

A Crash Course in Long-Term Care

If you've helped an elderly friend or relative find and figure out how to pay for long-term care, or you've done so yourself, you likely confronted a bewildering maze of unfamiliar terms as well as extreme financial complexity.

What's the right type of care given the person's needs? What type of care is covered by Medicare? When does your private insurance — either health or long-term care insurance — pick up the slack? And what expenses must be paid out of your own coffers? Can a spouse hang on to any assets before Medicaid kicks in and provides coverage for long-term care needs?

Unfortunately, many people are navigating the long-term care maze at times when they're contending with other major challenges. Older individuals may be confronting declining physical health and/or mental faculties at the same time they're attempting to make important long-term care decisions. And because long-term care may also bring a loss of independence, contemplating it can cause emotional distress for both older individuals and their loved ones.

Rather than having to sort out long-term care on the fly, it helps to be pre-emptive. Get familiar with the various types of care, as well as the financial ramifications, before you actually need to put the information to use. This article explains the key terms and variables that consumers should be aware of when navigating long-term care.

Activities of Daily Living (ADLs): Basic activities that are used to measure a disabled or elderly individual's level of functioning. The key ADLs are bathing, dressing, eating, ambulating/transferring (moving from place to place, or from standing position to chair), grooming, and toileting.

Skilled Nursing Facility (sometimes called a SNF or "Sniff"): A type of facility that provides skilled nursing care, usually medical care and/or rehabilitation services. Medicare covers, in full, the first 20 days of care in a skilled nursing facility following a qualifying hospital stay (defined as three days in a row in the hospital as an inpatient). For days 21-100 in a skilled nursing facility (again, following release from a qualifying hospital stay), you must pay a copayment (often covered by your supplemental health-insurance policy) while Medicare covers the remainder of the cost. For days 101 and beyond, Medicare does not cover the costs of care in a skilled nursing facility.

Nursing Home: A facility that helps individuals with the activities of daily living, including eating, bathing, and getting dressed. Nursing homes are also likely to coordinate and/or provide medical care for individuals who need it, but their central focus is to help residents

with their daily lives. In contrast to care provided in a skilled nursing facility to people who have had a qualifying hospital stay, nursing-home care (sometimes called “custodial care”) is not covered by Medicare. Instead, costs are covered out of pocket, by long-term care insurance (for those who have such policies), or Medicaid for individuals with limited assets.

Assisted Living Facility (ALF): A type of facility geared toward people who need assistance with the activities of daily living but who do not need the type of extensive care provided in a nursing home. Most assisted living facilities, like nursing homes, help patients coordinate medical care, but providing medical care to sick individuals is not the central focus. Many ALFs now have locked “memory care” units geared toward people with Alzheimer’s disease or dementia. As with nursing homes, stays in ALFs are not covered by Medicare; instead, such care is covered out of pocket, by long-term care insurance (for those who have it), or Medicaid.

Continuous Care Retirement Community (CCRC): A type of community geared toward providing a gradation of care to older adults—from independent living to assisted living to nursing-home care. The goal of the CCRC is to help older individuals reside in the same community for the remainder of their lives. Such communities tend to be the most costly of all elder-care options, often requiring an upfront sum as well as monthly charges that will vary depending on the level of care the individual is receiving. As with nursing homes and assisted living facilities, most of the care provided within CCRCs is not covered by Medicare, unless it’s medical care or skilled nursing care that is normally covered by Medicare (see “Skilled Nursing Facility,” above). The financial arrangements of CCRCs can be devilishly complicated; this article delves into some of the particulars.

Custodial Care: Non-medical care provided to assist older adults with the activities of daily living. As a rule, custodial care alone is not covered by Medicare; instead, such costs must be covered out of pocket with long-term care insurance, or by Medicaid for eligible individuals.

Hospice Care: Care provided to individuals at the end of their lives; the focus is on keeping the patient comfortable rather than extending life. Such care may be provided at home, in the hospital, or in a skilled nursing facility. Hospice care is covered by Medicare if your doctor and the hospice director certify that you’re terminally ill and have less than six months to live. To be covered by Medicare, hospice care cannot be delivered in conjunction with any curative treatment. This document provides more details on the interaction between hospice and Medicare.

Palliative Care: Care geared toward providing pain relief and emotional support to individuals with serious illnesses. In contrast to hospice care, which is for terminally ill patients, palliative care can be provided to individuals undergoing curative treatment. Medicare Part B may cover some of the prescriptions and treatments offered under the umbrella of palliative care.

Adult Day Services: Services, including social activities and assistance with activities of daily living, provided during the day to individuals who otherwise reside at home. Approximately half of the individuals who take part in adult day services have some form of dementia, according to the National Adult Day Services Association; thus, adult day services frequently focus on cognitive stimulation and memory training. Medicare may cover adult day services in certain limited instances, but generally does not.

Institutionalized Spouse: A spouse who has moved into a nursing home or other long-term care setting.

Community Spouse: A healthy spouse who remains in the community even after the other spouse has moved into a nursing home and requires Medicaid benefits.

Exempt (or Noncountable) Assets: Assets that can be owned by the institutionalized person without affecting Medicaid eligibility. Specific parameters depend on the state where you live, but exempt assets typically include \$2,000 in cash, a vehicle, personal belongings, and household goods. In most states, a primary residence is also considered an exempt asset, even if an individual ends up moving into a nursing home, so long as a spouse or child lives there. The individual's equity in the home cannot exceed certain limits, usually \$552,000 in most states. Moreover, the state can attempt to recover any money paid out through Medicaid when the owner dies and the home is sold.

Countable Assets: Assets that are counted when determining Medicaid eligibility. The specific parameters depend on the state in which you reside, but countable assets usually include checking and savings accounts, retirement-plan assets, and additional vehicles (in addition to the one vehicle that is considered exempt).

Community Spouse Resource Allowance (CSRA): The amount of assets that the community (in other words, healthy) spouse can retain, even as the institutionalized spouse qualifies for Medicaid. Those assets typically include a house, a car, and financial assets equal to one half of the couple's assets, subject to minimum and maximum thresholds. (The maximum allowable figure was recently \$119,220.)

Lookback Period: The five-year period prior to an individual's application for Medicaid benefits. If assets were transferred to children or any other individuals during this five-year period, it will trigger a period of ineligibility for Medicaid benefits. The length of the penalty period is calculated by dividing the amount of the transfer by the average monthly nursing-home costs in the region or state where the individual resides. The goal of this provision is to keep otherwise-wealthy individuals from transferring assets to qualify for long-term care coverage under Medicaid.

Elimination Period: Similar to a deductible for other types of insurance, this is the amount of time during which one must pay long-term care costs out of pocket before insurance kicks in. The longer the elimination period, the lower the premiums will be.

Benefit Triggers: Triggers used by insurers to determine whether a long-term care policy will begin paying benefits. These triggers typically depend on the individual's ability to complete a certain number of activities of daily living.

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