, the state may have the right to recover its **Medi-Cal** costs from the estate and the home equity of that deceased individual. This is known as **Medi-Cal** Estate Recovery. There is no estate recovery when a spouse or a disabled child is living in the home. For more information on **Medi-Cal** Estate Recovery, including changes to the policy for those who died on January 1, 2017 or later, visit the Department of Health Care Services (DHCS) website at http://www.dhcs.ca.gov/services/Pages/TPLRD_ER_cont.aspx.

In-Home Supportive Services

The In-Home Supportive Services (IHSS) program provides non-medical services to eligible aged, blind, and disabled persons who are unable to remain in their homes safely without this assistance. You may be eligible for IHSS if you meet specific eligibility criteria for the Supplemental Security Income/State Supplementary Program (SSI/SSP) for the aged, blind, and disabled. The IHSS program can provide household and related services such as heavy cleaning; menu planning; laundry services; meal preparation and cleanup; and

reasonable shopping errands. The IHSS program is administered by county Departments of Social Services under guidelines established by the state. For more information on the IHSS program, contact your county Department of Social Services.

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) provides social and health **care management** to assist persons aged 65 and over, eligible for **Medi-Cal** and certifiable for skilled nursing care, to remain safely at home. MSSP links older **Medi-Cal** eligible individuals with an array of health and social services in their community, as an alternative to moving to a **nursing home.** To see if this program is available in your community and for more information on the MSSP program, call 1-800-510-2020 or visit https://www.aging.ca.gov.

Spousal Impoverishment Prevention

Special **Medi-Cal** laws are in place to prevent the impoverishment of a spouse if the other spouse needs to go into a **nursing home** or needs home or community-based care. These laws allow one spouse to keep a certain amount of their combined income and assets when the other spouse needs **Medi-Cal** covered long-term care. For example, in 2017, the spouse at home can keep all of the couple's income up to $3,023 each month, and up to $120,900 in countable assets.[41] That spouse can also be granted more of their income, if necessary, through a "fair hearing," or by court order.[42] Any income in excess of the amount the one spouse can keep will go towards the other spouse's **Medi-Cal** share of cost, if there is one. The **Medi-Cal** eligible spouse in the **nursing home** is allowed to keep $35 a month for personal needs and up to $2,000 in assets.

IMPORTANT! The income and asset limits and eligibility criteria for **Medi-Cal** change each year. For more information on **Medi-Cal** eligibility guidelines and specific income and asset limits, contact your county Department of Social Services. You can also contact your local Information and Assistance program at 1-800-510-2020 for information on free legal services in your area for help in understanding these requirements.

Stand-Alone Long-Term Care Insurance

Insurance companies sell several different types of products that provide long-term care benefits. This chapter provides information on insurance policies designed exclusively to only pay for long-term care benefits (Stand-Alone policies). Other insurance products are discussed in the following chapter, Other Types of Insurance and Long-Term Care.

Stand-alone long-term care insurance can cover a wide variety of services ranging from home and community-based care to institutional care, depending on which type of policy a person buys. This insurance only pays for specific kinds of care. It doesn't pay for anything that is not shown in the policy. And, as with most health and life insurance, you can't purchase coverage once you have a health condition or if you already need care.

Buying this type of insurance has to be a personal decision based on a person's needs, resources, and financial circumstances. If you buy this type of insurance, the package of benefits you select should be consistent with your own personal finances and needs. In fact, a husband and wife don't usually need identical policies because women tend to live longer than men and need a paid caregiver for **home care** longer than a man.

Significant differences exist among the various types of policies, features, benefit options, and eligibility criteria, and each of these will affect the **premium** you pay. Choosing among all the various options and costs can be a challenge.

This purchase decision requires careful consideration of a number of factors related to your ability to balance the risk of paying for long-term care with your unique financial resources, planning strategies, and goals. It's very expensive to buy this type of insurance to cover 100 percent of your costs, or to pay for your care for as long as you live. It's likely you will need to decide how much of this type of insurance you can afford to buy based on your own economic circumstances.

What Is Stand-Alone Long-Term Care Insurance?

Stand-alone long-term care insurance policies are insurance products designed to pay benefits for some of the expenses you might have if you need supervision or assistance with basic **activities of daily living (ADLs),** like bathing, eating, continence, dressing, toileting, eating, and transferring. You might need this kind of help after an accident or illness such as a stroke, because of advanced age and frailty, or you might need supervision due to a cognitive disorder like **Alzheimer's disease** or another type of **dementia.**

This kind of insurance can pay for care in institutions such as **nursing homes** and **Assisted Living Facilities;** at home for **personal care, homemaker services, hospice care** and **respite care;** and in the community for care in an adult day care program. Some policies pay for all of these services. Others only pay for care in institutional settings like a **nursing home** or **Assisted Living Facility**. Some will only pay for home and community-based care.

Companies selling this insurance screen people carefully for previous or existing medical conditions when they apply for coverage. However, people who are actively employed and applying through an employer group may be accepted with less health screening.

What Is A Tax-Qualified Long-Term Care Policy?

The 1996 **Health Insurance Portability and Accountability Act** or **HIPAA** allows a tax deduction for **premiums** paid toward long-term care insurance if the policies meet certain federal standards. Some or all of the **premiums** for these policies may be deductible as a medical expense (depending on your age and adjusted gross income) ***if*** you itemize your expenses on your federal tax returns. You may also be able to deduct some portion of your **premium** on your state income tax return. Benefit payments are not taxable as income. All stand-alone long-term care policies sold since the change in federal law are generally **tax-qualified** policies.

IMPORTANT! Contact your tax advisor for more information or questions about **premiums** for long-term care insurance and your federal or state tax returns.

Long-Term Care Policies Do Not Offer The Same Benefits

In 2017, there are three types of long-term care insurance policies sold in California. Two types restrict benefit payments to specific places where care is received, and the third type provides comprehensive benefits.

1. **Nursing Home and Residential Care Facility Only Policies**
   These policies only pay for care in a **nursing home** and in an **Assisted Living Facility**. In California, **Assisted Living Facilities** are licensed as a **Residential Care Facility for the Elderly (RCFE).**
2. **Home Care Only Policies**
   These policies only pay for care in your home and in some community programs like **adult day care.** They are required to include benefits for **home health care, adult day care, personal care, homemaker services, hospice,** and **respite care.** Some may also include **care management services** and coverage for equipment prescribed for medical purposes. Some policies may pay for some modest modifications to your home if they are necessary to allow you to continue living there.
3. **Comprehensive Long-Term Care Policies**
   These policies have benefits for long-term care at home and in the community, as well as in a **nursing home** and for assisted living. All of the home and community services required in a **Home Care** Only policy must be included in a comprehensive policy.

Home Care Benefits Required In California

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

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

- **Respite Care –** short-term care in a **nursing home,** in your home, or in a community program to relieve the primary caregiver in your home.

IMPORTANT! Personal care, homemaker, and **hospice** services can be provided by a skilled or unskilled person when they are required in a Plan of Care developed by your doctor or another health care professional. Insurance companies cannot require these workers to be licensed or to work for a licensed **Home Health Care** agency.

If Martha had purchased a comprehensive long-term care insurance policy, many of her long-term care expenses, both in the ***nursing home*** *and in her own home, might have been covered, reducing or eliminating the amount she had to pay for her own care.*

What Do I Need To Know Before Purchasing A Policy?

Income

Before purchasing a policy, think about your continuing ability to pay the **premium**. A good benchmark to determine affordability is that the **premium** you pay should not exceed seven percent of your annual income. Remember that your income may not keep up with inflation as you get older, and if your spouse dies, your income could be reduced. You should also plan on leaving room in your finances to allow for future **premium** increases. If you don't take these factors into account you could be faced with some tough decisions later about what you can afford to continue paying with a reduced income.

IMPORTANT! ***You should always ask about*** **premium** ***increases for any long-term care policies the company sells now or has sold in the past.*** An insurance agent should give you a disclosure notice that will show you any **premium** increases that have been imposed by the company you are considering. You should also ask if the company you are considering has a history of increasing **premiums** once a policy has been issued. You can also call the company and ask about their **premium** increases or you can look up that information on the website of the California Department of Insurance located at http://www.insurance.ca.gov.

Assets

If you have abundant assets you might plan to use those to pay for some or all of any long-term care expenses you may have in the future. If your non-housing assets are very low (less than the cost of a year in a **nursing home**) you probably don't need and can't afford long-term care insurance. If you already qualify for **Medi-Cal** or would spend all your assets paying for care within a few months, you do not need long-term care insurance. If you are somewhere between these income levels, long-term care insurance may be worth considering. The amount of insurance coverage you buy should be roughly comparable to the assets you would otherwise have to spend before you could qualify for **Medi-Cal** benefits, and have a **premium** you can afford now and into the future.

Age

Premiums are based on your age when you buy a policy and the benefits you choose. The older you are when you purchase a policy, the more expensive the **premium** will be. It's important to know that many companies will not sell you long-term care insurance once you reach 80 years of age. If they do sell you coverage at this older age they may limit the amount of long-term care insurance you can buy.

Health

Companies screen people for medical conditions when they apply for a policy. You will be asked a series of health questions on the application and will be required to sign a release of your medical records so the insurance company can examine them. Some companies may require a paramedical exam and lab tests. Some may also require all applicants to participate in memory and mobility testing, or only those over a certain age who are retired. Paramedical exams are usually conducted in your home by a licensed medical professional who will review your medical history, measure your height and weight, and take your blood pressure and pulse, along with blood and urine samples. If a company accepts you even when you had certain serious health conditions in the past, your **premiums** are likely to be higher as a result. But it's rare for people with chronic or serious health problems to be accepted for long-term care insurance coverage.

Pre-existing Condition

An insurance company can refuse to pay benefits if you need care during the first six months after you buy the policy because of a health condition you had during the six months before you bought the policy. Some companies will pay for care caused by a pre-existing health condition during this time if you listed it on your application; others will not. You should always be certain that health questions on an insurance application are answered accurately to avoid any problems later.

Financial Rating Companies

If you are considering buying a long-term care insurance policy, there are "rating" companies that rate insurance companies on their financial condition and "claims-paying ability." These companies include A.M. Best, Fitch Financial, Moody's, and Standard & Poor's. A.M. Best Reports are often available at public libraries. These companies may give ratings over the telephone or on their websites. Some charge a fee for this information, others don't.

A.M. Best
Website: http://www.ambest.com
Telephone: 908-439-2200

Standard & Poor's
Website: https://www.standardandpoors.com
Telephone: 212-438-2000

Moody's
Website: https://www.moodys.com
Telephone: 212-553-0377

Fitch Financial
Website: https://www.fitchratings.com
Telephone: 800-753-4824

How Much Does Long-Term Care Insurance Cost?

The cost of long-term care policies varies according to the type of policy, the coverage provided, and the choices you make when you buy the policy. Some of the factors that can influence the cost of long-term care insurance include:

- Your age and your health at the time you apply for coverage;
- Your gender. If you are a single woman your **premium** is likely to be higher than the **premium** for a man of the same age. If you apply as a couple and your male spouse does not qualify for coverage your **premium** will likely be the same as a single woman's **premium;**
- **Inflation protection,** and what kind you buy;
- The **deductible/elimination period *(also known as a* waiting period)** you choose before the policy begins paying benefits;
- The combination of benefits you want included in the policy;
- The daily or monthly benefit amount you want the company to pay when you need care; and
- The number of years or total dollar amount you want the company to pay in benefits.

IMPORTANT! Policies that only pay for **nursing home** care and assisted living care are usually less expensive than comprehensive policies and may be a good choice for some people. **Home Care** Only policies may also be less expensive, but these policies will not pay anything if you need care in a **nursing home** or want to go to an **Assisted Living Facility**.

How Much Will A Policy Pay?

That depends on the benefits you choose. Most policies pay daily amounts (sometimes called **"daily benefits"** or **"daily benefit** maximums") that can range from $80 a day to more than $300 a day for the covered services described in the policy. The largest benefit amount is generally the benefit that will be paid for **nursing home** care, the most expensive kind of care. The amount for other covered benefits may be a smaller amount or a percentage of the **nursing home** benefit. If your daily **nursing home** expenses exceed the **maximum daily benefit** you select, you will be responsible for the additional cost.

For example, if you choose a **maximum daily benefit** of $150 per day and your **nursing home** expenses are $200 per day, you will be responsible for the difference, $50 per day, or $1,500 for a month. While you may have the income to pay this **nursing home** cost today, you need to be sure that you can pay it in the future too. California **nursing home** costs in 2017 averaged $300 a day and are projected to increase to $827 a day by 2037.[43] This means that any costs you must pay will also increase. Once you qualify for benefits many companies will pay your benefits on a monthly or weekly basis. For **home care** services this form of payment allows you or your caregiver to organize your care more efficiently. Most companies will require you to submit bills from the service providers that the company will use to verify your care and pay your benefits.

IMPORTANT! Companies will pay either the actual cost of your care or the **daily benefit** amount, whichever amount is less. For example, if you choose a **daily benefit** of $200 and your **nursing home** expenses are only $150, a company that reimburses for covered expenses will only pay $150, the actual cost of your care. If you choose a daily maximum of $200 and your **nursing home** expenses are $250 you will be responsible for the difference ($50).

How Does Inflation Protection Work?

When you buy individual long-term care insurance, the insurance company must offer you the option to purchase **inflation protection** that is built into the cost of your **premium.** At a minimum, the company must offer you five percent compounded **inflation protection**. Companies can also offer you other percentages and other methods such as five percent simple interest, or they can offer you the right to increase your benefits periodically without medical screening.

You choose one of these options at the time you purchase the policy. If you choose the compounded or simple option the cost is included in the annual **premium.** This method of **inflation protection** will increase your **daily benefit** amount each year by the percentage you selected when you bought your policy. If you selected five percent compounded, both your **daily benefit** amount and total maximum coverage will double every fourteen years. Long-term care expenses increase at a

compounded rate, and your benefits should too. Chart #5 shows the effect of inflation on long-term care benefits.

Some companies offer an option that allows you to periodically increase your existing benefits to keep up with inflation. This is sometimes known as a "periodic increase" **inflation protection** option. If you choose this option you will pay an additional **premium** amount to increase your benefits each time it's added to your policy. Your **premium** will be based on the increase in your benefits and your age at the time you accept the offer. If you turn this option down more than once, or you can't afford to pay the increased **premium,** you may lose the right to choose this option in the future.

State law requires insurance companies to offer you the chance to buy **inflation protection,** and you must sign a rejection form if you don't want it included in your policy. **Inflation protection** does increase the cost of your annual **premium,** either because it's built into your policy when you buy it, or when it's offered to you later. Without it you risk not being able to pay your share of the cost of care in the future.

CHART 5:

ESTIMATED DAILY COST OF NURSING HOME CARE

(with and without inflation protection) Cost shown in Thousands
Note: In 2017, the cost of care for one year is $109,500

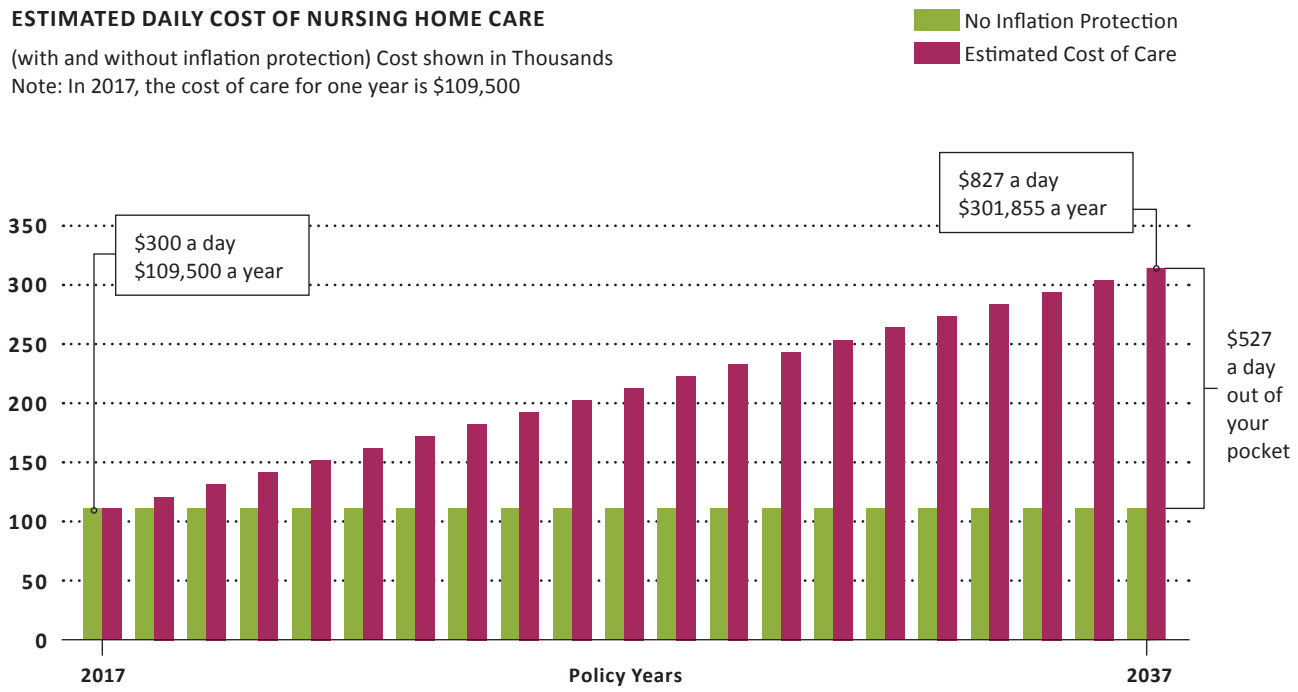


Chart #6 shows the average projected cost of nursing facilities is expected to rise nearly five percent or more annually.

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

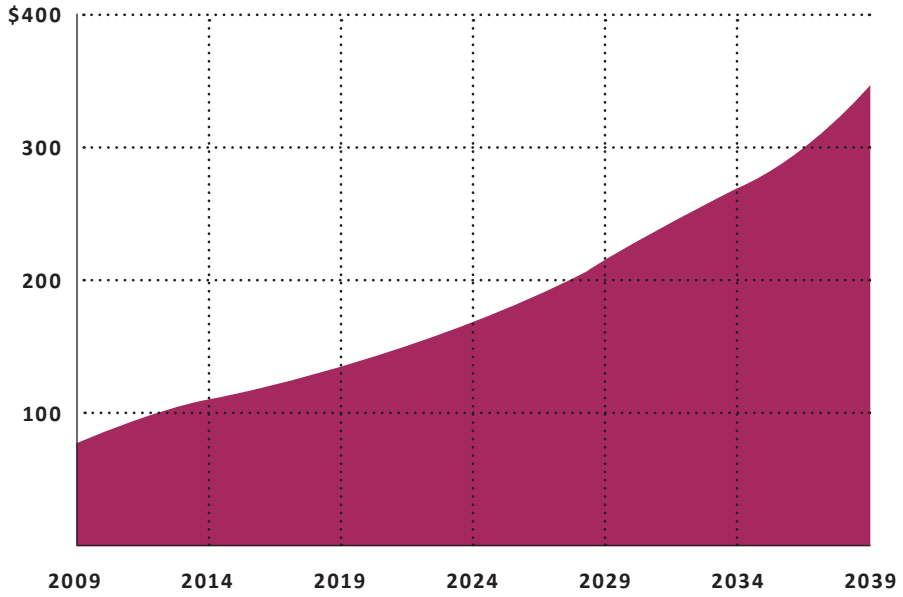
How Long Will A Policy Pay Benefits?

Most policies have a maximum number of days that benefits will be paid once you start using them. This time period is called a **"benefit period"** or "maximum **benefit period.**" It is the total amount of time or dollars that a company will pay for the benefits you bought. This is often referred to as the duration of your coverage or the total number of days, years, or dollars that the company will pay for your care once you start using benefits.

CHART 6:

AVERAGE PROJECTED COST OF NURSING FACILITIES

Average Annual Cost shown in Thousands



Companies sell long-term care coverage by a total number of dollars usually measured in one-year increments. You can buy a policy that will pay for as little as one year of care, two years of care, or more. Most companies have stopped selling a policy that will pay benefits for as long as you live once your benefits begin. The **premium** costs more the longer you want the company to pay benefits.

Most moderate-income people buy between two and five years of coverage. The younger you are when you buy a policy the less expensive the **premiums** will be, although the cost of **inflation protection** is likely to be more expensive to reflect the greater number of years that the company will have to increase your benefits before you are likely to need care.

How Can I Buy Long-Term Care Insurance?

Long-term care insurance is most often sold by insurance agents to individuals who pay the entire **premium** themselves. Some employers offer this type of insurance to their employees and retirees through a group plan, although the employee usually pays the entire **premium.** Some group plans also allow the spouses, parents, and sometimes the parents-in-law and even siblings of their employees and retirees to apply for the group coverage. For instance, the California Public Employees' Retirement System (CalPERS) allows public employees, retirees, and their parents and parents-in-law to apply for the CalPERS long-term care program. The federal government also allows qualified federal and postal employees, members of the military, annuitants, and qualified family members to apply for the federal long-term care program. Neither CalPERS nor the federal government pays any part of the **premiums** for their long-term care programs. Large associations such as AARP and some faith-based groups may also offer this type of insurance to the members of their group.

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

Benefit Eligibility Triggers

Eligibility for accessing the benefits of a long-term care insurance policy depends on your inability to perform two **"activities of daily living" (ADLs)** out of a list of six, or when your cognitive ability is impaired. These are referred to as **"benefit eligibility triggers."**

To be eligible for benefits you generally have to meet one of the two **benefit eligibility triggers** listed below. In addition, your doctor or other health care professional must draw up a Plan of Care, and certify that you are expected to need care for 90 days or more.

IMPORTANT! If you unexpectedly get better and stop needing care during this 90-day period it will have no effect on the **waiting period** you chose when you bought your policy.

Activities of Daily Living (ADLs)

These are the six **activities of daily living (ADLs)** for which you ordinarily would not need assistance from another person.

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

Impairment of Cognitive Ability

This is another benefit eligibility trigger that causes a person to need **substantial supervision** because of a severe **cognitive impairment.** People with **Alzheimer's disease** or other types of **dementia** often need **substantial supervision** to protect themselves or others around them.

What Other Conditions Must Be Met Before Benefits Will Be Paid?

Elimination, Deductible or Waiting Period

This is the number of days you must wait after the company certifies that you are eligible for benefits but before the policy begins paying for your care. You can choose a policy without a **waiting period** and benefits will be paid from the first day you qualify for them.

However, the most common **waiting periods** are 20 days, 30 days, 60 days, 90 days, or 100 days. You will be responsible for the cost of your long-term care expenses during the **waiting period** you choose when you buy your policy. The policy **premium** will generally be lower when you select a longer **waiting period,** but you will be responsible for the full cost of your care during that **waiting period.**

For example, if you need care in a **nursing home** and the cost is $200 each day, and you have a 60-day **waiting period,** you will pay the first $12,000 ($200 x 60) for your care before the policy pays anything. This example assumes that you continue to stay in the **nursing home** after 60 days. If your **nursing home** stay is shorter than your **elimination period,** the policy will pay nothing for your **nursing home** stay. Remember that **nursing home** costs will increase each year due to inflationary increases in the cost of providing care, and the amount you will pay for any **waiting period** will be more than it is today.

You should also understand how a company counts the days in the **waiting period.** Some companies count "service days" and others count "calendar days." For example, if you are getting covered care at home you might not need the care every single day. If only the days on which you actually receive **home care** services count, called a "service day" **waiting period,** a 90-day **elimination period** could take much longer than 90 days to satisfy. If all of the days you qualify for benefits count, even when you don't get care on some of those days, your **waiting period** will be 90 days. This is called a "calendar day" **waiting period.**

Most companies require you to meet the **waiting period** once during your lifetime; some may require you to meet it more than once. Be sure you understand this requirement in any policy you buy. For example, if you needed care for a total of 90 days and had a 30-day **waiting period** for each **period of care,** you would pay for the first 30 days and your policy would pay the remaining 60 days. Later if you needed to use your benefits again, you would have to pay for your own care during a new 30-day **waiting period.**

IMPORTANT! Remember that you cannot depend on **Medicare** to pay for the first 100 days you are in a **nursing home**. **Medicare** will only pay all the costs for the first 20 days and part of the cost from days 21 to 100 if you are receiving daily skilled care and rehabilitative services. Policies sold as **tax-qualified long-term care policies** are ***not*** allowed to pay the **Medicare** coinsurance after the 21st day if **Medicare** is still paying for your **nursing home** stay. If the ***only*** care you need is **personal care** services, you or your long-term care insurance will pay for your care, depending on how your policy is designed.

Plan of Care

A Plan of Care is a document written by your doctor or a medical team, such as a nurse or social worker from a home health agency, and required by insurance companies as part of filing a claim. It establishes that you need care, describes the kind of care you need, and specifies the frequency and length of time you are expected to need care. Most insurance companies also require that the Plan of Care be updated periodically.

Care Assessment and Care Management

Care management is a process to assess, plan, coordinate, and monitor long-term care. Most policies sold today must allow you to use an independent care manager to assess

your need for care and to develop your Plan of Care. Some companies may provide care assessment and service referrals as part of their benefit package. If you need ongoing **care management** you will probably have to pay for that yourself.

Who Can Provide The Care I May Need?

Policy definitions determine where you can get care and who can provide care. In California, companies must pay **nursing home** benefits in any state licensed **nursing home.** Policies that pay benefits for assisted living must pay for care in licensed places like **Residential Care Facilities for the Elderly (RCFEs)** in California, or if you receive care in another state as it is described in your policy.

Most policies also pay for **hospice care** at home and for inpatient **hospice care** when those services are not covered by **Medicare. Home health care** agencies can provide any of the required **home care** services. Licensed professionals such as nurses, physical therapists, and social workers may also be eligible providers of certain skilled care services.

Policies with **home care** benefits must cover **personal care, homemaker services,** and some **hospice** services if the care is recommended in the Plan of Care. Policies that pay for **home care** cannot require people who provide **personal care** or **homemaker services** to be licensed if the state doesn't require such a license. Most policies will not pay **home care** benefits when family members provide care.

What Other Policy Features Are Offered?

Benefits for Assisted Living

This is a growing and popular option for people when they cannot stay in their own homes. Many newer facilities offer **independent living** with on-site services like meals, housekeeping, supervision for people with **cognitive impairment,** and assistance with **activities of daily living** in addition to assisted living services. **Home Care Only** policies are the only long-term care policies sold in California that are not required to include this benefit. When assisted living is covered in a policy the benefit amount cannot be less than 70 percent of the **nursing home** benefit amount you choose.

Flexible Benefits

Long-term care policies must allow the total amount of all of the policy benefits to be used interchangeably, or in any combination of

benefits covered by the policy. For example, if you have a comprehensive policy that pays $200 a day in a **nursing home** for two years, and the daily **home care** benefit is $100, it could take four years to use up the maximum benefit for **home care,** but only two years for **nursing home** care.

However, policies can still limit the **maximum daily benefit** for each service. For instance, if a policy pays $150 daily for **nursing home** care, the benefit for **home care** might be only 50 percent of that amount, or $75. Some companies selling long-term care insurance policies today may use the same maximum daily amount regardless of whether care is provided in a **nursing home**, **Assisted Living Facility**, or at home. In either case, the company must continue to pay benefits until all policy benefits are exhausted, unless the person dies or doesn't continue to meet all of the requirements of the policy.

Waiver of Premium

Many policies allow you to stop paying **premiums,** known as a **premium waiver,** while you are collecting benefits. A **premium waiver** usually begins after the elimination, **waiting period** or deductible has ended. Most **premium waivers** begin 90 days after the policy begins paying benefits. A **premium waiver** may only apply when you are using a nursing facility benefit or other institutional benefit, although some policies may waive **premiums** while you are using the **home care** benefits of the policy.

Nonforfeiture Benefits

Nonforfeiture benefits allow you to keep some benefit amount of a long-term care insurance policy if you can't pay the **premium** and have to drop your policy. The details and terms of a nonforfeiture benefit will be described in the policy if that benefit was included in your policy. Another form of nonforfeiture is an option you may be offered if your **premium** increases. You might be offered an option to stop paying **premiums** and keep some amount of your existing coverage, sometimes called a shortened **benefit period** or a contingent benefit. The amount of benefits you can keep will be spelled out in a notice with the **premium** increase, or any other time the company offers you this option.

For example, a shortened **benefit period** or contingent benefit allows you to keep the amount of your existing benefits that are equal to the amount of **premiums** you've paid since you bought the policy. You would always have the same benefits you originally purchased but benefits would be paid for a shorter period of time than the maximum policy benefits you originally bought. For instance, your **daily benefit** amount would remain the same, along with all of the other benefits in your policy, but those benefits would last for a much shorter period of time once you started to use them.

A Return of **Premium** benefit refunds a percentage of the total **premiums** paid, minus any claims paid, based on the number of years you paid **premiums.** For instance, if **premiums** had been paid for 20 years, the company

might refund 100 percent of the **premiums** you had paid. Some companies have a return of **premium** benefit only if the insured person dies before a certain age, or after they had paid **premiums** for a certain number of years. The cost of this benefit is included in the **premium** you agreed to pay for the policy.

Substitute or Alternative Benefits or Services

If you qualify for benefits covered by your policy, but you want the policy to pay for a provider, a service, or in a place that is not specifically listed in your policy, you can request that benefit from the insurance company if your doctor agrees with your need for the change you request. However, the company has absolute discretion to grant or deny your request for an alternate benefit. Some companies offer the right to request an alternate benefit in their contracts; others don't. You can always submit a request for payment of alternative benefits, whether or not your policy has this feature. The company will decide if it is willing to pay for the alternate benefit you request.

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

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

30-day Free Look

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

Guaranteed Renewable Protection

Every long-term care policy sold to an individual must be **"guaranteed renewable."** This means that the company cannot cancel your policy, unless you fail to pay the **premiums.** Insurance companies are, however, allowed to increase **premiums** on all similar policies sold in your state, but not for you individually because of a change in your health or the length of time you've had your policy.

Forgetfulness Feature

Companies are required to allow you to reinstate your policy if it **lapses** because you forgot to pay **premiums** for reasons related to a **cognitive impairment** or a functional disability. You or someone you appoint will have no less than five months after the last missed **premium** to reinstate your policy. You must have missed those payments because of impairment in your cognitive or functional abilities. Companies will ask you when you apply for coverage to designate someone to receive the **premium** notices if you miss a payment. They will also give you the opportunity every two years to designate someone else if you choose. You should seriously consider designating one

or two people to be notified if the company doesn't receive your **premium** payment. This will protect your coverage if you get sick or don't remember to pay your **premiums.** Be sure to notify the company of any change of address for the people you designate to receive this notice, also referred to as a **third-party notice,** if you fail to pay the **premium**.

Downgrades

California law requires companies to allow you the option to reduce your coverage in exchange for a lower **premium**. This right to reduce coverage can be exercised any time after the first year or whenever your **premium** increases. There are several ways this can be done. For instance, you can reduce the amount of the **daily benefit** or reduce the total number of years the policy will pay, or you might be able to change your coverage from a Comprehensive policy to a **Nursing Home** Only policy, but only if the company sells one. Companies must also offer you the option to reduce your benefits if you stop paying **premiums** and your policy is about to **lapse.** This law was enacted to help people maintain at least some of their benefits when they can no longer afford the **premiums** they have been paying.

IMPORTANT! Companies may also offer you these options when they notify you of an impending **premium** increase. You may be able to lower some or all of the increased **premium**, depending on options the company offers you and the amount that those options reduce the new **premium**.

New Benefits

If you have an existing long-term care policy, the company must offer you any new long-term care benefits they begin selling in California. You can apply for these new benefits under the same health screening applied to anyone else. Your **premium** for any new benefits will be based on your current age, but the **premium** for the benefits you already have will stay the same. If a company offers to replace your entire policy with a new one that includes the new benefits, the company must reduce your new **premium** by applying a five percent **premium** credit for each year you had your existing policy. The maximum **premium** credit can't be more than 50 percent of the new **premium**.

Continuation or Conversion Coverage

If you purchase a long-term care certificate through a group, you can continue or convert your coverage if the group cancels the master policy or terminates coverage. Continuation means you keep the same coverage for as long as you pay the new **premium** on time. Conversion means you get a new individual insurance policy with identical or equivalent coverage without health screening. In either case, your **premium** can change when you are no longer part of the group. Some groups may continue your group coverage even if you leave the group. In other cases a group may only sponsor individual policies that are sold to group members. In that case people don't need to convert their coverage if the individual leaves the group or the group stops sponsoring coverage because they already have an individual policy, not one issued to the group.

Outline of Coverage

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

Forbidden Requirements

Policies sold after 1990 cannot require you to be in a hospital before benefits will be paid in a **nursing home,** or to get skilled nursing care before **personal care** services are covered. Companies can't refuse to pay your benefits because you weren't in a hospital or **nursing home** before you needed **home care** or community care. Companies also cannot refuse to pay covered benefits to people who are diagnosed with a mental illness or **cognitive impairment,** including **Alzheimer's disease**, if they meet the eligibility trigger in the policy.

Duties of Agents and Companies

California law requires agents to comply with certain standards when selling insurance and to give consumers certain information at the time they make a sales presentation. If you are replacing a policy, agents are required to give you a fair and accurate comparison of any benefits you may already have, with the policy you are considering for purchase. If you are adding a new policy to an older policy with fewer benefits, be sure the agent explains any

coordination of benefit rules that could apply in one or both of the policies.

If you are buying any long-term care insurance, you must be given a "Long-Term Care Insurance Personal Worksheet." This form gives you important information about any rate increases the company has had, and asks you to consider certain other issues related to buying long-term care insurance and your ability to pay **premiums** over time. If you do not complete this form, the company is required to contact you before issuing coverage to make sure the agent showed it to you, and that you meet their standards for income and assets to purchase this product. The Personal Worksheet is intended to help you purchase the right type of policy and an appropriate amount of coverage for your particular circumstances.

Insurance agents have a duty of honesty, good faith, and fair dealing to all consumers. They are prohibited from using high-pressure tactics

to sell you insurance and are not allowed to sell inappropriate coverage or excessive amounts of insurance. Advertisements and other marketing materials used by agents and by companies cannot be misleading. Violations of these standards should be reported to the California Department of Insurance (CDI) at 1-800-927-HELP (4357) or by using the CDI website at https://www.insurance.ca.gov/01-consumers/101-help.

Agent Training

All agents and other financial consultants selling long-term care insurance must be licensed by the California Department of Insurance. Agents must receive special training before they can sell long-term care insurance and they must complete additional training every two years before they can renew their license. Insurance companies have to keep a list of the agents authorized to sell their long-term care insurance policies. The California Department of Insurance keeps a copy of that list. You can check their website to see if an agent's training is up to date.

IMPORTANT! You can call the California Department of Insurance to verify whether an agent is authorized to sell long-term care insurance by calling 1-800-927-HELP (4357) or check their website at http://www.insurance.ca.gov

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

You can get more information and free individual counseling on long-term care insurance from your local Health Insurance Counseling and Advocacy Program (HICAP). HICAP is a free statewide program administered by the California Department of Aging. Call 1-800-434-0222 to find the HICAP office nearest you or visit HICAP on the web at https://www.aging.ca.gov. HICAP uses trained volunteers who will meet with you to objectively discuss your long-term care needs and help you with the questions you may have about long-term care insurance.

Consumer Questionnaires

Questions to ask yourself before purchasing long-term care insurance.

Tailoring Benefits to Your Own Needs

1. Seven percent of my annual income is approximately $ _____
   *(This is the maximum amount of annual income experts advise spending on a **premium.**)*

2. The cash value of my non-housing assets* is $ _____
   (This is the amount you would otherwise have to spend for long-term care.)

3. The total amount of time my non-housing assets would last is _____ years if I needed care today.
   (This is the approximate number of years of coverage you might consider buying based on the cost of care where you live.)

4. I can afford to pay $ _____ a day towards the cost of my own care.

5. The difference between the amount I can pay and the cost of care today is $ _____ a day.

6. I can afford to pay $ _____ for the first days of care in a **nursing home.**

7. I will need a **waiting period** no longer than:

   30 days $ _____ 60 days $ _____ 90 days $ _____

Worksheet

The five questions in the worksheet below will help you determine the benefits you need. Fill in the spaces using your answers to the questions on the previous page.

1. The **premium** range I can afford is $ _____
   Your answer to Question #1 on page 45.

2. The number of years a policy should pay is _____ years.
   Your answer to Question #3 on page 45

3. The **daily benefit** amount I need is $ _____
   Your answer to Question #5 on page 45.

4. The **elimination period** I can afford is _____ days.
   Your answer to Question #7 on page 45.

(To determine the amount you would pay, multiply the daily **nursing home** cost times the number of days in the **waiting period**.) For more information on **nursing home** costs, see page 21.

*Non-housing assets are things you own that don't include the equity you own in your house. When you apply for **Medi-Cal** the value of your house and car is generally not counted. Changes in federal law may cap the amount of home equity you can have, or make other changes that affect your ability to qualify for **Medi-Cal** in the future. The value of your other assets like savings, stocks, bonds, and investments will be counted. Contact your local Department of Social Services for more specific information about **Medi-Cal** and applications for this state program for low-income people, including changes in federal or state law that can affect your eligibility. For a directory of local offices, visit the Department of Health Care Services at www.dhcs.ca.gov and search for "**Medi-Cal** Offices."

Questions to ask an Agent About any Long-Term Care Policy I Consider Buying

1. Has the company ever raised **premiums** on any long-term care policies they sold?

   _____

2. How does the **inflation protection** in the policy I am considering work?

   _____

3. Does the policy have a **premium waiver?**
   - When does it begin?
   - Does it apply to all of the benefits in the policy?
   - When the **premium** is waived will the company refund any of the annual **premium** I paid in advance?

   _____

   _____

4. Do I have to satisfy the **waiting period** before benefits begin more than once?

   _____

5. How are the days in the **elimination period** counted?
   - Every day I need care?
   - From the day I am first eligible for benefits?

   _____

   _____

6. If **Home Care** is a covered benefit, is **care management** a benefit of the policy?
   - Is the cost of **care management** deducted from any of my benefits?
   - Does the company use their own care manager or can I choose my own?

   _____

   _____

7. Does the policy include a nonforfeiture benefit? If so, how does it work and what does it cost?

   _____

Things to Know About the Agent

1. Is the agent authorized to sell me either an individual policy or a "Partnership" policy?

   _____

2. Did the agent explain the Personal Worksheet?

   _____

3. Did the agent give me an Outline of Coverage (a summary of the policy you are buying)?

   _____

4. Did the agent give me *Taking Care of Tomorrow, the California Department of Aging's Consumer's Guide to Long-Term Care?*

   _____

5. Did the agent leave me written information about how to reach the local HICAP?

   _____

6. If the agent was replacing my existing policy did he/she give me a written comparison of the two policies and the reason my existing policy is being replaced?

   _____

Other Types Of Insurance And Benefits For Long-Term Care

Life Insurance

If you have a whole life insurance policy it will usually have a cash value. You might be able to take a loan against the cash value of a whole life policy that could be used to pay for long-term care expenses. Check to see if you have a life insurance policy that would allow you to "accelerate" the death benefit to pay for your care. If you have a term life insurance policy it's unlikely you have any cash value to draw against.

IMPORTANT! If you have an existing life insurance policy, contact the company to find out what options you may have if you need to pay for long-term care services.

Life Insurance With Benefits For Long-Term Care

Most companies selling life insurance today offer an option or an additional benefit to cover the cost of long-term care. These are known as life-linked long-term care insurance policies, hybrid long-term care policies, or combination policies. These products are designed in various ways. Some include long-term care benefits in addition to a death benefit, some offer a rider for long-term care benefits, and others use an Accelerated Death Benefit to pay for long-term care expenses later.

A life insurance policy that accelerates the death benefit pays you a percentage of that death benefit when certain requirements specified in the policy are met. The death benefit is usually calculated to increase each year based on investment earnings specified in the policy. The long-term care benefit is often shown on a schedule or **illustration** attached to the policy as a separate benefit amount for each year the policy is in force. The underlying death benefit is drawn down at an amount or percentage specified in the policy to pay for future care. In most cases a minimum amount of the death benefit must remain in the policy to be paid at the time of death.

Several **"illustrations"** will come with a life-linked long-term care policy. **Illustrations** are separate documents that use words and pictures to provide information to prospective or new policy owners on how the policy should perform based on a specified set of factors. They will show you how the account value, the cash value, and the death benefit change each year you pay for the policy, based on costs and earnings within that policy.

Premiums

These types of insurance policies offering long-term care benefits can be purchased with one large **premium** payment or with **premiums** you pay periodically over time, either annually or for a fixed number of years. These policies are generally more expensive than a stand-alone long-term care insurance policy because they often require a lump sum **premium** payment of $50,000 or more, and another large **premium** for an optional rider to extend the long-term care benefits once most of the death benefit has been used up. Some policies include an acceleration option against the death benefit within a life insurance policy; others charge an additional **premium** to accelerate the death benefit. A rider might be available at additional cost with benefits that only begin after the death benefit has been used to pay for long-term care. **Inflation protection** may be offered as a separate benefit. In some policies the amount of the death benefit is guaranteed. In others it is not guaranteed and can go up or down depending on earnings and costs applied within the policy, loans that have been taken against the death benefit, or other factors that are described in the policy.

If you change your mind about a life-linked policy and want your **premium** back, some of these policies will allow you to surrender your policy and get back the single large **premium** you paid. Some life-linked policies may deduct a surrender charge from any **premium** that is refunded during the first ten years. There may be a different surrender charge amount applied to riders than is applied to the life insurance policy. A life-linked policy will have a schedule of payments to show you how much the surrender fee will be and for how many years it will apply.

IMPORTANT! Be sure that you understand all of the details of having your **premium** refunded if you change your mind about the policy.

Tax Issues

Some of these products are **tax-qualified,** but others may not be. The 1996 federal tax law, **HIPAA,** may allow a deduction on your federal tax return of the portion of the **premium** that pays for the long-term care benefit, and the benefits you receive might not be taxed as income. Some, or all, of the **premium** you pay for one of these policies might be deductible depending on your age. Make sure you consult a tax advisor before you purchase one of these policies to find out what you can deduct, what benefits are excluded from income, and what amounts may or may not be taxable.

Benefit Triggers

Some life-linked long-term care policies use the same long-term care **benefit eligibility triggers** as do stand-alone long-term care insurance policies, and pay for the same kinds of expenses. Others use those eligibility triggers but include a wide range of other eligibility triggers such as the need for an organ transplant. Some policies require you to receive long-term care services before they pay a fixed amount towards the cost of those services. Other policies pay a daily or monthly amount based on meeting the **benefit trigger,** but don't require you to submit bills for any care you receive.

These life-linked policies typically delegate a certain percentage of the death benefit amount as the monthly benefit for long-term care expenses. The death benefit may increase over time in some policies, based on the costs and earnings applied to the policy. In some policies the monthly benefit is less for **home care** than it is for **nursing home** care; in others it may be the same amount. Since the monthly benefit for care is a fixed-dollar amount it may or may not be enough to keep up with the cost of care in the future, depending on how, or if, the death benefit increases over time.

Be sure you understand how costs will be calculated and applied to any benefits you may receive. There may be administrative and other costs deducted from the benefit amount when you use a death benefit to pay for your long-term care. All of this information should be in the **illustrations** that come with the policy.

Be sure that you know and understand which costs, earnings, and benefits are guaranteed not to ever be lower than they were at the time the policy was issued. Guarantees on these elements often make one of these policies more expensive than a stand-alone long-term care insurance policy because the policy is providing benefits for your care or a death benefit for your beneficiary.

IMPORTANT! While these policies may provide an attractive combination of benefits for some people, they should not be purchased without consultation with an accountant or trusted tax attorney to help you understand the interaction of the different benefits and costs. You will also need to know if there will be any tax liabilities involved in the particular policy design you might consider.

Annuities And Long-Term Care

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

Immediate annuities make periodic payments for a certain number of years, or until a specific event such as your death has occurred. If you purchase an immediate annuity you could receive periodic payments until you die or until the end of the contract period in the policy. With a deferred annuity, payments do not begin until a specific event occurs, such as retirement, reaching a certain age specified in the policy, or following your death if there is a death benefit feature in the annuity.

People who have a health condition and would not qualify for a long-term care policy sometimes purchase annuities to create an income stream to help pay for the costs of long-term care. You generally pay one large **premium** up front, and the annuity begins paying right away (immediate), or later (deferred). Typically you will have to pay a penalty called a "surrender fee" if you decide later that you want to get your original **premium** back or you want payments to begin sooner than the terms of the contract provide. Annuity contracts have a schedule of payments to show you how much the surrender fee will be and for how many years it will apply. If you need long-term care before annuity payments begin, some companies may waive the surrender fee if that provision is in the policy.

Some annuities have a specific benefit for long-term care or a specific **benefit trigger** that allows payment of the annuity benefit. Annuities that include long-term care vary widely and the methods used to calculate these benefits can be very complex.

An annuity generally pays you a percentage of the benefit when certain requirements specified in the policy are met. An annuity benefit is usually calculated to increase each year based on investment earnings specified in the policy. The long-term care benefit is often shown on a schedule or in an illustration that is attached to the policy as a separate benefit amount for each year the policy is in force. The **benefit triggers** are usually similar to those in a freestanding long-term care policy.

Monthly administrative fees and certain other insurance costs may be deducted from the interest earnings of these policies, and those fees and costs may increase or decrease over time. In a low interest rate environment these fees and costs may be as much or more than the interest the policy is earning. In addition, some of the costs or earnings are guaranteed never to be lower than those that are guaranteed in the policy, so you should make sure that you understand which factors are guaranteed and which are not.

IMPORTANT! Make sure you consult a tax advisor before you purchase one of these policies to find out what, if anything, you can deduct, what benefits are excluded from income, and what benefit amounts may or may not be taxable. You should also consult a trusted tax advisor before purchasing any kind of annuity to make sure you understand the benefits as well as any estate or tax implications. Call the California Department of Insurance at 1-800-927-HELP (4357) immediately if you are being asked to put most of your assets into an annuity with payments that won't begin for several years. Some of these arrangements are unsuitable for seniors.

Viatical And Life Settlements

A Viatical Settlement is an arrangement whereby individuals sell their existing life insurance policies to a third party for more than the cash value, but less than the death benefit, because they have a terminal illness or because their life expectancy is less than two years. The sale can be made to the issuing company or to a third party for an immediate discounted amount of the death benefits.

A Life Settlement is the sale of a life insurance policy to a third party when the insured person is chronically ill or disabled and needs long-term care services. The sale of a life insurance policy, whether it is a Viatical Settlement or a Life Settlement, is often negotiated by a broker who receives a commission for negotiating the purchase and the subsequent sale to a third party. The settlement amount, an immediate discounted amount of the death benefit, is based on the anticipated life expectancy of the insured person. The shorter the life expectancy, the greater the percentage of the death benefit a third party will offer to pay.

In both cases the third parties who buy these life insurance policies continue to pay the **premiums** in order to collect the full amount of the death benefit when the insured person dies. The anticipated proceeds of these life insurance policies are often sold to investors, singly or bundled together, similar to the way mortgages are bundled for investment purposes.

Due to previous abuses in the purchase of life insurance policies, brokers who negotiate these sales and the third parties who buy these policies must meet certain state requirements to protect the insured individuals who are selling their life insurance benefits.

IMPORTANT! You may have a tax liability when you sell an existing life insurance policy. If you are approached to sell a life insurance policy you should consult with a trusted financial or tax advisor to ensure that such a transaction is in your best interest and you understand any tax liabilities that may exist.

Disability Income Insurance And Long-Term Care

Disability Income insurance, also known as disability insurance, doesn't pay for medical care, **personal care** or long-term care, regardless of whether it is "short term" or "long-term" disability income protection. The

purpose of this type of insurance is to replace earned income, although there is no restriction on how the funds are used. Disability Income insurance generally pays a percentage of a person's earned income if the insured person becomes disabled while covered by the policy. Because it's called disability insurance, some people may mistakenly assume they are also covered for the cost of long-term care services. Some newer disability income policies may include a rider that will pay benefits for long-term care services, but those benefits are separate from the income portion of the policy.

Home Companion Care Programs

Some individuals have been selling "home companion care" programs to senior citizens, primarily targeting the over-80 population. These "products" claim not to be long-term care insurance. The contracts can require an advance payment of thousands of dollars plus annual "association" or "membership" fees and may promise to provide one year of home companion or homemaker care, full-time or part-time, and a variety of other member services or discounts, or discounted care providers. **Co-payments** may be required for each "service" provided by these contracts, and lengthy **waiting periods** may apply before a person can use the promised benefits.

Companies selling these products are ***not*** covered by the state insurance guarantee fund in the event one of these companies becomes insolvent, and the contracts are currently unregulated by state government. These contracts have been sold with only a three-day (rather than a 30-day) "free look" period for cancellation and return of funds. Companies selling these products may also charge for the same types of services available free or at a low cost from government and community-based organizations. Some of these "home companion" programs have been the subject of law enforcement action because they violated insurance laws enacted to protect consumers. Information on free or low cost services available in your area can be obtained by calling the California Department of Aging Senior Information Line at 1-800-510-2020, or visit https://www.aging.ca.gov.

IMPORTANT! If you are asked to buy one of these contracts it is strongly recommended that you first check with the California Department of Insurance at 1-800-927-HELP (4357).

Other Resources

The Veterans Administration (VA) Aid and Attendance Program

The Veterans Administration (VA) provides a wide variety of services for aging veterans through traditional hospital programs and VA **nursing home**s. The VA offers many other programs including **home care, adult day care,** mental health care, day treatment centers, caregiver-support programs, and the Aid

and Attendance program. California also has homes, similar to **Assisted Living Facilities,** for California veterans and their spouse.

Veterans and survivors of veterans who are eligible for or are receiving a VA pension can apply for the VA Aid and Attendance program if they need the assistance of another person because of a physical, vision, or **cognitive impairment,** are housebound, or confined to a **nursing home.** Eligibility for this program is not restricted to service connected disabilities. There are income and asset limits that apply. This program can generate money to pay for long-term care services that increases or adds to the eligible person's pension from the VA. Learn more about this enhanced pension by visiting https://www.benefits.va.gov/pension/aid_attendance_housebound.asp.

IMPORTANT! Unscrupulous insurance agents, attorneys, and financial planners may try to persuade older veterans to transfer assets or invest in insurance products in order to qualify for the VA Aid and Attendance program. Learn more about this scam by visiting the Federal Trade Commission (FTC) website at http://www.consumer.ftc.gov/articles/0349-veterans-pensions.

Eligible individuals, their caregivers, or family members can apply to the VA for this benefit. A detailed report from the attending physician, similar to a Plan of Care, must be submitted. The report outlines the person's care needs, where they live and what they are able to do each day, their level of disability, and where their care will be or is being provided.

Application can be made by visiting the local regional VA benefit office which can be located by using the VA Facility Locator on the VA's webpage at https://www.va.gov/directory/guide/home.asp or by visiting the California Department of Veterans Affairs (CalVet) Service Officers directory at https://www.calvet.ca.gov/VetServices/Pages/CVSO-Locations.aspx.

IMPORTANT! Not all veterans are eligible for these services, and some services are primarily for disabled veterans. It is important to ask about any benefits before you need assistance. For information call the U.S. Department of Veterans Affairs at 1-844-MyVA 311 (1-844-698-2311), or specifically for benefits, call 1-800-827-1000. You may also call CalVet at 1-800-952-5626.

Fraternal Organizations, Churches, and Long-Term Care

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

California Partnership For Long-Term Care

What Is The California Partnership For Long-Term Care?

The "Partnership" is an innovative alliance between the State of California and a select number of private insurance companies. The California Department of Health Care Services designed the Partnership program to help you maintain your financial independence by creating special types of long-term care insurance policies. They provide a way to obtain high quality, affordable, private insurance and receive guaranteed lifetime asset protection in the event you ever need to apply for **Medi-Cal** (California's **Medicaid** program). The Partnership has three major goals:

- To help all consumers understand the risk and costs of long-term care;
- To offer high quality private insurance protection that helps avoid wiping out a lifetime of savings or losing financial independence paying for long-term care; and
- To ease the strain on the **Medi-Cal** program of paying for long-term care costs.

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

Partnership-approved long-term care insurance policies are offered by private insurance companies and sold by specially trained agents. These state-approved policies must meet stringent requirements established by the California Department of Health Care Services and contain many features that are not required in other long-term care insurance policies. Some of the most important are:

- Each policy has standardized terms and a core set of benefits that make it easier to compare policies from different companies;
- Automatic **inflation protection** is built into every policy to help your benefits keep up with the rising costs of care;
- The **premium** is waived from the first day you receive care in a **nursing home** or **Assisted Living Facility;**
- A Plan of Care based on individual needs and resources is developed by a Care Coordinator

(from a Care Provider Management Agency selected by the Partnership) who is a licensed health care professional and is independent of the insurance company. The Care Coordinator can also manage and monitor the quality of your care if requested;

- Services can be provided in your own home or in a community program like an **Adult Day Care** Center, in an **Assisted Living Facility** licensed as a **Residential Care Facility (RCF),** or in a nursing facility;
- Monthly home and community-based care benefits allow you to obtain services that may exceed the amount available under fixed daily or weekly amounts;
- Special agent training requirements ensure that Partnership policies are only marketed by licensed insurance professionals who have completed additional training required by the State of California;
- **Premium** increases are limited by how much and how frequently increases can occur; and
- Asset protection is included in every policy. A thorough explanation of the asset protection feature is described in the next section of this chapter.

Insurance companies participating in the Partnership must have their policies approved by both the California Department of Insurance and the Partnership program. For a list of the participating insurance companies, you can visit the Partnership's website at http://www.rureadyca.org or call 1-800-227-3445 for free brochures.

What is Asset Protection?

Partnership approved policies have a unique asset protection feature that ensures that every dollar paid out in benefits will protect an equal amount of your assets from **Medi-Cal** eligibility **spend-down** requirements. These policies pay for your care in the same way other long-term care policies would, until you have used up all of the policy benefits. Then if you still need long-term care you can keep more of your assets than if you had used up the benefits of an ordinary long-term care policy.

Please Note: The explanation and example of asset protection in this section applies to an individual. Spouses may have additional protections that apply. You can discuss how this would apply to your situation with a trusted financial advisor or your attorney.

Here's how it works:

Each dollar your Partnership policy pays in benefits protects one dollar of your assets when applying for **Medi-Cal** and later from **Medi-Cal** Estate Recovery. You can keep each dollar of those protected assets for your own use, for your spouse, or to pass on to your loved ones.

For example, assume you have $73,000 in lifetime savings (assets) and bought a Partnership policy covering the same amount of long-term care services. Later, you require care and you use up all of the benefits of your policy, but still require care. If you apply for **Medi-Cal,** you can keep the entire $73,000 of your assets, not just the $2,000 limit that would otherwise apply

for a single person. This amount ($73,000) is in addition to any other exemptions **Medi-Cal** allows. Each dollar your policy pays for your care equals one dollar of asset protection ($73,000 of your lifetime savings in this example). Please keep in mind that these guidelines can change annually. Be sure to check with your local county Health and Human Services Agency for a detailed listing of asset exemptions.

IMPORTANT! This example applies only to the assets of an individual. How asset protection applies to one spouse of a married couple is more complicated. You can discuss how this would apply to your situation by contacting the California Partnership.

Because **inflation protection** is built into every Partnership policy the amount of assets you can protect increases each year you keep the policy. For instance, if you did buy $73,000 in benefits with inflation protection, those benefits will grow by the amount of **inflation protection** you bought each year that you keep the policy. Because the **daily benefit** is increasing each year, the total amount of asset protection you have is also increasing. That means that at the end of 14 years the amount of assets that will be protected from **Medi-Cal spend-down** requirements will have almost doubled. While other policies may include **inflation protection,** only a Partnership policy gives you this important asset protection feature.

IMPORTANT! If you are 70 years old or older when you buy a policy you can choose simple **inflation protection** instead of the compounded **inflation protection.** In that case your asset protection would grow at a somewhat slower rate. (Turn to page 25 for more information on **Medi-Cal** Estate Recovery.)

How Will Asset Protection Work When I Need Care?

If you buy a Partnership-approved policy and later need care, you will first use your insurance benefits to pay for your care. As you use those benefits you will receive a quarterly report from the insurance company. The report will tell you how much your policy has paid in total benefits, and the amount the company paid during that quarter.

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

IMPORTANT! If your total assets are more than the amount protected by a Partnership policy you will have to spend those unprotected assets before you will qualify for **Medi-Cal** and before **Medi-Cal** will begin to pay for your care. Asset protection applies only to the assets of the individual who used the Partnership benefits and qualified for **Medi-Cal.**

If Medi-Cal Pays for My Care Will Medi-Cal Collect from My Estate?

Asset protection applies to the value of any asset you own, including equity you may have in your house. The Partnership asset protection guarantee continues even after your death. **Medi-Cal** will only collect from your estate when your assets are more than the amount your Partnership-approved policy paid out in benefits. Even then, **Medi-Cal** can only collect the amount paid by **Medi-Cal** for covered services and some assets are exempt under state law.

How Do I Know How Much Asset Protection to Buy?

You can purchase coverage equal to all the assets **Medi-Cal** would count, or you can choose to protect only some of those assets. You will need to balance the cost of the **premium** against the amount of assets you want to protect. The amount of coverage you buy is up to you. Remember, if you must buy less coverage than the assets you currently have, the **inflation protection** feature of the policy will increase your asset protection each year. The assets you own may increase in value, too. If you bought a compounded form of **inflation protection** the amount of asset protection you bought will have almost doubled after you have owned the policy for a full 14 years and have filed no claims.

IMPORTANT! Participating insurance companies offer benefit amounts that will last for one or more years. You can protect as little as $73,000 in assets up to $500,000 or more.

What Kind Of Policies Can I Buy Through The Partnership?

There are three kinds of Partnership-approved policies. One is a facility only policy that covers care in a **nursing home** or assisted living in a **residential care facility.** The second is a comprehensive policy that covers care in a **nursing home** or **residential care facility** and includes a full range of benefits for home and community services. Home and community services include **home health care, personal care, homemaker services, adult day care, hospice,** and **respite care.**

The third is a Home Care, Community-Based Services, and Residential Care Facility Only policy. This policy covers care at home and in the community including **home health care, personal care, homemaker services, adult day care, hospice,** and **respite care,** ***as well as assisted living care in a residential care facility.***

Each kind of policy has built-in **inflation protection** in an amount you choose. The **daily benefit** and the **maximum lifetime benefit** automatically increase each year by the amount of **inflation protection** in your policy. When you buy a Partnership policy, you choose the **daily benefit** that will be paid for services covered by the policy and the amount of **inflation protection** that will increase your benefits. You also choose the number of years you want the policy to pay benefits once you need care.

All Partnership-approved policies calculate the home and community-based benefits as a monthly pool of funds that can be used to

pay for any of the home and community-based services covered by the policy. For instance, if you bought a policy with a $100 **daily benefit,** your potential monthly pool of benefits would be $3,000. If you used less than that amount in any month the balance would remain in the policy to pay for your future care. The pool of funds you buy in a Partnership policy are available to pay for any benefit covered by the policy. This gives you the flexibility to arrange services at the times and in the amounts needed. You are not limited to a set amount of care each day, regardless of how many or how few services you need.

Note: A Partnership option is offered by the California Public Employees' Retirement System (CalPERS). You may visit their website at http://www.calpers.ca.gov or call (800) 205-2020 to find out more about long-term care benefits offered to CalPERS members.

How Much Do Partnership Policies Cost?

The cost of a policy will depend on your age, your health, the amount of **daily benefit** and **inflation protection** you select, and the features you choose. The more years you want the policy to pay, the higher the **premium** cost will be. Most people buy a policy that will pay for two, three or four years. In addition, the older you are when you buy a policy, the higher the **premium** will be. (Turn to page 30 for more information on things to consider when buying long-term care insurance. You can also turn to pages 45-48 for a Questionnaire which can help you make your long-term care decisions.)

When Does a Partnership Policy Pay Benefits?

To qualify for benefits, you must require human assistance or supervision in one of two ways. One way to qualify is if you are unable to perform at least two of the six **activities of daily living (ADLs),** and are expected to need that care for at least 90 days. Those six ADLs include bathing, dressing, toileting, transferring, continence, and eating. The other way to qualify is if you have a severe **cognitive impairment,** like **Alzheimer's disease** or another type of **dementia.**

IMPORTANT! Partnership policies use the same benefit eligibility standards required by federal law to be considered a **tax-qualified** policy. **Premiums** paid for policies labeled as **tax-qualified** may be deductible as a medical expense if you itemize your federal (and state) income tax returns. Consult your tax advisor for information on whether this tax deduction affects you. (Turn to page 28 for more information on **tax-qualified** policies.)

How Is the Need for Care Determined?

When you need care, a care coordinator from a **care management** agency approved by the Partnership and independent of the insurance company will assess your physical, mental and social needs in a face-to-face meeting. The care coordinator will develop a Plan of Care that describes the services you need. The cost of the care coordination will not be deducted from your benefits. Some policies will even pay the care manager to coordinate your services, as well as monitor the ongoing delivery of those services.

What If I Am Denied Benefits?

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

Who Is Eligible To Purchase A Partnership Policy?

There are no special eligibility rules except that you must be a resident of California at the time you buy a policy. The insurance benefits of your policy can be used anywhere in the United States. Any benefits paid for your care will count towards your asset protection, even if you live in another state when you received the care. However, you must live in California and apply for **Medi-Cal** to claim the asset protection. If you return to California and still need care, your assets will be protected up to the amount your policy has paid in benefits.

Can I Get a Partnership Policy if I Already Have a Long-Term Care Policy?

If you already have a policy from one of the companies participating in the Partnership you may be able to replace your current policy with a Partnership policy from that company. You might be charged a higher **premium** based on your current age, but you may also get some **premium** credit towards the **premium** for the new policy. This may make it possible to upgrade an older policy purchased before many of the improvements in newer policies.

While companies can require you to pass new health screening, it cannot be stricter than it is for other people applying for new policies.

How Can I Find Out More About Partnership Policies?

Partnership policies are offered by private insurance companies participating in the Partnership program and sold by specially trained insurance agents. You should ask your agent, or any agent selling long-term care insurance, if they have taken the required training to sell Partnership policies. For a list of the participating insurance companies, you can visit the Partnership's website at http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx or http://www.rureadyca.org or call 1-800-227-3445 for free brochures.

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

CalPERS Long-Term Care Program

The California Public Employees' Retirement System (CalPERS) is the largest public pension system in the United States, with assets totaling $298.7 billion as of June 30, 2016. CalPERS has a history of financial stability and commitment to meeting its members' retirement and health care needs.

Since 1995, CalPERS has offered a long-term care benefit for California public employees, retirees and their extended family members. This innovative program, designed to help protect eligible individuals from the potentially devastating cost of long term care, currently has more than 132,000 members.

The CalPERS Long-Term Care (LTC) Program is a voluntary, not-for-profit, self-funded program. The Program is funded with **premiums** covered members pay into the program and investment earnings on those **premiums.** Funds for the Program are held in a separate trust fund exclusively for the benefit of the Program's covered members. The investment performance of the trust fund is continually monitored by the CalPERS Board of Administration.

Who Is Eligible?

CalPERS Long-Term Care coverage is designed for current and former California public employees, retirees, their spouses, parents, parents-in-law, step parents, children, siblings (including stepbrothers and stepsisters),

grandparents, grandchildren, nieces, nephews, aunts, uncles, sons-in-law, daughters- in-law, brothers-in-law, and sisters-in-law, between the ages of 18 and 79.

California public employees include, but are not limited to, those employed by the State of California and all state departments, state Assembly and Senate, judicial systems, school districts, cities, counties, special districts, public universities, and community colleges.

About The Coverage Choices

Members choose the type and amount of long-term care coverage they need after they review the information included in the CalPERS Long-Term Care Program application kit. The Program does not use agents to sell the Program, but applicants can speak with trained Long-Term Care Specialists by calling a toll-free number provided in the application kit. The Long-Term Care Specialists are available to help applicants understand their coverage options and select a plan that is affordable and best meets their needs.

There are two basic plan choices:

1. Comprehensive Plan

This plan covers care in a wide variety of settings including licensed **nursing homes, Assisted Living Facilities, adult day care** centers and care provided at home.

2. California Partnership Plan

This is a comprehensive plan that covers care in a **nursing home, Assisted Living Facility**, **adult day care** center, and at home. This plan is offered through a "partnership" between the State of California's **Medi-Cal** program and CalPERS. It is described in more detail on pages 56–61.

All the plans generally include both home and facility care as well as **respite care, hospice care,** and Care Advisory Services which help people find the most appropriate services and care providers to meet their needs.

Members choose their total coverage amount, **daily benefit** amounts, and type of coverage they want from the plans being offered at the time they apply. The Program offers several choices in daily and monthly benefits, as well as total coverage amounts to meet the needs of the member.

Inflation Protection

Built-in **inflation protection** increases all coverage amounts annually by the percent elected at the time of purchase. CalPERS offers three percent or five percent compound interest **inflation protection** or three percent or five percent simple interest **inflation protection.** The cost of built-in **inflation protection** is factored into the **premium** at the time you apply. While the **premium** may increase (discussed in more detail on the next page), it will not increase because of the automatic increase in benefit amounts each year due to built-in **inflation protection.**

CalPERS also offers the Benefit Increase Option (BIO). This form of **inflation protection** also allows you to increase your benefits to keep up with inflation, but does so differently. Instead of being built into the initial **premium**, increases are offered every three years, and may be added by the policyholder to their policy. If an increase is elected, the **premium** associated with the increase will be based on your age at the time you elect the increase.

Premiums

Premiums are based on your age at the time you apply and can be paid through automatic payroll or pension deduction if available from your employer or retirement system, through electronic funds transfer from a checking or savings account, or by direct bill. **Premiums** do not increase simply because you get older or you begin to receive care. However, **premiums** may increase if the CalPERS Board determines this is necessary. If a **premium** increase is necessary it will affect all members with similar coverage; no one can be singled out individually for a **premium** increase. **Premium** payments are waived if you are receiving benefits from the Program and have satisfied the deductible period.

One-Time Calendar Day Deductible Period

The Program's calendar day deductible period is designed to minimize members' out-of-pocket expenses. The deductible period starts once a member has been determined eligible to receive benefits and has received at least one day of covered long-term care services. Every day after that counts towards your deductible period even if you don't receive care on all of those days. The care received during the deductible period may be paid for by the member or another payor, such as **Medicare.**

Important Consumer Protections

Coverage is fully portable so members can receive care anywhere in the United States. Coverage continues without any change in benefits or **premiums** even if the member retires, changes employment, moves, or goes through a divorce. It is also **guaranteed renewable** which means coverage can't be cancelled as long as **premiums** are paid. Coverage continues until benefits have been exhausted.

How To Apply

CalPERS offers the Program through an Open Application Period which means an applicant can apply at any time. An eligible member or extended family member can apply by completing the application form. Each applicant must pass medical screening, known as underwriting, prior to being approved for coverage. The Program evaluates your health based on the application and may also collect additional information from you and your physician.

For More Information

To find out about the next CalPERS Long-Term Care Program application period and request an application kit to learn more about the Program, call 1-800-338-2244 or visit the CalPERS Long-Term Care website at https://www.calperslongtermcare.com.

The Federal Long Term Care Insurance Program

What Is The Federal Long Term Care Insurance Program?

The Federal Long Term Care Insurance Program (the Federal Program, or sometimes, FLTCIP) is a long term care insurance program for current and retired Federal government employees, active and retired members of the uniformed services, and their families. It was established by Federal law in September 2000 and is the largest employer-sponsored long term care insurance program in the nation. The United States Office of Personnel Management (OPM) serves as the program's sponsor and regulator.

The Office of Personnel Management selected John Hancock Life Insurance Company (John Hancock) as the current vendor to offer insurance under the Federal Program. Long Term Care Partners, LLC, a wholly owned subsidiary of John Hancock, handles applications and enrollments. No agents are used to market the Federal Program. Application forms are available through Long Term Care Partners, on the website, http://www.ltcfeds.com or by calling 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) to talk to a trained and certified Program Consultant.

Who is Eligible to Apply?

Eligible groups include:

- Federal and U.S. Postal Service employees in positions that convey eligibility for the Federal Employee Health Benefits (FEHB) Program and annuitants
- Active and retired members of the uniformed services
- Active members of the Selected Reserve
- Retired "grey" reservists, even if they are not yet receiving retirement pay
- Separated Federal and U.S. Postal Service employees with title to a deferred annuity

- Commander, Navy Installations Command (CNIC) employees and annuitants (formerly Navy Personnel Command (BUPERS) Non-Appropriated Fund)
- Compensationers receiving compensation from the Department of Labor
- Tennessee Valley Authority employees and annuitants even though they may not be eligible for FEHB coverage
- District of Columbia (D.C.) Courts employees and annuitants
- D.C. Government employees and annuitants who were first employed by the D.C. Government before October 1, 1987
- Secret Service agents covered by the D.C. Police Officers and Firefighters Retirement Plan
- Deferred annuitants and separated employees with title to a deferred annuity

Qualified relatives can also apply and include:

- Current spouses of eligible persons in the groups described above
- Adult children of living eligible persons in the groups listed above
- Parents, parents-in-law, and stepparents of living eligible employees and active members of the uniformed services
- Surviving spouses receiving a survivor annuity
- Domestic partners (both same sex and opposite sex) of employees and annuitants.

IMPORTANT! A complete list of eligible groups can be found at www.ltcfeds.com/eligibility. You can also call 1-800-582-3337 for more information.

Medical Underwriting

The Federal Program is medically underwritten, which means that applicants have to answer questions about their health as part of the application. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. People who are in the eligible groups listed above will need to apply to find out if they qualify for coverage under this program.

Portable And Guaranteed Renewable

Enrollment in the Federal Program is fully portable. If an enrollee leaves government service or retires, coverage will remain in force as long as the required **premium** is paid and the enrollee has not exhausted **Maximum Lifetime Benefits.** Coverage cannot be canceled due to the enrollee's age or because of a change in health. **Premiums** can only be changed with the Office of Personnel Management's approval and only on a group, not an individual basis.

What Type Of Care Does The FLTCIP Cover?

Enrollees prior to 2009 were able to purchase, and can still keep, a Facilities-Only Plan which covers all levels of **nursing home** care, including skilled, intermediate, and **custodial care.** Care in **Assisted Living Facilities** and inpatient **hospice care** is also covered.

A "Comprehensive Plan" is currently available. This Plan covers everything the Facilities-Only Plan covers as well as additional services. A Comprehensive Plan also covers care provided at home by a nurse, home health aide, therapist, or other authorized provider (including an informal caregiver), care in **adult day care** centers, and home **hospice care.** Both Facilities-Only and Comprehensive Plans cover **respite care.**

For more information visit https://www.ltcfeds.com/help/faq/basics.html and select "What is long term care?" and "What is long term care insurance?"

Inflation Protection Option

The Program provides two **inflation protection** options – the Automatic Compound Inflation Option (ACIO) or the Future Purchase Option (FPO). With the Automatic Compound Inflation Option, the **Daily Benefit** Amount and any remaining portion of the **Maximum Lifetime Benefits** will automatically increase by either four percent or five percent (depending on what level was chosen by the insured when signing up), compounded every year with NO corresponding increase in **premium**. The increases continue as long as the policy remains in force. With health care costs continuing to rise almost every year, the Automatic Compound Inflation Option may be a more cost-effective choice. While the initial **premium** is higher, benefits increase year after year, without causing a corresponding increase in total **premiums.**

With the Future Purchase Option, the enrollee receives an automatic inflation increase every two years, unless the enrollee declines the increase. Future Purchase Option inflation increases are based on the Consumer Price Index for Medical Care for purchasers before 2009 and the Consumer Price Index for Urban Consumers for those after that date. The additional **premium** for increased coverage

is based on the enrollee's age at the time the increase takes effect. To learn more about the Consumer Price Index visit the Bureau of Labor Statistics at https://www.bls.gov/audience/consumers.htm.

IMPORTANT! For individuals who enrolled prior to the 2009 change in FLTCIP, the offer for the Future Purchase Option (FPO) will stop after declining a total of three increases, unless the enrollees can pass underwriting again. Individuals who enrolled after 2009 have no limit to the number of times they can decline the FPO. Each time enrollees are offered the FPO, they can switch to the automatic compound inflation option (ACIO) without proof of good health, as long as they are not eligible for benefits at that time. This also applies to enrollees prior to 2009 who have not declined the FPO three times in the past.

Built-In Features

Trained Consultants

The Federal Program does not use agents to sell coverage. Eligible persons who are interested in the Federal Program can get help from experienced and knowledgeable Certified Long Term Care Insurance Consultants. These representatives can help compare plans, provide personalized rate quotes, answer questions about the Federal Program, and assist in completing an application for coverage.

Informal Care

The Federal Program's Comprehensive Plan covers care provided by friends, family members, and other non-licensed caregivers who didn't normally live in an enrollee's home at the time the enrollee became eligible for benefits. When informal care is provided by family members, it is covered for up to 365 days (500 days for those who enrolled after 2009) during an enrollee's lifetime. Caregiver training is also available for those friends or relatives who are providing care.

Care Coordination Services

Enrollees have unlimited access to the Program's Care Coordinators. These are registered nurses who have worked extensively in the field of long term care. Enrollees can contact them to ask questions about long term care (even if they are not receiving benefits). Once a person initiates a claim and is approved for benefits, telephone-based Care Coordinators will work with the person and family members to develop a plan of care to meet the person's individual care needs, and help find high quality local care providers. Care Coordinators can also arrange for discounted services, monitor the care being received, and assist with changing the plan of care as needs change. Unlike most long term care insurance plans, the Federal Program also provides certain care coordination services to qualified relatives of enrollees at no cost. The use of the care coordination feature is voluntary.

Alternative Plan of Care

Under certain circumstances, Care Coordinators can authorize benefits for services that are not specifically covered (for example, a facility that

is not otherwise covered under the Federal Program, such as a licensed residential care facility in California that provides assisted living care).

Stay at Home Benefit

For people who enrolled in the Federal Program after 2009, there is a new stay-at-home benefit, designed to enable enrollees who are in need of long term care services to stay at home for as long as possible. The stay-at-home benefit is equal to 30 times your **daily benefit** amount and is not restricted by the **waiting period.** Benefits paid under the stay-at-home benefit will not reduce the **Maximum Lifetime Benefits.**

The stay-at-home benefit will reimburse expenses for the following:

- care planning visits
- home modifications
- emergency medical response systems
- durable medical equipment
- caregiver training
- home safety checks

Benefits provided under the stay-at-home benefit must be included in your plan of care, which must be approved by your Care Coordinator.

Waiver of Premium

Enrollees do not pay **premium**s while receiving benefits. Once a claimant has completed the **waiting period,** the **waiver of premium** feature allows the claimant to stop paying **premiums** while receiving benefits.

Weekly Benefit Amount Option

People who enrolled in the Federal Program before 2009 and selected the Comprehensive Plan option and the weekly benefit amount option, (at an additional **premium** cost), will have benefits for covered services calculated on a weekly basis. The weekly benefit amount is equal to seven times the **daily benefit** amount. If the daily costs exceed the **daily benefit** amount, but the total of that week's reimbursable long term care expenses does not exceed the weekly benefit amount, the expenses will be fully reimbursed.

International Benefits

Most other long term care insurance plans do not pay benefits outside the United States. Because the Federal Program was designed exclusively for the Federal Family, it features international benefits that provide coverage for enrollees who may get their care outside the United States. The Program will calculate benefits in the usual way except that it will pay benefits up to 80 percent of the **daily benefit** amount or **maximum lifetime benefit** amount. The person can use up to 80 percent of the **maximum lifetime benefit** for services received outside of the United States; the other 20 percent is reserved for covered services in the United States. (For those who have selected an unlimited **benefit period**, benefits for services received outside of the United States are limited to 10 years.)

Appeals Process

The Federal Program includes a unique third-party review of claims. If an enrollee disagrees with a claims decision, and the insurance company has denied a request for reconsideration, the enrollee may request an independent third-party review. A third-party, which has been mutually agreed to in advance by the Office of Personnel Management and Long Term Care Partners, will provide a final and binding determination within 60 days of receiving all relevant information.

Payroll and Annuity/Pension Deduction

Enrollees can pay **premium**s through payroll deductions or annuity/pension deductions, automatic bank withdrawals, or by direct bill.

IMPORTANT! For more information about the Federal Long Term Care Insurance Program or to request an Information Kit and application, visit https://www.ltcfeds.com or contact Long Term Care Partners at 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557).

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Glossary Of Terms

Activities of Daily Living (ADL): Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring. Ambulating may be an additional ADL in some older policies.

Adult Day Care/Adult Day Programs: Community-based programs that provide individualized non-medical day care in a protective setting to persons 18 years of age or older who need personal care services, supervision or assistance with ADLs.

Adult Day Health Care (ADHC): Community-based day health programs that provide medical, rehabilitative and social services through an individualized plan of care to individuals with chronic medical, cognitive, or mental health conditions and/or disabilities who are at risk of needing institutional care.

Alzheimer's Day Care Resource Centers: Individualized day care for people with moderate to late stage Alzheimer's disease or related dementias.

Alzheimer's Disease: A progressive, degenerative form of dementia that causes severe intellectual and subsequent physical deterioration.

Assisted Living Facility: In California, this is a licensed Residential Care Facility or Residential Care Facility for the Elderly. (Some facilities may have a separate program or units for people with dementia, sometimes referred to as "memory care.")

Benefit Eligibility Triggers: Criteria used by insurance companies to determine when the beneficiary is eligible to receive benefits.

Benefit Period: A period of time that begins when you are first determined to be eligible for benefits, and ends when you are no longer eligible for benefits.

Care Management Services: Services in which a professional, typically a nurse or social worker, may assess service needs and/or arrange, plan, monitor or coordinate long-term care services.

Cognitive Impairment: A deficiency in a person's short or long-term memory, including orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to the person's safety awareness. (Refer to **Dementia**)

Community-Based Adult Services (CBAS): Services designed to help older people stay independent and remain in their own homes. (Refer to **Adult Day Health Care**)

Continuing Care Retirement Communities: Retirement communities that provide independent living, assisted living, and nursing home care.

Co-Payment: The amount a beneficiary pays in addition to the payment made by an insurance company. Or, the co-payment can be the difference between the dollar amount of a benefit paid for long-term care and the cost of a particular service.

Daily Benefit: A specified dollar amount that is the maximum amount paid per day for services covered by the policy.

Dementia: Deterioration of intellectual faculties, usually due to a disorder of the brain. (Refer to **Cognitive Impairment**)

Elimination Period: A specified amount of time during which an individual must pay for covered services before the insurance company will begin to make payments (also referred to as a Deductible Period or **Waiting Period**)

Guaranteed Renewable: A term meaning that a company cannot cancel your policy or change any of the benefits, unless you fail to pay the premiums. A company may increase premiums for all policyholders within a particular group or state, but not for an individual or a single member of a group because of their health or age (also referred to as noncancelable protection).

Health Insurance Portability and Accountability Act (HIPAA): Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

Home Care: Care in the home that usually includes the following benefits in a long-term care insurance policy: home health care, personal care, homemaker services, hospice services, and respite care.

Home Equity Conversion (HEC)/ Reverse Mortgage: Complex financial products that may allow older people to use the equity in their home to pay for long-term care or other needs.

Home Health Care: Formal paid health care services provided in the home by a nurse or other licensed professional.

Homemaker Services: Assistance with chores or activities that are necessary for an individual to be able to remain in their residence.

Hospice Care: End-of-life care that can be provided at home or in an inpatient facility if necessary. It is designed to bring comfort and support to persons who are terminally ill and their families.

Illustrations: Insurance documents that use words and pictures to show how the benefits of a life insurance policy or an annuity are expected to perform under specified conditions.

Inflation Protection: A policy option that increases the daily benefit amount to help keep up with future inflationary increases in the cost of long-term care services.

Inpatient: Indicates that a person has been formally admitted to a hospital for treatment of a health condition.

Instrumental Activities of Daily Living (IADLs): Daily activities necessary for functioning in the community, that include activities such as driving, managing medications or finances, shopping, and cooking.

Lapse: Termination of an insurance policy after a 30 day grace period when premiums have not been paid. (See **Third-Party Notice**)

Long-Term Services and Supports (LTSS): Care provided in the home, in community-based settings, or in facilities, such as nursing homes. Also referred to as long-term care, LTSS are designed for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves.

Maximum Daily Benefit: The maximum dollar amount a policy will pay for each day of covered services.

Maximum Lifetime Benefit: The total dollar a policy will pay for covered services.

Medicaid (Medi-Cal in California): A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

Medical Underwriting: A method insurers use to evaluate an individual's personal health and potential claim risk when deciding whether to issue a policy, and sometimes the amount of premium that will be charged.

Medicare: The federal program providing health insurance to qualified people age 65 and older, or under age 65 with certain illnesses or disabilities. Benefits for nursing home and home health services are limited.

Medicare Advantage: Medicare Advantage Plans (sometimes referred to as Medicare Part C or MA Plans) are Medicare-approved health plans offered by private companies. These plans cover all Medicare services and may provide additional coverage for services such as vision, hearing, dental, and prescription drugs.

Nursing Home (Skilled Nursing Facility): Facilities that are licensed to provide short-term skilled nursing and rehabilitative care for people who may be recovering from surgery or other serious health conditions, and long-term care for people who need hands-on assistance with basic daily activities.

Observation Services: Refers to care received in a hospital prior to admission to the hospital as an inpatient.

Outpatient: Refers to medical services received without being admitted to a hospital as an inpatient.

Personal Care/Custodial Care: Non-skilled care to help individuals perform activities of daily living, as well as some other basic activities.

Period of Care: A period of time during which you need and receive continuous care.

Pre-existing Condition: Illnesses or disability for which you were treated or diagnosed prior to applying for a life, health, or long-term care insurance policy.

Premium: A specified sum of money paid to an insurance company for an insurance policy that guarantees the payment of specified benefits. This payment may be a single payment or periodic payments.

Residential Care Facilities for the Elderly (RCFE): Commonly referred to as Assisted Living Facilities, they provide non-medical care and supervision for persons who need assistance with activities of daily living.

Respite Care: Services that provide temporary or periodic relief for caregivers.

Spend-Down: A process of spending excess assets to meet Medi-Cal (Medicaid) eligibility requirements.

Substantial Supervision: A term meaning that the presence of another person is required to direct and watch over someone with a cognitive impairment or to assist with an ADL.

Tax-Qualified Long-Term Care Insurance Policy: A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Third-Party Notice: A form of protection that allows a designee (friend, relative, etc.) appointed by the policyholder to be notified if a policy is about to lapse due to non-payment of a premium.

Waiting Period: The amount of time a policyholder must wait until a policy will begin to pay for covered services (also known as a deductible amount or **elimination period**).

Waiver of Premium: A provision in an insurance policy that allows the policyholder to stop paying premiums once certain benefits are being paid by the policy. The point at which the waiver begins and ends, and which benefits the premium waiver applies to, differs from one policy to another.

Glossary Information provided with the assistance of the California Partnership for Long-Term Care: 2015 Comprehensive Brochure.

Index

A

accelerated death benefit....49
activities of daily living (ADLs)..... 6, 37, 76
adult day health care 13, 21, 29, 76
Adult Day Programs 13, 76
agent training/duties 44, 57
alternative benefits.....41
Alzheimer's disease..... 7–10, 14, 37, 43, 60, 76
annuities.....52
Area Agencies on Aging (AAA)..... 14, 15, 17
Assisted Living Facilities..... 6, 18, 21, 76

B

benefit period 35, 40, 70, 76
benefit eligibility triggers.....37, 51, 76

C

CA Department of Health Care Services (DHCS)..... 25, 46, 56
CA Department of Insurance (CDI)...30, 44, 53, 54, 57
CA Department of Social Services (DSS) 18, 26, 46
California Public Employees Retirement System (CalPERS) 36, 60, 62–64
California consumer protections 41, 64
congregate housing/living 18
continuation/conversion coverage 42
Continuing Care Retirement Communities (CCRC) 17, 18, 77
cost (long-term care)..... 21–26, 56

D

deductible 32, 37, 64
downgrades.....42

E

Eldercare Locator 14, 15
elimination period.....32, 37–38, 77
Emergency Response System (ERS) 16, 17

F

Facility Only Policy 29, 59
Family Caregiver Support Program/caregiving.... 9–10 54–55, 69
family circumstances and support..... 9
Federal Housing Administration (FHA).....24
financial rating companies 32
forgetfulness feature 41–42
forbidden requirements.....43
fraternal organizations.....55
functional limitations 7, 10

G

gender 7, 32
guaranteed renewable..... 41, 64, 67, 77

H

Health Insurance Counseling and Advocacy Program (HICAP).....44, 83
Health Insurance Portability and Accountability Act (HIPAA) 22, 28, 50, 77
home care 14, 21, 25, 29, 32–33, 38–40, 51, 54, 59, 77
home companion care 54
home equity conversion (HEC) / reverse mortgage 24, 25, 77
home health care 13, 23, 29–30, 39, 59, 77
homemaker services 13–14, 21–22, 28–29, 39, 59, 77
hospice 13, 28–30, 39, 59, 63, 67, 77

I

independent living 13,18, 39
inflation protection 33–36, 50, 56, 58–59, 63–64, 67, 77
In-Home Supportive Services (IHSS) 25–26
illustrations 50, 51, 77

L

life insurance 27, 49–51, 53
living trust 20
long-term care (LTC) 6, 21
long-term services and supports 6, 22, 78

M

marital status 7
maximum daily benefit 33, 40, 78
Medi-Cal 20, 22, 25–26, 31, 46, 56–59, 61, 63, 78
Medicare 5, 20, 22–24, 38, 39, 64, 78
Multipurpose Senior Services Program (MSSP) 26

N

nonforfeiture benefits 40

O

outline of coverage 43

P

personal care 6, 13, 18–19, 22–23, 28–29, 38–39, 43, 53, 59, 78
plan of care 38–39, 55–57, 60–61, 68–69

R

Residential Care Facility (RCF) 6
Residential Care Facility for the Elderly (RCFE) ... 6, 18, 29, 39, 57, 59, 79
respite care 13, 28–30, 59, 63, 67, 79
risks of needing LTC 6–12

S

Skilled Nursing Facility / Nursing Home (SNF) 6, 14, 18–19, 78
spend-down 57–58, 79
support systems 9, 17
surrender fee 50, 52

T

tax-qualified policies 28, 38, 50, 60, 79

V

Veterans Administration (VA) 54–55
viatical settlements 53

W

waiting period 32, 37–40, 54, 69, 79
waiver of premium 40, 69, 79

Suggestions For Further Reading

A Shopper's Guide to Long-Term Care Insurance

National Association of Insurance Commissioners

https://www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf

For more information, contact:
Phone: (816) 842-3600

Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers

https://www.aarp.org/health/medicare-insurance/info-2006/2006_13_ltci.html

Bonnie Burns, California Health Advocates

For more information, contact:
Phone: (202) 434-3840
https://www.aarp.org/ppi

2015 Comprehensive Brochure, California Partnership for Long-Term Care

California Partnership for Long-Term Care

http://rureadyca.org/sites/default/files/uploads/2015_comprehensive_brochure_5-28-2015.pdf

For more information, contact:
Phone: (916) 552-8990

No Wrong Door: Person-and-Family-Centered Practices in Long-Term Services and Supports

https://www.aarp.org/content/dam/aarp/ppi/2017-01/LTSS-Promising-Practices-No-Wrong-Door.pdf

Christina Neil Bowen and Wendy Fox-Grage
AARP Public Policy Institute March 2017

For more information, contact:
Phone: (202) 434-3840
https://www.aarp.org/ppi

The Long-Term Care Poll: Opinions and attitudes about long-term care in the United States

The Associated Press – NORC Center for Public Affairs at the University of Chicago

https://www.longtermcarepoll.org

For more information, contact:
Email: info@apnorc.org
Phone: (888) 569-7226

Caregiving in the United States 2015

Research Report, AARP Public Policy Institute and National Alliance for Caregiving

https://www.aarp.org/ppi/info-2015/caregiving-in-the-united-states-2015.html

For more information, contact:
Phone: (202) 434-3840
https://www.aarp.org/ppi

Disrupting the Marketplace: The State of Private Long-Term Care Insurance, 2018 Update

Insights on the Issues, AARP Public Policy Institute

https://www.aarp.org/ppi/info-2018/disrupting-the-marketplace-the-state-of-private-long-term-care.html

For more information, contact:
Phone: (202) 434-3840
https://www.aarp.org/ppi

Resource Guide

Alzheimer's Association
1-800-272-3900
TTY: 1-866-403-3073
https://www.alz.org

American Foundation for the Blind
1-800-232-5463 (1-800-AFB-LINE)
https://www.afb.org

Better Business Bureau
1-703-276-0100 or check your phone directory for the local office
https://www.bbb.org

California Advocates for Nursing Home Reform
1-800-474-1116 (Consumers only)
http://www.canhr.org

California Department of Aging
1-916-419-7500
TTY: 1-800-735-2929
https://www.aging.ca.gov

California Department of Insurance Consumer Hotline
1-800-927-HELP (4357)
http://www.insurance.ca.gov

California Department of Health Care Services (DHCS) Local phone numbers for county offices:
http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

CalPERS Long-Term Care Program
1-888-225-7377 (1-888-CalPERS)
TTY: 1-877-249-7442
https://www.calpers.ca.gov

California Department of Veterans Affairs (CalVet)
1-800-952-5626
https://www.calvet.ca.gov

California Long-Term Care Ombudsman State Crisisline
1-800-231-4024
https://www.aging.ca.gov/Programs/LTCOP

California Partnership for Long-Term Care
1-800-227-3445
http://www.rureadyca.org

California State Independent Living Council
1-866-866-7452
TTY: 1-866-745-2889
https://www.calsilc.ca.gov

California Telephone Access Program (CTAP)
1-800-806-1191
TTY: 1-800-806-4474
http://ddtp.cpuc.ca.gov

Centers for Medicare & Medicaid Services (CMS)
1-800-633-4227
(1-800-MEDICARE)
TTY: 1-877-486-2048
https://www.cms.gov/medicare/medicare.html

Consumers Union/ West Coast Office
1-415-431-6747
https://www.consumersunion.org

Eldercare Locator
1-800-677-1116
https://eldercare.acl.gov

Federal Long Term Care Insurance Program
1-800-582-3337 (1-800-582-3337)
TTY: 1-800-843-3557
https://www.ltcfeds.com

Federal Trade Commission
1-202-326-2222
https://www.ftc.gov

Health Insurance Counseling and Advocacy Program (HICAP)
1-800-434-0222
https://www.aging.ca.gov/hicap

Information and Assistance InfoLine
1-800-510-2020
https://www.aging.ca.gov/ProgramsProviders/AAA/AAA_Listing.aspx

Mental Health America of California
1-916-557-1167
http://www.mhac.org

National Alliance on Mental Illness – California
1-916-567-0163
https://namica.org

California Lawyers Association-Educating Seniors Project
1-415-795-7195
https://calawyers.org/Sections/Trusts-Estates/Educating-Seniors

The SCAN Foundation
1-888-569-7226
http://www.thescanfoundation.org

U.S. Department of Veterans Affairs
1-844-698-2311 (1-844-MyVA311)
https://www.va.gov

World Institute on Disability
1-510-225-6400
TTY 1-510-225-0478
http://www.wid.org

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Taking Care of Tomorrow — 2018 Edition

The California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) has published this consumer's guide to long-term care as a resource for consumers who are planning for, or researching, their long-term care options. This 2018 update was made possible by a grant from the federal Administration for Community Living (ACL) and funding from the State of California. HICAP is a member of the federal State Health Insurance Assistance Program (SHIP) network, an ACL-sponsored program.

Local HICAP offices provide free community education and confidential individual counseling statewide on Medicare Parts A & B, Medicare supplement policies, Medicare Advantage Plans, Medicare Prescription Drug Plans, and long-term care insurance. HICAP Counselors are trained to assist you with filing Medicare and private insurance claims and/or preparing Medicare appeals if your claim has been denied. If you are considering purchasing long-term care insurance or Medicare supplement insurance, HICAP Counselors can help you compare policies and explain what services each policy provides.

If you would like to schedule a counseling appointment or have questions about your Medicare-related health insurance, you can call HICAP at 1-800-434-0222.

HICAP does not sell, endorse or recommend any specific insurance company or product.

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ship NATIONAL NETWORK state health insurance assistance programs

LOCAL HELP FOR PEOPLE WITH MEDICARE

California Department of Aging
Sacramento, California
https://www.aging.ca.gov

For HICAP counseling information call:
1 (800) 434-0222