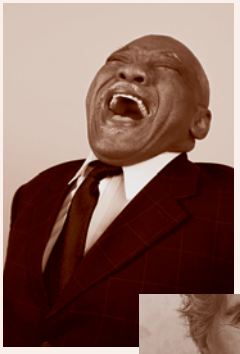
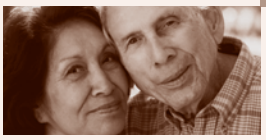
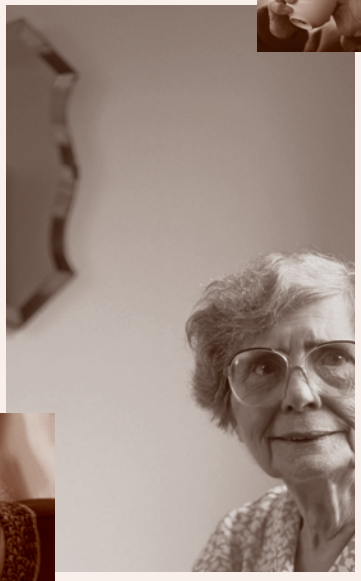


California Department of Aging



TAKING CARE *of* TOMORROW



A Consumer's Guide to Long-Term Care

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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 Medicare problems and other related health insurance concerns.

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Phone numbers, web addresses and contact information for resource organizations contained in this guide are accurate as of the 2007 Edition. Please note that contact information could be subject to change by the individual organizations without the knowledge of the California Department of Aging.

California Department of Aging
Sacramento, California
www.aging.ca.gov

for HICAP counseling information call:
1-800-434-0222

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INTRODUCTION: ABOUT THIS GUIDE

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 the guide with your family and friends, using the information to begin discussing your long-term care needs and financial options before a crisis arises.

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 may be different from the one chosen by another family member or friend.

The information in this guide was prepared to:

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

We hope you will take the time to read the guide carefully. 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. Depending on your situation, a review of certain chapters may prove helpful in the future.

Throughout this guide, you will find the names and telephone numbers of agencies that can provide you with additional information on specific topics concerning long-term care. These numbers are also listed in the reference area of this guide on page 75. We also suggest 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, we have included on pages 47-49 a list of helpful questions to assist you if you decide to purchase insurance to help you pay for long-term care; and on page 74 there is a selection of reference materials for further reading. There is also an index on pages 72-73 to help you quickly locate information on specific topics.

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

understanding
LONG-TERM CARE

Martha has always been a saver. She planned for emergencies. She thought Medicare would pay most of her medical costs; she even purchased a Medicare supplemental policy to limit how much she would have to pay out of her own funds. Now, she has learned that in her case, Medicare will only pay for the first 35 days of her stay in the nursing home. Apparently, there's a rule about needing to receive therapy every day, not just once or twice a week. Now she will have to pay the nursing home expenses herself, and her savings could be used up very quickly. And then, what would 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, will we be able to live at home? Will we spend some time in a nursing home, like Martha? Will we need long-term care?

NOTE: *Medicare only pays for nursing home care if there is a prior qualifying hospital stay of at least three days and skilled nursing or rehabilitative care is needed every day. In some cases an HMO enrollee may not have to meet the three-day hospital requirement, but will have to meet the need for skilled nursing or rehabilitative care. In any event, the Medicare benefit for nursing home care will only last for a maximum of 100 days and, in most cases, for far fewer days.*

What Is Long-Term Care?

Long-term care is the kind of help you require for taking care of your personal needs, such as bathing, dressing, eating, continence, toileting, and transferring. These needs are commonly referred to as Activities of Daily Living or ADLs. You might need this kind of help because of a chronic medical or physical condition like Martha had. Frequently, people with Alzheimer's disease or other health conditions may need ongoing supervision as well because of cognitive impairment. People who can no longer drive, manage their medications, or their finances often need help with these "instrumental activities" before they will need or qualify

for formal long-term care services. Long-term care covers a broad range of needs and services. Services to meet those needs include care at home or in a community program like adult day care, as well as assisted living or nursing home care.

As Martha improves, she may be able to go home and have services brought to her — such as a nurses aide to help with ADLs, homemaker services to help her with housework, or perhaps physical therapy to help her recover from her broken hip. These services could be covered by the Medicare Home Health benefit if she meets the requirements for care; otherwise she will have to pay out of her own funds for any services she may need.

NOTE: *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.*

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

Anyone at any age may need long-term care. An accident or a sudden, serious illness can create a need for care, as can the slow progression of chronic diseases such as rheumatoid arthritis, Alzheimer's disease, or Parkinson's disease. The senior population is increasing and age or frailty may also be contributing factors, as shown in Charts #1 and #2. People who live to be very old are more likely to need long-term care than those at younger ages.

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; at age 90 and over, women outnumber men by nearly three to one.[i] And as of 2005, 66 percent of nursing home residents were women; 34 percent were men.[ii]

Marital Status

Traditionally, women have married men who are older. Since women also live longer, many eventually outlive their husbands. 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 often provides care to a family member who lives at home. But frequently a widowed spouse needs more care than family members can provide at home and will eventually receive long-term care in a nursing home. According to a 2002 national study, from 1992 to 1998 there was a significant increase in the proportion of women in nursing homes who were widowed, separated, or divorced.[iii] And, married people are half as likely as unmarried

MORE FRAIL ELDERLY, MORE CARE NEEDED

Projected Number of Californians, Age 85 and Older, 1990-2030

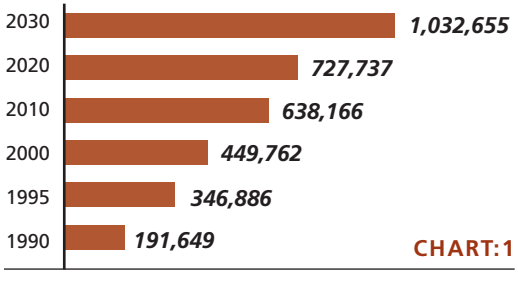


CHART:1

AGES OF RESIDENTS OF CALIFORNIA FREESTANDING NURSING HOMES, 2005

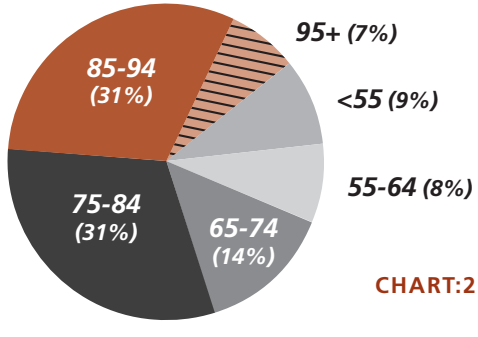


CHART:2

persons to be admitted to a nursing home,[iv] further illustrating the difficulty of providing continuous care at home to a single or widowed family member.

Functional Limitations

Women develop chronic diseases, such as arthritis and osteoporosis, more often than men. These diseases limit the ability to walk, get in and out of a chair, and to do other tasks of daily life. Men are more likely to have acute health episodes that lead to earlier and quicker death, and shorten the length of time a man is likely to need long-term care. However, when thinking about long-term care, you should remember that these are generalizations and your situation may be different.

Cognitive Impairments

Cognitive impairments caused by Alzheimer's disease, strokes, or other conditions often lead to the need for long-term care. People with these disorders go into nursing homes more frequently than those who are physically impaired. Advanced age is one risk factor for Alzheimer's with half of those over age 85 affected by the disease.[v] Some families may have a genetic disposition toward Alzheimer's disease, stroke, or other mentally disabling conditions and be at higher risk of needing care. Four and one half million men and women had

ESTIMATED NUMBER OF AMERICANS AGE 65+ WITH ALZHEIMER'S DISEASE THROUGH 2050

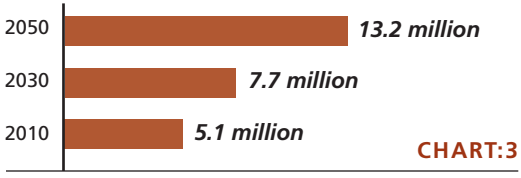


CHART:3

Alzheimer's disease in 2004, more than double the number in 1980.[vi] Chart #3 illustrates 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 their 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 their family, family caregivers may work full time or be unable to offer as much help as is needed. Family members, however, do provide significant amounts of unpaid long-term care. "More than 7 out of 10 people with Alzheimer's disease for instance live at home where their families and friends provide almost 75 percent of their care."[vii] The typical caregiver is a 46-year old woman.[viii] Many middle-aged women find themselves sandwiched between the needs of

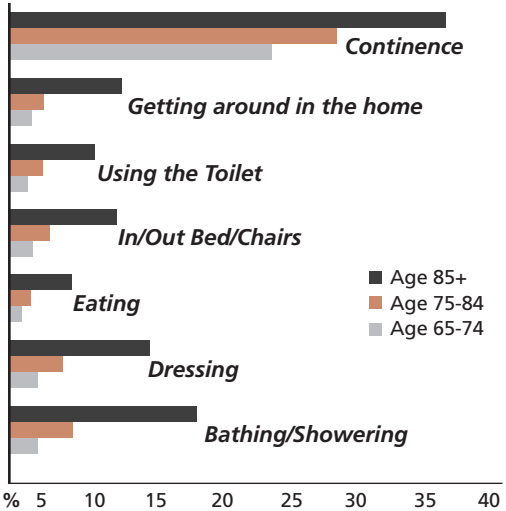
their school age children and family responsibilities, their jobs, and the needs of an older family member who has cognitive or functional limitations.

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. People frequently need help getting around inside the home to toilet, shower, or get in and out of bed. Chart #4 shows common limitations in activities of daily living (ADLs) for people 65 and older who live in the community.

COMMUNITY RESIDENTS NEEDING HELP WITH ADL'S



(Percentage of People)

CHART:4

Nursing Home Care

A 1991 government study projected that 57 percent of people 65 and older would never be in a nursing home during their lifetime.[ix] Some people may use a nursing home for a month or two following a hospital stay to recover from an illness or injury. Others may need to move to a nursing home when they can no longer stay safely in their own home. Approximately 9 percent of people 65 and older are estimated to live in a nursing home for five years or more as shown in Chart #5. However, this does not mean those who didn't use a nursing home did not need or receive long-term care services. Many people receive care at home or in an assisted living facility, but die before entering a nursing home.

PROJECTED LIFETIME USE OF NURSING HOMES FOR PERSONS WHO REACHED AGE 65 IN 1990

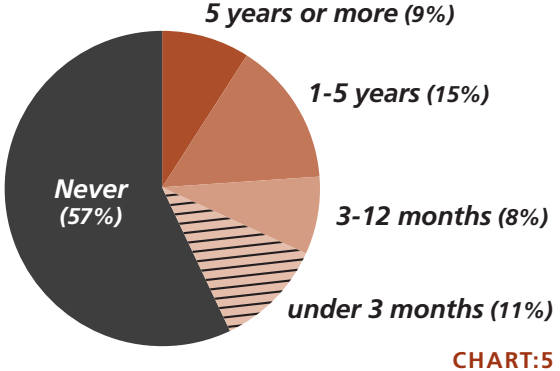


CHART:5

PLEASE NOTE: *This government study of lifetime risk of needing nursing home care has not been updated since 1991.*

What Can I Do To Reduce My Chance 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 accidents can occur at any time, and advanced age is often accompanied by increased frailty. However, recent 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, low-fat diets decrease the incidence of cancer, heart disease, and many other "modern" ailments as well. And exercise may be equally as important as nutrition in helping us to remain active throughout our lifetime.

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, combined with moderate stretching exercises to retain flexibility, is by far the best exercise. Although illness or injury can affect the muscles and joints, with good medical treatment even this damage can be greatly reduced. 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. Alzheimer's and similar diseases 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 disorder like Alzheimer's disease. Not only is this a devastating condition for patients and their families, but there is also no known cure at the present time.

"Many families muddle along avoiding action until an acute episode, such as a hip fracture, forces them to think about long-term care."

Trudy Lieberman and The Editors of Consumer Reports,
Complete Guide to Health Services for Seniors

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.

planning for LONG-TERM CARE

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

Formal paid services include:

- **Home Health Care:** from a nurse or other licensed personnel;
- **Personal Care:** help with bathing, grooming, getting 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:** formerly known as Adult Day Care, these community-based programs provide individualized 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:** day care that provides medical, rehabilitative and social services through an individualized plan of care to persons 18 years of age or older with functional limitations caused by physical or mental impairment; 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.

NOTE: *The availability and cost of home care services and assisted living care vary greatly from one community to another and from one state to another. The national average hourly wage for home care in 2006 was $25.32,[x] and the national average daily cost of assisted living was $88.48.[xi]*

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, local Information and Assistance (I&A) services can be reached 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 centers, 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, check the telephone directory under County Services for the Area Agency on Aging (AAA) nearest you or call 1-800-510-2020 for Information and Assistance services. 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.

NOTE: *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.*

When Martha is ready to leave the nursing home, she and the discharge planner should discuss the services Martha will need to stay safely in her home, as well as the cost of these services. How many and what services Martha will need depend not only on her health, but also on 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 when Martha's family doesn't live in her community.

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

Preventing Falls

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.

Falls are a major cause of injury or disability in the home and can even be the cause of death. 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. 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. On average, an older person requires 4 times more light than a younger person and even without eye injury or disease, an 80-year-old needs ten times the intensity of light to see as well as a 25 year-old in similar situations.[xii] 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. So remember that lighting should be more intense as you get older, but avoid creating glare.

Stoves are another source of concern. If you forget to turn off the burners of your stove occasionally, try using a timer as a reminder or only use the microwave when you are home alone.

Telephones

Hearing losses 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 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!

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 non-emergency systems expect you to call-in by a certain time each day and verify that you are all right. If you don't call, someone comes out to check on you. Some emergency response systems are inexpensive and may be available from a local hospital; others are sold commercially and can be very expensive.

NOTE: *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.*

Turn to page 75 to find additional resources and their contact information.

Support Systems

Many older people develop a support system with their neighbors. They signal each other by raising the blinds by a certain time each day. A simple system like this 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 delay the need for long-term care.

If your health remains good and the neighborhood continues to meet your needs, 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 getting around in your neighborhood becomes more difficult, the emotional cost and worry may not make this an ideal situation.

What Are My Housing Options?

Though most of us want to grow old in our homes, there may come a time when it may 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, or mobile homes, and independent living units in some retirement communities. Independent living does not usually include on-site services such as meals and housekeeping services.

Congregate Housing

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

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

Residential care facilities 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, to facilities with over 200 living units. Some larger RCFEs

"Though most of us want to grow old in our homes, there may come a time when it may be more practical to consider alternative living arrangements that provide some degree of support or assistance."

Taking Care of Tomorrow, CA Department of Aging

may offer a broader range of services than a small "mom and pop" operation is able to provide. All of these facilities are licensed by the California Department of Social Services Division of Community Care Licensing.

NOTE: *Some of these facilities offer specialized services for people with Alzheimer's and other cognitive disorders and are also licensed by the 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 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. CCRCs are licensed by the Departments of Social Services and/or Health Services.

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 usually recovering from serious illness or surgery and need continuous nursing services, observation, and rehabilitation or therapy services. The most common type of care given in nursing homes is personal care or assistance with ADLs. While some residents can also receive skilled services in addition to personal care service 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 cognitive disorders 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.

"The most common type of care given in nursing homes is personal care or assistance with Activities of Daily Living (ADLs)."

Taking Care of Tomorrow, CA Department of Aging

paying for LONG-TERM CARE

How Much Does Long-Term Care Cost?

- Nursing home costs in California can range from $130 to $200 a day. (The statewide average was $190 in 2006);[xiii]
- Assisted living care can cost an average of $88.48 or more a day, depending on their size, location, and amenities;
- A live-in companion or homemaker can cost $150 or more a day, depending on where you live. The cost is much higher if you need someone with medical training;
- Home caregivers provided through an agency can cost an average of $25.32 an hour or more;

- A visit in your home by a registered nurse can cost $100 a visit or more;
- A home visit by a medical social worker can cost $110 a visit or more;[xiv] and
- Dementia Day Care can cost $25 to $65 a day or more depending on where you live.[xv]

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

Nursing home care can average $68,000 or more a year.[xvi] People with very high incomes are likely to have the financial resources to pay for the care they need. They may also be able to deduct some or all of their costs as an itemized medical expense on their state and federal income tax returns because of changes in the federal tax law.

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

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

Yes, if you meet all of the requirements of a 1996 federal tax law. This law, the Health Insurance Portability and Accountability Act, or HIPAA, amended the federal tax code. 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. California passed similar legislation allowing a medical deduction for some long-term care expenses on state tax returns. All of your medical expenses, including those for federally qualified long-term care costs, must first exceed 7.5 percent of your adjusted gross income (AGI). Then you can deduct amounts that exceed that percentage. You should consult your tax advisor for more information on how this could affect you.

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. The care they receive is personal care, sometimes still referred to as custodial care. Medicare does not pay for this kind of care. It pays less than 10 percent of all nursing home costs. Medicare only pays when you are receiving medical and rehabilitative care, and then only for a set period of time. To qualify for the limited Medicare nursing home benefit, 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. 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 ($119 in 2006) for each day of the next 80 days that Medicare continues to pay for your stay. Medicare will not continue to pay after it has paid for your nursing home care for 100 days within a benefit period.

NOTE: *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 stay.*

Martha received only 35 days of care paid by Medicare (the average number of days Medicare pays for nursing home care).[xvii] This was because during the weekly review of her Plan of Care she no longer met Medicare's requirement for daily skilled rehabilitative care.

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 set period of time. These requirements apply whether you are in a Medicare managed care program like an HMO or receiving traditional Medicare fee-for-service benefits. You must be homebound and require skilled nursing or rehabilitation services at least several times weekly 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 services along with any skilled care you require. 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 those costs yourself.

Do Medicare HMOs Pay For Long-Term Care?

No. Some Health Maintenance Organizations (HMOs) and other Medicare Advantage plans have a contract with the federal government to provide Medicare covered services to Medicare beneficiaries. Members of these plans generally have no more coverage for long-term care than someone with traditional Medicare fee-for-service benefits. Medicare HMOs and other Medicare Advantage plans usually provide only those skilled nursing facility services and home health services that are covered by Medicare and meet the same requirements for skilled care. However, members of these plans may or may not have to pay co-payments for these services depending on the requirements of that person's Medicare Advantage plan.

Does Disability Income Insurance Cover Long-Term Care?

No. Disability Income 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. Disability Income insurance generally pays a percentage of an employed person's earned income if they are disabled while covered by the plan. 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 does pay benefits for long-term care services, but those benefits are generally separate from the income portion of the policy.

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

Life Insurance Policies with Long-Term Care Benefits

Sometimes long-term care benefits are included in a life insurance policy or are sold as a rider to a life insurance policy. With one version called an "Accelerated Death Benefit," your insurance company pays you a reduced amount of your death benefit as a lump sum or in periodic payments before you die to help you pay for long-term care services. These benefits are usually only paid when certain conditions are met. For example, benefits might be paid if you are diagnosed with a terminal illness, have a major organ transplant, or have been in a nursing home for six months.

Another type includes coverage for long-term care as part of the life insurance benefit. These policies generally draw down the death benefit first and then a rider pays for any long-term care needed after the death benefit has been entirely used up. Policies that combine life insurance and long-term care benefits vary widely and the methods used to calculate these benefits can be very complex.

These policies can be purchased with one large premium payment or with premiums paid periodically over time. Monthly administrative fees and certain other insurance costs may be deducted from the cash value or from the interest earnings of these policies. 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, and the benefits you receive might not be taxed as income. You should 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 could be taxable.

NOTE: *While these policies may provide an attractive combination of benefits for some people, they should not be purchased without consultation with an accountant or tax attorney to help you understand the interaction of the different benefits and costs.*

Viatical or Life Settlements

Some commercial companies will buy your existing life insurance policy by paying you a percentage of your death benefit when you have a catastrophic or life-threatening illness (a viatical agreement). Others may offer to purchase a large death benefit you no longer need (a life settlement). The company that purchases your policy pays you a lump sum percentage of your death benefit (usually 50 to 80 percent) and continues to pay your premium. The purchasing company will collect the death benefit when you die or, if they sold others an investment in your death benefit, they will split the proceeds with those investors.

These companies must be licensed by the California Department of Insurance. Any medical information they collect as part of a viatical agreement or life settlement application must be kept confidential. Agents must also tell you that there may be tax consequences when you sign one of these contracts. If you are considering a viatical agreement or life settlement, contact your own life insurance company first. That company may allow you to use some portion of your death benefit to pay for your long-term care expenses without selling your policy to a third party.

The 1996 tax law, HIPAA, may allow some or all of the payments from a properly executed viatical agreement or life settlement to be excluded from income. You should consult your insurance agent and tax advisor before selling your life insurance policy.

NOTE: *If your own insurance company cannot help you, call the California Department of Insurance at 1-800-927-HELP (4357) to make sure that any company offering a viatical agreement or life settlement is properly licensed.*

You can get more information and free individual counseling on long-term care insurance from your local HICAP office. To find the HICAP office nearest you, call 1-800-434-0222 or 1-800-510-2020

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

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

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

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 the cost 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. Annuity contracts have a schedule

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.

NOTE: *You should consult a 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 have been found to be unsuitable for seniors.*

Will A Living Trust Protect My Assets From Long-Term Care Costs?

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 estate. You can name yourself as the trustee of a living trust with a successor who will make decisions for you if you become incapacitated. Generally, if you have a living trust you will still need enough assets 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. (Turn to page 24 for information on Medi-Cal.)

An Irrevocable Trust is often promoted as a means of protecting a person's assets and getting around the rules for Medi-Cal eligibility. However, irrevocable means the trust is permanent and can't be changed and there are some restrictions on what assets can be put into such a trust. Once the assets are transferred to an irrevocable trust they are permanently the property of the trust. In addition, the person creating the trust cannot be the trustee. Recent changes to state and federal law make it much harder to transfer assets and apply for Medi-Cal. People using these strategies risk a period of ineligibility for Medi-Cal benefits or other economic harm.

NOTE: *For more specific information, check with a free legal services program in your community, your financial advisor, or an Elder Law attorney.*

Turn to page 75 to find additional resources and their contact information.

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 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.

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. It provides health care services to people on public assistance and to others who cannot afford to pay for these services themselves. Medi-Cal can pay for hospital and medical care approved by your doctor, prescription drugs if you don't have Medicare, and nursing home care. It can also cover some home care services known as In-Home Supportive Services (IHSS), which are described later on in this guide.

Eligibility for Medi-Cal is based on countable income and assets. A person who has

countable assets greater than the amount allowed by Medi-Cal must "spend down" their excess assets before he or she will qualify for the Medi-Cal program. A person whose income is greater than the amount allowed by Medi-Cal can still be covered by the program, but their own income must be used to pay for their care before Medi-Cal will cover the remaining cost of their long-term care each month. This is known as having a "share of cost."

In the past the value of a person's home has generally been excluded from the calculation of countable assets when applying for Medi-Cal. The Federal Deficit Reduction Act of 2005 now limits the amount of home equity a person can claim to $500,000 (or up to $750,000 if a state adopts a higher limit) and still be eligible for federal Medicaid benefits. Individuals with home equity higher than the federal limit will be ineligible for Medi-Cal until those excess funds are no longer available.

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. These laws allow the spouse remaining at home to keep a certain amount of their combined income and assets when the other spouse goes to a nursing home. In 2007, the spouse at home can keep all of the couple's income up to $2,541 each month, and up to $101,640 in countable assets. (These amounts change every year.) The spouse at home can be granted more of their income, if necessary, through a "fair hearing," or by court order. If the spouse in the nursing home has a "share of cost," any income in excess of the amount the spouse at home can keep will go towards the other spouse's share of cost. The spouse in the nursing home is allowed to keep $35 a month for personal needs and up to $2,000 in assets.

NOTE: *The income and asset limits for Medi-Cal change each year. For more information on Medi-Cal eligibility guidelines, specific income and asset limits, "spend-down" requirements, and any changes in state or federal requirements, contact your county social services departments. You can also contact your local Information and Assistance program at 1-800-510-2020 for information about free legal services in your area and help in understanding Medi-Cal requirements*

Turn to page 75 to find additional resources and their contact information.

Community-Based Services

In-Home Supportive Services

In-Home Supportive Services (IHSS) 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 Supple-

mentary Program (SSI/SSP) for the aged, blind, and disabled. The IHSS program can provide domestic and related services such as heavy cleaning; menu planning; laundry services; meal preparation and cleanup; and reasonable shopping errands. The IHSS program is administered by county social services departments under guidelines established by the state. For further information on the IHSS program, contact your county social services departments.

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) provides social and health case management to assist persons aged 65 and over, eligible for Medi-Cal and certifiable for skilled nursing care, to remain safely at home. It links older Medi-Cal eligible individuals, when they need nursing home care, with many health and social services in their community. To see if these services are available in your community and for more information on the MSSP program, call 1-800-510-2020.

The Family Caregiver Support Program

The Family Caregiver Support Program provides assistance to spouses, adult children, other relatives, and friends who are acting as caregivers to people with chronic, disabling health conditions. This valuable unpaid role can also be very stressful, sometimes resulting in emotional burnout, physical exhaustion, and financial burden for the person providing care. Assistance for these caregivers may include education, care planning, counseling, specialized training, temporary respite, and other supportive services. For more information on the Family Caregiver Support Program call 1-800-510-2020.

Should I Rely On Family Members?

Many families do provide substantial amounts of personal care for their older family members. However, it is difficult to predict if potential caregivers will be available to provide care when you need it. Many family members do not live close by their older relatives and would be unable to provide daily care. However, families that do live nearby often do provide substantial amounts of informal care to their family members. According to an AARP study, 34 percent of caregivers age fifty and older are taking care of their mothers; 10 percent are taking care of their fathers; and 11 percent are taking care of their grandmothers.[xviii]

What About Fraternal Organizations And Churches?

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.

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

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

NOTE: *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 1-800-827-1000.*

What About 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. Co-payments may be required for each "service" provided by these contracts.

Companies selling these products are not covered by the state insurance guarantee fund, 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. Information on free or low cost services available in your area can be obtained by calling 1-800-510-2020.

Turn to page 75 to find additional resources and their contact information.

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

Another way of paying for long-term care is long-term care insurance. This type of insurance can cover a wide variety of services ranging from home and community-based care to institutional care.

LONG-TERM CARE insurance

As with most health and life insurance, you have to meet minimum health standards, and you cannot purchase coverage once you have a health condition or already need benefits. The decision to purchase a long-term care policy must be made while you are still relatively healthy, and the type of policy you select will depend on your own personal finances and needs.

For example, significant differences exist among policy types, features, benefit options, and eligibility criteria; and each of these affect the premium you will pay. Choosing among these options and costs can be a challenge. Choosing a long-term care insurance policy requires careful consideration of a number of factors related to your own ability to balance the risk of paying for long-term

care with your individual financial resources, planning strategies, and goals.

What Is Long-Term Care Insurance?

Long-term care insurance is designed to pay benefits for some of the expenses you may have if you need supervision or assistance with basic activities of daily living (ADLs), including bathing, eating, continence, dressing, toileting, eating and transferring. You may need this kind of help following an accident or illness such as a stroke, because of advanced age and frailty, or because you need supervision due to a cognitive disorder like Alzheimer's disease.

Long-term care insurance can pay for care in institutions such as Skilled Nursing Facilities; assisted living provided in Residential Care Facilities; at home for home health care, personal care, homemakers services, hospice care, and respite care; and in the community for adult day care. 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 policies will only pay for home and community care.

Companies selling this insurance will screen people for existing medical conditions when they apply for coverage. However, people who are actively employed and applying through an employer group may be accepted with little or no health screening, or only be refused coverage when they have a serious health condition.

What Is A Tax Qualified Long-Term Care Policy?

In 1996 Congress passed legislation allowing a tax deduction for premiums paid toward long-term care insurance if the policies meet certain federal standards. This legislation was called the Health Insurance Portability and Accountability Act or HIPAA. Policies that qualify for the new tax treatment use a standard of eligibility for benefits that is stricter than standards previously established in California. Policies that are labeled as "Federally Tax Qualified" use the federal standards for paying benefits. Some or all of the premiums for these policies may be deductible as a medical expense (depending on your age and adjusted gross income) on your tax returns. Benefit payments are not taxable as income.

NOTE: *As stated above, premiums for a tax-qualified policy may qualify as a medical expense. Taxpayers who itemize medical expenses on their federal tax return and have total medical expenses greater than 7.5 percent of their adjusted gross income may be able to deduct some portion of the premium for one of these policies. You may also be able to deduct some portion of your premium on your state income tax returns. Contact your tax advisor for more information.*

Premiums paid for policies purchased after 1996 that use benefit eligibility standards previously established by California are not deductible under federal law. It is not clear whether the benefit payments of these "non-tax-qualified" policies are taxable as income. However, long-term care benefits have not been previously taxed as income. Differences between the benefit eligibility standards for these two kinds of policies are discussed on page 37, How Do I Qualify for Benefits?

NOTE: *All long-term care policies that were sold in California before January 1, 1997, regardless of their design, automatically qualify for the federal tax deduction. These policies do not have to be replaced with a new tax qualified policy. Consult your tax advisor for more information.*

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

No. There are three types of long-term care insurance policies. Two of them restrict benefit payments to certain places where care is received and one provides comprehensive benefits. In addition, each type of policy can be designed to qualify for the federal tax incentive depending on which set of eligibility standards the company uses – the federal standards or the state's previous standards.

Nursing Home and Residential Care Facility Only Policies

These policies only pay for care in a nursing home and for assisted living in a Residential Care Facility for the Elderly (RCFE) or Residential Care Facility (RCF).

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 will pay for some modest modifications to your home if they are necessary to allow you to continue living there.

"Before purchasing a policy, think about your continuing ability to pay the premium."

Taking Care of Tomorrow, CA Department of Aging

Comprehensive Long-Term Care Policies

A comprehensive policy has benefits for long-term care at home and in the community, as well as in a nursing home and for assisted living in a Residential Care Facility for the Elderly (RCFE) or a Residential Care Facility (RCF). All of the home and community services required in a Home Care Only policy must be included in a comprehensive policy.

NOTE: *Any of the three types of policies can be tax qualified or not, depending on which set of benefit eligibility standards are used by the company. A tax-qualified long-term care insurance policy must be labeled as "intended to meet federal tax requirements." Very few companies sell policies with the more generous eligibility standards described in "How Do I Qualify for Benefits?" on page 37 that were previously required in California.*

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:** these are adult day care programs that usually provide personal care, supervision, protection, or assistance in eating, bathing, dressing, toileting, moving about, and taking medications; and can include 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 medication, shopping for essentials, preparing meals, laundry, and light housekeeping;
- **Homemaker Services:** assistance with chores or activities that are necessary for you to be able 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.

NOTE: *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 a care team under medical direction.*

If Martha had purchased a comprehensive long-term care insurance policy, many of her long-term care expenses, both in the nursing facility 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 7 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 a comfortable margin in your finances for future rate increases. If you don't take these potential changes into account you could be faced with some tough decisions later about what obligations you can afford to continue paying with a reduced income.

NOTE: About Premium Increases

An insurance agent should be able to tell you about any premium increases by the company you are considering. You should always ask about premium increases for any long-term care policies the company sells now or has sold in the past. It is important that you know if the company you are considering has a history of increasing premiums after a policy has been issued. You can also call the company and ask about their premium increases or you can look up that information at www.insurance.ca.gov, the website of the California Department of Insurance.

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 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 qualifying for Medi-Cal benefits and be at 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. However, premiums can't go up after you buy a policy just because you are older. It's important to know that many companies will not sell you long-term care insurance once you reach 85 years of age, and most companies limit how much long-term care insurance you can buy once you reach age 80.

Health

Companies screen people for medical conditions when they apply for a policy, often referred to as medical underwriting. 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 will call or send someone to interview applicants who are age 70 or older to verify their physical and cognitive condition. A few companies will accept you if you have certain chronic conditions, but your premiums are likely to be higher. A few companies may issue coverage in exchange for a much higher premium, even if another company has turned you down. However, people with serious health problems are rarely accepted for long-term care coverage.

Pre-existing Condition

An insurance company can refuse to pay if you need care during the first six months after you buy the policy because of a 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, Standard & Poor's, and TheStreet.com (formerly Weiss Ratings, Inc.). A.M. Best Reports are often available at public libraries. The other companies will give ratings over the telephone. Some charge a fee; others don't.

A.M. Best 1-908-439-2200
Fitch Financial 1-800-753-4824
Moody's 1-212-553-0377
Standard & Poor's 1-212-438-2000
TheStreet.com 1-800-289-9222

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;
- Inflation protection and what kind you buy;
- The deductible, waiting period, or elimination period you choose before the policy begins paying benefits;
- The combination of the 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.

NOTE: *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 get assisted living care.*

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") from $80 a day to more than $300 a day for the covered services described in the policy.

For Example: If you choose a daily maximum 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 a month. (This is your co-payment.)

While you may have the income to pay this co-payment today, you need to be sure that you can pay it in the future too. Nursing home costs have increased 5.4 percent annually since 1980 and will continue to increase each year due to inflationary increases in the cost of providing care (refer to Chart #6). This means that the co-payment you choose will also increase.[xix] Once you qualify for benefits, many companies will pay your benefits on a monthly or weekly basis, which

AVERAGE PROJECTED COST OF NURSING FACILITIES

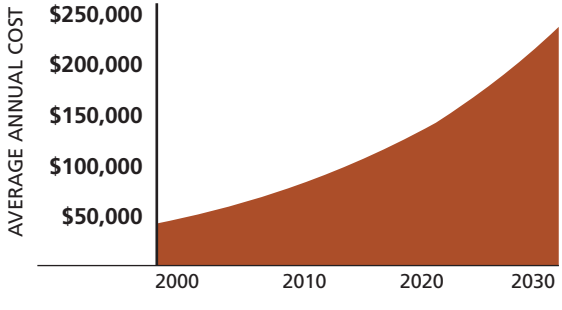


CHART:6

allows you or your caregiver to organize your care more efficiently.

NOTE: *Some companies pay you for the cost of your covered expenses only "up to" the daily benefit amount that you chose when you bought your policy. In that case you will be responsible for any amounts greater than the daily benefit.*

In Another Example: If you choose a daily maximum of $200 and your nursing home expenses are $275, you will be responsible for the difference ($75).

Conversely, 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.

Inflation Protection

When you buy individual long-term care insurance, the insurance company must offer you the option to purchase inflation protection. At a minimum, the company must offer you 5 percent compounded inflation protection. Companies can also offer you other methods such as 5 percent simple interest or the right to increase your benefits periodically.

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 by 5 percent (compounded or simple) each year. With the 5 percent compounded method, both your daily benefit and total maximum coverage will double every 14 years. Long-term care expenses increase at a compounded rate, and your benefits should too. You can see the effect of inflation on long-term care benefits in Chart #7.

Some companies offer an option to periodically increase your existing benefits to keep up with inflation. Each time you choose this option your premium will go up to reflect the increase in your benefits. 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

ESTIMATED COST OF NURSING HOME CARE

Note: In 2007, the cost of care for one year is $73,000.

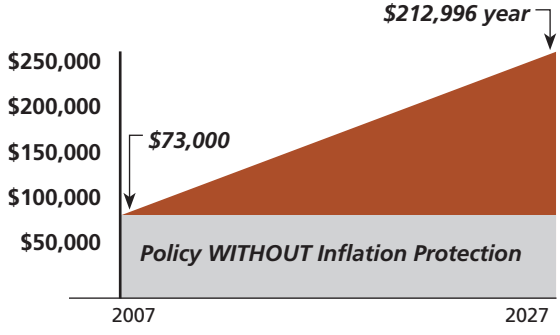


CHART:7

"When you buy individual long-term care insurance, the insurance company must offer you the option to purchase inflation protection."

Taking Care of Tomorrow, CA Department of Aging

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. While inflation protection increases the cost of your annual premium, without it you risk not being able to pay your share of the cost in the future.

NOTE: *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 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.

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, or one that will pay benefits as long as you live after 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 and the more likely it will be that you can buy greater amounts of coverage.

How Can I Buy Long-Term Care Insurance?

Long-term care insurance is most often sold by insurance agents to individuals who pay all of the premiums. Some employers offer this type of insurance to their employees and retirees through a group plan, although the employee usually pays the 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. (Refer to the CalPERS chapter beginning on page 57.) 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. (The federal long term care chapter can be found on page 61.) However, neither CalPERS nor the federal government pay 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 their members.

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

Benefit Eligibility Triggers

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

California Policies

At one time companies selling long-term care policies in California were required to offer policies with seven ADLs, rather than the six required by HIPAA, but that requirement ended. While some companies still sell policies with an eligibility trigger that includes the seven ADL standard, most only sell the federally tax qualified policies with six ADLs, eliminating ambulating from the list. Policies that do use the California eligibility standard must pay benefits when you are unable to do 2 out of the 7 ADLs listed below:

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

OR, when you need help or supervision because of cognitive impairments. (An example would be someone with Alzheimer's disease or with dementia following a stroke who needs supervision.)

Tax Qualified Policies

Tax qualified policies cannot pay benefits until a health care practitioner certifies that you are unable to perform 2 out of the 6 ADLs listed below, without substantial assistance from another person, and that you are expected to need care for at least 90 days:

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

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

NOTE: *While a health care professional must certify that you are expected to need care for 90 days or more, this is only an estimate. You might unexpectedly get better and stop needing care during this 90-day period. This certification also has no effect on the waiting period you may have chosen before benefits will be paid for your care. (Refer to the Elimination, Deductible, or Waiting Period section on page 39.)*

Impairment of Cognitive Ability

Policies that use the California eligibility standard define cognitive impairment as needing supervision or assistance to protect you or others because of Alzheimer's disease or other disorders. In policies that use the federally tax qualified eligibility standard, you must need substantial supervision because of severe cognitive impairment.

Definitions of Activities of Daily Living (ADLs)

California law requires one set of ADL definitions for policies using the California eligibility standards and a different set for policies using the federally tax qualified eligibility standards. These definitions describe each ADL on the list used to determine eligibility for benefits. When a person cannot do two of the ADLs described in their policy, they have qualified for the benefits in that policy. The maximum number of ADLs needed to qualify for benefits in policies sold in California is two.

NOTE: *The additional ADL (ambulating) in the California eligibility standards may make it easier for some people to qualify for benefits sooner than they would with a tax-qualified policy. In addition, people with these policies don't need to get certification that they are expected to need care for at least 90 days. However, few companies still sell policies using the California standard.*

What Conditions Must Be Met Before Benefits Will Be Paid?

Elimination, Deductible, or Waiting Period

This is the number of days you must wait after the company certifies that you are eligible for benefits but before the policy begins paying for your care. While a few policies have no waiting period and pay benefits from the first day, the most common waiting periods available are 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 chose when you bought the policy. The policy premium will be lower if you select a longer waiting period, but you will pay the full cost of your care during that time.

For Example: If your nursing home 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. (Since nursing home costs will increase each year, the amount you will pay for any waiting period will be more than it is today.)

While some companies require you to meet the waiting period once during your lifetime, others require you to meet it for each **period of care** (Refer to page 70 in the Glossary.)

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, in some policies you would have to pay for your own care during a new 30-day waiting period.

Be sure you understand how a company counts the days in the waiting period. If only the days you actually receive care count, called a "service day" waiting period, a 90-day elimination period could take much longer than 90 days to satisfy. Some companies count all of the days you qualify for benefits even when you don't get care on some of those days. This is called a "calendar day" waiting period.

NOTE: *Remember that you cannot depend on Medicare to pay for the first 100 days you are in a nursing home. Medicare will only pay 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. 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. Federally tax qualified policies are not allowed to pay the Medicare co-insurance after the 21st day if Medicare is still paying for your nursing home stay. Policies using the California eligibility standard do not have this restriction.*

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, that prescribes the care you will need. The Plan of Care establishes that you need care, describes the kind of care you need, and the frequency and length of time you are expected to need care. Tax qualified policies require a Plan of Care before any benefits can be paid, and some companies may require the Plan of Care to describe every service you need. Many insurance companies require that the Plan of Care be updated periodically.

Care Assessment and Care Management

Tax qualified policies approved for sale after October 6, 1997, must allow you to use an independent care manager to assess your need for care and to develop your Plan of Care. Care management is a process to assess, plan, coordinate, and monitor long-term 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 places like Residential Care Facilities for the Elderly (RCFEs) or in Residential Care Facilities (RCF). Most policies also pay for hospice care at home and for inpatient hospice care when those services are not covered by Medicare. Home health 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.

All policies sold after January 1, 1993, 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. 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. While a few policies might pay home care benefits when family members provide unskilled personal care, most will not. All policies that pay for home care are also required to pay for community care in both

medical and non-medical adult day care centers and Alzheimer's day care centers.

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 ADLs. Home Care Only policies are the only long-term care policies sold in California that are not required to include this benefit, although some companies may include it voluntarily. When assisted living is included in a policy, the benefit must be no less than 70 percent of the nursing home benefit 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 a policy pays $200 a day in a nursing home for 2 years and the daily home care benefit is $100, it could take 4 years to use up the maximum benefit for home care, but only 2 years for nursing home care. (This example assumes you have a comprehensive policy.)

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. Many

"Many policies allow you to stop paying premiums, known as a premium waiver, while you are collecting benefits."

Taking Care of Tomorrow, CA Department of Aging

companies selling long-term care insurance policies today pay the same daily amount regardless of whether care is provided in a nursing home, assisted living facility, or at home. The company must continue to pay benefits until all of the policy benefits are exhausted, unless the person dies or does not meet other 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 the nursing facility benefit or other institutional benefit, although some policies may waive premiums while you are using the home care or other benefits of the policy.

Nonforfeiture Benefits

Nonforfeiture benefits allow you to retain some benefit of a long-term care insurance policy even if you have to drop your policy. The details and terms of a nonforfeiture benefit will be described in the policy.

For Example:

- A shortened benefit period pays the full daily benefit, but for a shorter period of time than the maximum policy benefits. For instance, a policy that paid $200 per day for three years will still pay $200 a day, but for a much shorter period of time. Generally, you must have paid premiums for a certain number of years (usually 10 years) before dropping the policy to get this benefit. The amount of premium you paid while you had your policy will usually determine how long the policy will pay a nonforfeiture benefit.

- 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.)

Some companies have a return of premium benefit if the insured person dies before a certain age or after they had the policy for a certain number of years. The cost of this benefit is included in the premium you agree to pay for the policy.

Alternative Benefits or Services

If you are eligible for benefits and you want the policy to pay for a benefit or service that is not listed in your policy, you can request that benefit from the insurance company. Although the company has absolute discretion to grant or deny your request, it may agree to your request. Some companies offer the right to an alternative benefit in their contracts; others don't. You can always submit a request for payment of alternative services, whether or not your policy has this feature. The company will decide if it is willing to pay for those services.

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 get the policy or certificate.

Guaranteed Renewable or Non-Cancelable Protection

Every long-term care policy sold to an individual must be either "guaranteed renewable" or non-cancelable. "Guaranteed renewable" means that the company cannot cancel your policy or change any of the benefits, unless you fail to pay the premiums. Insurance companies are, however, allowed to increase premiums for a "class" of guaranteed renewable policies, but not for you individually. Non-cancelable means that your policy can never be canceled, the benefits changed, or the premium increased. Companies are not offering non-cancelable long-term care policies at this time.

Forgetfulness Feature

Companies are required to allow you to reinstate your policy if it lapses because you forgot to pay premiums. 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.

Downgrades

California law requires companies to allow you to reduce your coverage in exchange for a lower premium. This right to reduce coverage can be exercised anytime after the first year or whenever your premium increases. There are three ways this can be done. You can reduce the amount of the daily benefit or reduce the total number of years the policy will pay, or you can change your coverage from a Comprehensive policy to a Nursing Home Only policy if the company sells one. Companies must also offer you this option if you stop paying premiums. 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.

New Benefits

Companies 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 5 percent premium credit for each year you had your existing policy. The maximum premium credit can't equal 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 premium on time. Conversion means you get a new individual policy of insurance with identical or equivalent coverage without health screening. In each case, your premium can change when you are no longer part of the group. Some groups may continue the 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 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 you benefits because you weren't in a hospital or nursing home before you needed covered home or community services. 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 policies you may already have with one you are considering for purchase.

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

"You should seriously consider designating one or two people to be notified if the long-term care insurance company doesn't receive your premium payment. This will protect your coverage if you get sick or don't remember to pay your premiums."

Taking Care of Tomorrow, CA Department of Aging

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 at 1-800-927-HELP (4357).

Agent Training

All agents and other financial consultants selling long-term care insurance must be licensed by the California Department of Insurance. Agents must receive special training before they can sell long-term care insurance and 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 Department of Insurance keeps a copy of that list, and you can check their website to see if an agent's training is up to date.

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

You can get more information and free individual counseling on long-term care insurance from your local HICAP office. To find the HICAP office nearest you, call 1-800-434-0222 or 1-800-510-2020

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 HICAP office. Call 1-800-434-0222 or 1-800-510-2020 to find the HICAP office nearest you. HICAP is the Health Insurance Counseling and Advocacy Program, a free statewide program through the California Department of Aging. HICAP uses trained 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

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. My non-housing assets would last _____ years if I needed care today.
   (This is the approximate number of years of coverage you might consider buying.)

4. I can afford to pay $_____ a day towards the cost of my own care. The difference between the amount I can afford and the cost of care today is $_____. *(This is the approximate amount of daily benefit you will need.)*

5. I can afford to pay a total of $_____ for the first days of care in a nursing home. Therefore, I will need a waiting period no longer than:
   30 days $_____ 60 days $_____ 90 days $_____.
   (To determine the amount you would pay, multiply the daily nursing home cost times the number of days in the waiting period.)

**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. Recent changes in federal law may cap the amount of home equity you can have 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 county social services departments 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.*

Your Answers To The Questions On Page 47 Will Help You Determine What Benefits You Need.

- The premium range I can afford is $_____.
  (Fill in your answer to #1 on page 47.)

- The number of years a policy should pay is _____ years.
  (Fill in your answer to #3 on page 47.)

- The daily benefit amount I need is $_____.
  (Fill in your second answer to #4 on page 47.)

- The elimination period I can afford is _____ days.
  (Fill in your answer to #5 on page 47.)

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 Buyers Guide for Long-term Care Insurance?

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?

QUESTIONS TO ASK MY AGENT WHEN I CONSIDER BUYING A LONG-TERM CARE POLICY

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?
    a. When does it begin?

    b. Does it apply to all of the benefits in the policy?

    c. 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 elimination period more than once?

5. How are the days in the elimination period counted?
    a. Every day I receive paid care?

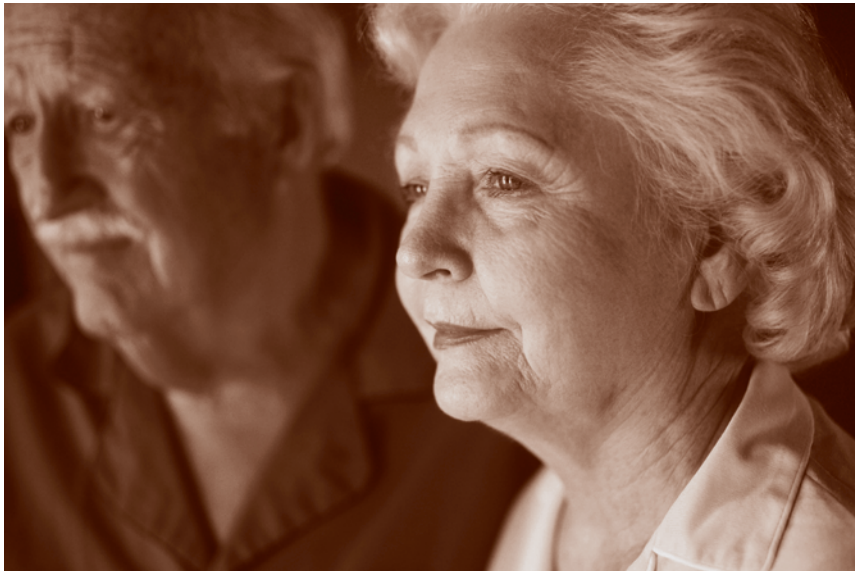
    b. From the day I am first eligible for benefits?

6. If Home Care is a covered benefit, is care management a benefit of the policy?
    a. Is the cost of care management deducted from any of my benefits?

    b. 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?

What Is The Partnership For Long-Term Care? The "Partnership" is an innovative alliance between the State of California and a select number of private insurance companies. The California Department of Health Services designed the Partnership program to help you maintain your financial independence by creating a special type of long-term care insurance policy.



California Partnership

FOR LONG-TERM CARE

It provides 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 you avoid wiping out a lifetime of savings or losing your

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 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;
- Assisted living is included as a benefit in all Partnership policies;
- 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.

NOTE: *Insurance companies participating in the Partnership must have their policies approved by both the Department of Insurance and the Partnership program. For a list of the participating insurance companies, you can visit the Partnership's website at: www.dhs.ca.gov/cpltc 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.

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: Suppose you had $70,000 in lifetime savings 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, while still requiring care. If you apply for Medi-Cal, you can keep the entire $70,000 of your assets, not just the $2,000 limit that would apply otherwise for a single person. This amount is in addition to any other exemptions Medi-Cal allows. Each dollar your policy pays for your care (a total of $70,000) equals one dollar of asset protection ($70,000 of your lifetime savings in this example).

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 $70,000 in benefits with compounded inflation protection, those benefits will grow by 5 percent compounded 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, no other policy gives you this important asset protection feature.

NOTE: *If you are 70 or older when you buy a policy you can choose simple interest instead of the compounded inflation protection. In that case your asset protection would grow at a somewhat slower rate.*

How Will The 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 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.

NOTE: *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. If you become eligible for Medi-Cal, you may have to use most of your income towards the cost of your care before Medi-Cal will begin to pay.*

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

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

How Do I Know How Much Asset Protection To Buy?

You can purchase coverage equal to all 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. After you have owned the policy for a full 14 years, and have filed no claims, the amount of compounded asset protection you bought will have almost doubled.

NOTE: *Participating insurance companies offer benefit amounts ranging from coverage for one year up to coverage for the rest of your life. You can protect as little as $52,000 in assets up to $300,000 or more*

What Kind Of Policies Can I Buy Through The Partnership?

There are two kinds of Partnership approved policies. One is a facility only policy that covers care in a nursing home or assisted living in a residential care facility. The other 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 Partnership does not include a Home Care Only policy because it could leave you without any benefits if you needed care in an institution and couldn't be cared for at home.

Both kinds of policies have built-in inflation protection. The daily benefit and the lifetime benefit maximum automatically increase by 5 percent each year. When you buy a Partnership policy you choose the daily benefit that will be paid for services covered by the policy. You also choose the number of years you want the policy to pay benefits once you need care. Every participating insurance company offers a one year policy with a 30-day waiting or elimination period. These companies also sell policies that pay longer than two years and even offer policies with lifetime benefits.

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

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 1-800-982-1775 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 you select, and the features you choose. The more years you want the policy to pay, the higher the premium cost. Lifetime coverage is the

most expensive. 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. (Refer to page 32 for more information on things to consider when buying long-term care insurance. You can also turn to page 47 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 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.

NOTE: *Partnership policies use the same benefit eligibility standards required by federal law to be considered a tax qualified policy. Premiums paid for policies labeled as tax qualified may be deductible as a medical expense if you itemize your federal (and state) income tax returns. Consult your tax advisor for information on how the tax changes affect you. (Turn to page 29 for more information on tax qualified policies.)*

How Is The Need For Care Determined?

When you need care, an independent care management agency will assess your physical, mental and social needs in a face-to-face meeting. The care manager will develop a Plan of Care that describes the services you need. The cost of the care manager 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 management agency must give you an explanation of your right to appeal and the procedures you must follow.

Who Is Eligible To Purchase A Partnership Policy?

There are no special eligibility rules except that you must be a resident of California at the time you buy a policy. The insurance benefits of your policy can be used anywhere 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 new improvements in newer policies. While companies can require you to pass new health screening, it cannot be stricter than it is for other people applying for new policies.

How Can I Find Out More About Partnership 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 www.dhs.ca.gov/cpltc or call 1-800-227-3445 for free brochures.

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

Turn to page 75 to find additional resources and their contact information.

The California Public Employees' Retirement System (CalPERS) is the largest public pension in the United States, with assets totaling $232.5 billion as of January 31, 2007. CalPERS has a history of financial stability and commitment to meeting its members' retirement and health care needs.

CalPERS

LONG-TERM CARE PROGRAM

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 173,000 members.

The CalPERS Long-Term Care (LTC) Program is a voluntary, not-for-profit, self-funded program with no insurance company involved. 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?

All California public employees, retirees and annuitants are eligible to apply for coverage under the Program. This includes members of a wide range of public retirement systems including CalPERS, the California State Teachers Retirement System (CalSTRS), the University of California Retirement System (UCRS), and all other city and county retirement systems.

Extended family members are also eligible to apply. This includes the spouse, parents, parents-in-law and adult siblings of eligible public employees and retirees. Those eligible for the Program must be between the ages of 18 and 79 when they apply.

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 LTC Specialists by calling a toll-free number provided in the application kit. The LTC Specialists are available to help applicants understand their coverage options and select a plan that is affordable and best meets their needs.

There are three basic plans:

- **Comprehensive Plan**
  This plan covers care in a wide variety of settings including any licensed nursing home, assisted living facility, adult day care center and care provided at home.

- **Facilities Only Plan**
  This plan covers care in any licensed nursing home or assisted living facility, but it does not pay for care at home. It provides a more affordable coverage option for those who may have family who can provide at-home care or who only want coverage for the most catastrophic cost of long term care.

- **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 50-56.

All the plans include Respite Care, Hospice Care, Bed Reservation, 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

Inflation protection can help benefits keep pace with the rising cost of long-term care. The Program offers two choices for protecting the value of benefits from the rising costs of care.

Built-in Inflation Protection provides an automatic increase in all of the benefit amounts by five percent (5%) compounded annually. The cost is built into the premium at the time you apply, so premiums do not change due to the automatic increase in benefit amounts each year.

The Benefit Increase Option (BIO) lets members "upgrade" their coverage amounts once every three years to keep benefits in step with rising costs of care at an additional premium cost based on the member's age when they exercise this option.

Premiums

Premiums are based on your age at the time you apply and can be paid through automatic payroll or pension deduction, if available by your employer or retirement system, 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. Once you have satisfied the deductible period, premium payments are waived as long as you are receiving benefits from the Program.

NOTE: *Although the premium for the Built-In Inflation Protection is included in a member's original premium amount, premiums may increase if the CalPERS Board determines a premium increase 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.*

One-Time Calendar Day Deductible Period

The Program's calendar day deductible period is designed to minimize a member's 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. The care received during the deductible period may be paid for by the member or another party like Medicare. Once the deductible period begins, each day you continue to be eligible for benefits whether or not you receive covered care, is counted as one day toward satisfying the deductible period.

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 Application Period which is typically four or five months long. An eligible member or extended family member can apply by completing the application form available during the application period. 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. Once someone is approved for coverage, there are no limits or exclusions based on any prior health conditions you may have.

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 1-800-982-1775 or visit the Long-Term Care section of the CalPERS website at www.calpers.ca.gov.

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.

Federal Long Term Care

INSURANCE PROGRAM

It was established by Federal law in September 2000 and is the largest employer-sponsored long term care insurance program in the nation. The U.S. Office of Personnel Management (OPM) serves as the program's sponsor and regulator.

OPM selected *John Hancock Life Insurance Company* (John Hancock) and *Metropolitan Life Insurance Company* (MetLife) to offer insurance under the Federal Program. Long Term Care Partners, LLC, a jointly held subsidiary of John Hancock and MetLife handles applications and enrollments.

No agents are used to market the Federal Program. Application forms are available through Long Term Care Partners, either by calling 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or by visiting www.LTCFEDS.com.

Who Is Eligible To Apply?

Eligible groups include:

- Federal and U.S. Postal Service employees 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
- Navy Personnel Command (BUPERS) NAF employees and annuitants
- Compensationers receiving compensation from the Department of Labor
- Tennessee Valley Authority employees and annuitants even though they may not be eligible for FEHB coverage
- 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

Qualified relatives can also apply:

- 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

Medically Underwritten

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.

Persons who are not approved for coverage are offered a non-insurance package providing access to care coordination and discounts, for a low annual fee.

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 the Maximum Lifetime Benefit. Coverage will not be cancelled as long as premiums are paid on time and cannot be cancelled due to the enrollee's age or because of a change in health. Premiums can only be changed with OPM's approval and only on a group, not an individual, basis.

What Type Of Care Does The FLTCIP Cover?

Applicants select either a *Facilities-Only Plan* or a *Comprehensive Plan.* A Facilities-Only Plan covers all levels of nursing home care, including skilled, intermediate, and custodial care. Care in assisted living facilities and inpatient hospice care are also covered. A Comprehensive 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.

Inflation Protection Option

The Program provides two inflation protection options – the *Automatic Compound Inflation (ACI) Option* or the *Future Purchase Option (FPO)*. With the Automatic Compound Inflation option, the Daily Benefit Amount and any remaining portion of the Maximum Lifetime Benefit will automatically increase by 5% 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 ACI option may be the best choice in the long run. 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. FPO inflation increases are based on the Consumer Price Index for Medical Care. The additional premium for increased coverage is based on the enrollee's age at the time the increase takes effect. (Important Note: the offer for the Future Purchase Option will stop after you decline a total of three increases unless you can pass underwriting again or while you are eligible for benefits.) Each time the enrollee is offered the FPO, he/she can switch to the ACI option without proof of good health, as long as the enrollee is not eligible for benefits at that time and has 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 by calling Long Term Care Partners at 1-800-582-3337 (TTY 1-800-843-3557). 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 he/she became eligible for benefits. When informal care is provided by family members, it is covered for up to 365 days in an enrollee's lifetime. Caregiver training is also available for those friends or relatives providing care.

Care Coordination Services – Enrollees have unlimited access to the Program's Care Coordinators. These are registered nurses (RNs) who have worked extensively in the field of long term care. Enrollees can contact them to ask any questions about long term care (even if they are not receiving benefits). Once a person initiates a claim and is approved for benefits, Care Coordinators will work with him/her and family members to develop a plan of care to meet the person's individual care needs, and help find high quality care providers in that area. Care Coordinators can also arrange for discounted services, monitor the care being received, and assist with changing the plan of care as needs change. This is a personal service that allows the claimant or family member to talk to the same nurse each time, one who knows their particular situation. Unlike most long term care insurance plans, the Federal Program also provides certain care coordination services to qualified relatives of enrollees at no cost. Also, the use of this care coordination feature is voluntary.

Alternative Plan of Care – Under certain circumstances, Long Term Care Insurance 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).

Waiver of Premium – Enrollees do not pay premiums while receiving benefits. Once a claimant has completed the Waiting Period, the waiver of premium feature allows them to stop paying premiums while receiving benefits.

Weekly Benefit Amount Option - If the enrollee selects the Comprehensive Option and also selects (at an additional premium cost) the Weekly Benefit Amount option, he/she will have benefits for covered services calculated on a weekly basis. This option allows caregivers to plan care more efficiently when the cost of care is higher than the Daily Benefit Amount (DBA) on some days of the week and lower on others. 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. The Weekly Benefit Amount is equal to seven times the DBA.

International benefits - Most other long term care insurance plans do not pay benefits outside the U.S., but because this 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% of the Daily Benefit Amount or Maximum Lifetime Benefit Amount. The person can use up to 80% of the Maximum Lifetime Benefit for services received outside of the United States; the other 20% 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 will be 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 OPM 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 premiums through payroll deduction or annuity/pension deduction, automatic bank withdrawal, or by direct bill.

Contact Information

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

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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, transferring, and for non-tax-qualified policies, ambulating.

Adult Day Health Care – Day care that provides medical, rehabilitative and social services through an individualized plan of care to persons 18 years of age or older with functional limitations caused by physical, cognitive or mental impairment.

Adult Day Programs – Also known as Adult Day Care, these community-based programs provide individualized day care in a protective setting to persons 18 years of age or older who need personal care services, supervision or assistance with ADLs.

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 referred to as a licensed Residential Care Facility or Residential Care Facility for the Elderly.

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

Care Management or Care Coordination Services – A service 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.

Community-Based Services – Services designed to help older people stay independent and remain in their own homes.

Custodial Care (Personal Care) – Care to help individuals perform activities of daily living, as well as some other basic activities.

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.

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 Benefit Waiting Period).

Federally Insured – Refers to federally guaranteed insurance for deposits (generally up to $100,000) in member institutions. Securities, mutual funds and annuities are not covered by this insurance.

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 raise premiums for all policyholders within a particular group, but not for an individual member of a group.

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 which usually includes the following: home health care, personal care, homemaker services, hospice services and respite care.

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.

Inflation Protection – A policy option that provides increases in benefit levels to help cover expected inflationary increases in the cost of long-term care services.

Lapse – Termination of a policy within a specified timeframe and under certain conditions, when premiums are not paid.

Long-Term Care Ombudsman – A state-certified advocate serving residents in nursing homes and Residential Care Facilities for the Elderly.

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 determining whether to issue a policy, and sometimes how much to charge as a premium.

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.

Non-Cancelable – A term meaning that a policy will remain in force and the premium and benefits will remain the same, as long as policy premiums are paid.

Period of Care – A period of time during which you need and receive continuous care that is covered by your long-term care policy.

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 a policy that guarantees the payment of specified benefits. This payment may be a single sum 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 which provide temporary or periodic relief for caregivers.

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

Substantial Assistance – "Hands-on" or "stand-by" help required to perform an ADL.

Substantial Supervision – A term meaning that the presence of another person is required to direct and watch over someone with a cognitive impairment perform 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.

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

Glossary Information provided with the assistance of the California Partnership for Long-Term Care: 2007 Comprehensive Brochure

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SUGGESTIONS FOR FURTHER READING

A Shopper's Guide to Long-Term Care Insurance
National Association of Insurance Commissioners
To order, contact:
1-816-842-3600
www.naic.org

Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers
Bonnie Burns, CA Health Advocates
AARP Publications
601 E Street, NW
Washington, DC 20049
1-888-687-2277
http://assets.aarp.org/rgcenter/il/2006_13_ltci.pdf
www.aarp.org/ppi

Complete Guide to Health Services for Seniors
Trudy Lieberman & The Editors of Consumer Reports
Consumers Union 2000 copyright
Three Rivers Press/Crown Publishing Group/Random House, Inc.
ISBN 0-8129-3147-5

Long-Term Care: Facts and Figures
Charlene Harrington, Ph.D., R.N., Janis O'Meara, M.P.A.,
Theodore Tsoukalas, Ph.D., and Terence Ng, M.A., UCSF
California HealthCare Foundation 2007
www.chcf.org

Snapshot: The Changing Face of California's Nursing Home Industry
Charlene Harrington, Ph.D., R.N., and Janis O'Meara, M.P.A., UCSF School of Nursing
California HealthCare Foundation 2007
www.chcf.org

RESOURCE GUIDE

Alzheimer's Association
1-800-272-3900
TDD 1-866-403-3073
www.alz.org

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

Better Business Bureau
(Check your phone directory for the local office.)
www.bbb.org

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

California Department of Aging
1-916-419-7500
TDD 1-800-735-2929
www.aging.ca.gov

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

California HealthCare Foundation
1-510-238-1040
www.chcf.org

California Ombudsman Crisis Hotline
1-800-231-4024

California Partnership for Long-Term Care
1-800-227-3445
www.dhs.ca.gov/cpltc

California State Independent Living Council
1-866-866-7452
TTY 1-866-745-2889
www.calsilc.org

CalPERS Long-Term Care Program
1-800-982-1775
www.calpers.ca.gov

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

Eldercare Locator
1-800-677-1116
www.eldercare.gov

Federal Long Term Care Insurance Program
1-800-LTC-FEDS (1-800-582-3337)
TTY 1-800-843-3557
www.LTCFEDS.com

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

Information and Assistance InfoLine
1-800-510-2020

Mental Health Association in California
1-916-557-1167
www.mhac.org

National Alliance on Mental Illness
1-800-950-NAMI (6264)
www.nami.org

Veterans Administration
1-800-827-1000
www.va.gov

World Institute on Disability
1-510-763-4100
TTY 1-510-208-9493
www.wid.org

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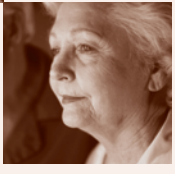
Local HICAP offices provide free community education and confidential individual counseling statewide on Medicare, Medicare supplement policies, Health Maintenance Organizations (HMOs) and long-term care insurance. HICAP Counselors are trained to assist you with filing Medicare and private insurance 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 set up a counseling appointment or have questions about your health insurance, you can call HICAP at 1-800-434-0222. If you are calling from within the State of California this number will route you to the HICAP program closest to the area from which you are calling.

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



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Health Insurance Counseling and
Advocacy Program (HICAP)
www.aging.ca.gov

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1-800-434-0222

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