DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Long-Term Care Insurance

What is long-term care insurance and how do you decide if it's right for you?

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INTRODUCTION

Many people think the phrase “long-term care” refers to an insurance policy. While insurance may be part of your strategy, long-term care encompasses everything from long-term care services, support, and helping to manage finances, to where you will live and how you will navigate the myriad of legal, family, and social dynamics along the way.

Most people do not like to think about the possibility of needing long-term care. But as we get older, the likelihood that we will need some kind of assistance is very real.

Long-term care is a range of services and supports you may need to meet your personal care needs. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, otherwise known as activities of daily living, such as:

- Bathing
- Dressing
- Using the toilet
- Transferring (to or from bed or chair)
- Caring for incontinence
- Eating

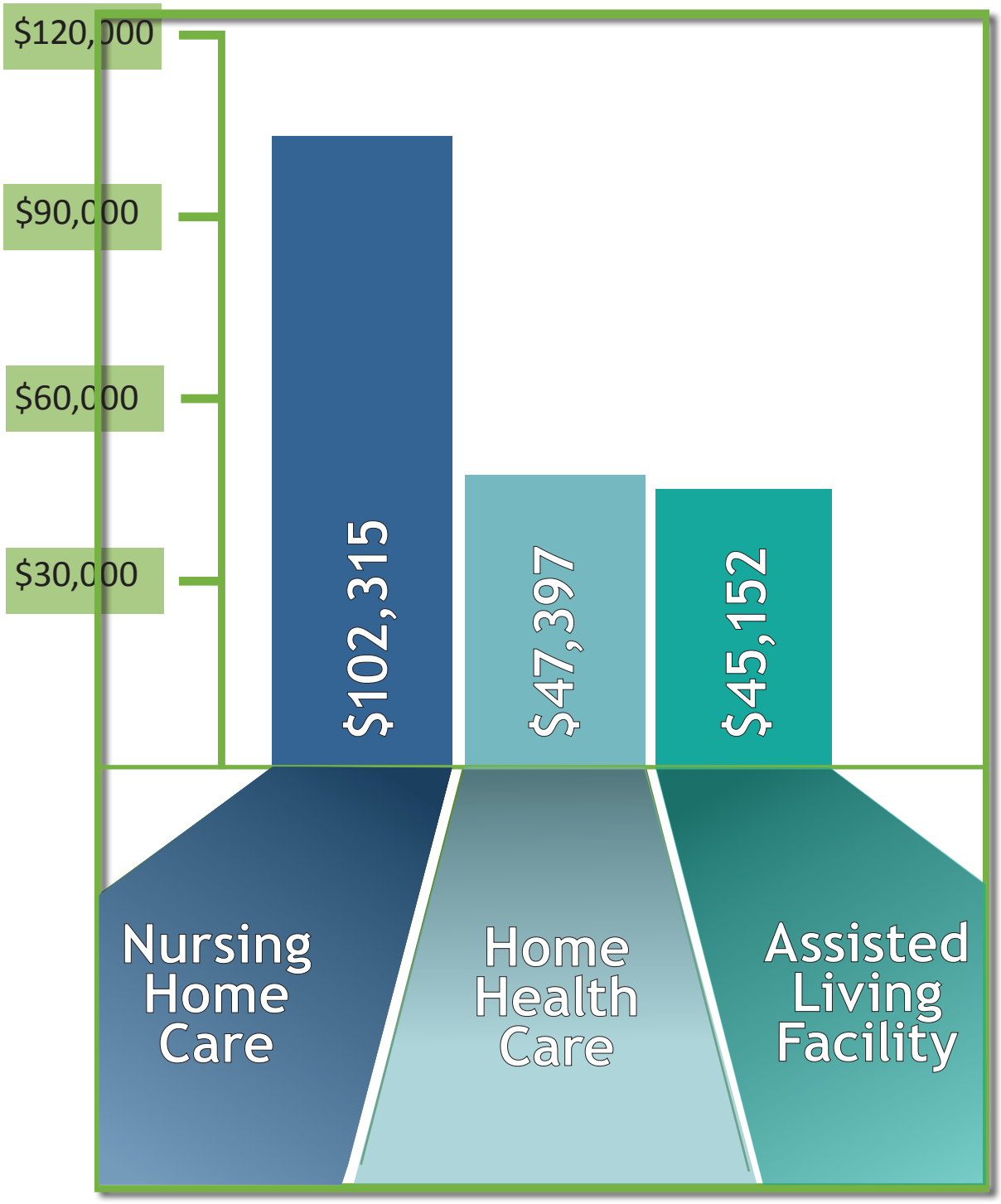
Other common long-term care services and supports are assistance with everyday tasks, sometimes called instrumental activities of daily living including:

- Housework
- Managing money
- Taking medication
- Preparing and cleaning up after meals
- Shopping for groceries or clothes
- Using the telephone or other communication devices
- Caring for pets
- Responding to emergency alerts such as fire alarms

Intermediate/basic/custodial nursing care is care that includes assistance with activities of daily living that can be provided by persons without medical skill in a licensed intermediate or skilled nursing care facility. Skilled care is care that requires daily attendance, monitoring, evaluation and/or observation by licensed health personnel in a licensed skilled nursing care facility.

Long-term care can be expensive. The cost depends on the amount and type of care you need and where you get it. This publication provides you with some average annual costs for care in a nursing home, an assisted living facility, and your own home. Long-term care may cost more or less where you live.

What's



* According to LTCConsumer.com- http://ltcconsumer.com/resources/cost-care-map. Costs based on 2015 figures.

the Cost*?

Nursing Home Costs:

In 2015, the Michigan average cost of nursing home care was about **$102,315** per year. This cost does not include items such as therapies and medications, which could greatly increase the cost.

Home Health Care Costs:

In 2015, the cost of basic home health care averaged **$47,397** per year. Skilled care from a nurse is more expensive. Annual costs for home health care depends on the number of days per week the caregiver visits, the type of care required, and the length of each visit. Home health care can be expensive if round-the-clock care is required.

Assisted Living Facility Costs:

In 2015, the average annual cost of assisted living facilities was **$45,152** per year. Some residents in the facilities may pay more if they need more care.

Is long-term care insurance for you?

You SHOULD NOT buy long-term care insurance if:

- You can't afford the premiums.
- You have existing serious medical conditions.
- You don't have many assets.
- Your only source of income is a Social Security benefit or Supplemental Security Income (SSI).
- You often have trouble paying for utilities, food, medicine, or other important needs.
- You're on Medicaid.

You SHOULD consider buying long-term care insurance if:

- You have many assets and/or a good income.
- You don't want to use most or all of your assets and income to pay for long-term care.
- You can pay the insurance premiums, including possible premium increases, without a problem.
- You don't want to depend on support from others.
- You want to be able to choose where you receive care.

WHO PAYS?

People pay for long-term care in different ways. These include individuals' or their families' personal resources, long-term care insurance, and some help from Medicaid for those who qualify. Medicare, Medicare supplement insurance, and the health insurance you may have at work usually won't pay for long-term care, or pay very limited benefits.

Personal Resources:

Individuals and their families usually use some of their own money to pay for part or all of their long-term care costs. Many use savings and investments. Some sell assets, such as their homes, to pay for their long-term care needs.

Long-Term Care Insurance:

There are different types of policies that provide benefits for long-term care services. Some policies provide coverage for home-health care only or only pay benefits for stays in a long-term care facility. These policies must be titled in such a way that is clear to consumers that the coverage is limited and are not comprehensive, long-term care policies. The law regulating long term care insurance was passed in Michigan in 1992. The law required that a long-term care insurance policy that is titled and sold as a long-term care policy must provide coverage for care in an intermediate care or a skilled nursing facility and must also provide coverage for home care services that is at least half of the dollar amount of coverage available for nursing home benefits under the policy. For example, if a long-term care policy provides a benefit of $100 per day for care in an intermediate or skilled nursing facility, the policy must provide a home health care benefit that is at least $50 per day.

Long-term care insurers cannot limit or exclude paying benefits based on the type of illness you have, the type of health care provider that is treating you, your geographic location (except locations in Canada or Mexico), or by the treatment, medical condition or whether your condition was caused by an accident. However, the company may deny coverage if your need for long-term care services is the result of an automobile accident, in which case the individual's no-fault automobile insurance will cover their long-term care needs pursuant to the Michigan No-Fault Law. Although the company cannot exclude or limit your coverage based on the type of illness you have, it can exclude or limit coverage for conditions for which you have already been diagnosed for a limited period of time. In addition to pre-existing conditions, the company can exclude coverage for alcoholism or drug addiction, or any illness, treatment, or medical condition arising out of war or an act of war or from service in the armed forces, your participation in a felony or riot, or self-inflicted injuries, including suicide attempts.

After you purchase the policy, a thirty-day (30) period must be provided as a "free look" period; and, if an individual decides they do not want the policy, they are under no obligation and will receive a total refund of any premiums they paid. If an individual cancels their policy after the "free look" period, the company must provide a prorated refund of premiums paid for the current year.

FOR EXAMPLE:

If a long-term care policy provides a coverage amount of $100.00 per day for nursing home care then that policy MUST provide a coverage of a minimum of $50.00 per day for home care.

The policy must be a guaranteed renewable policy, although the premium rate is not guaranteed.

All companies must offer inflation protection and there is typically a charge for this added protection. Inflation protection causes your policy benefits to increase, allowing you to maintain the value of your policy. At a minimum, the company must offer to sell you inflation protection that will increase your benefit levels annually so that the increases are compounded at a rate of not less than five percent (5%). Many companies have the required inflation protection but they may have other inflation options for you to consider. Always ask the company or your agent about the company's inflation protection options and ask them to explain how the options you have chosen compare to other available options. Once the offer is rejected the company does not have to offer inflation protection again.

A company which previously offered group employees a long-term care policy, but then terminates the benefit, must offer employees individual long-term care coverage with similar benefits of the prior group coverage, this is referred to as conversion.

If issued after June 2, 1992, a policy cannot require prior hospitalization as a provision before paying benefits.

Medicare:

Medicare provides very limited coverage for long-term care services. Under the original Medicare program, Medicare will pay the full cost for days 1 to 20; for days 21 to 100, Medicare pays all costs except the daily coinsurance ($161.00 per day in 2016); beyond day 100 Medicare pays nothing.

Medicare Supplement Insurance:

Medicare Supplement insurance (Medigap) is private insurance that helps pay for some of the gaps in Medicare coverage, such as hospital deductibles and physician charges greater than Medicare approves. Medicare supplement insurance policies usually don't cover long-term care costs.

MEDICARE COVERS HOW MUCH?

Days 1-20:

Medicare covers 100% of the cost.

Days 21-100:

Medicare covers all the costs with the exception of the daily coinsurance (in 2016, this amounted to $160.00/day)

After 100 Days:

Medicare does not cover anything beyond 100 days.

Medicaid:

Medicaid is a federal program administered by the states currently providing health coverage to those meeting certain income requirements: pregnant women, people with disabilities, people in need of nursing home care and others. If your income puts you above the federal guidelines set for Medicaid eligibility, you might have to prove that you cannot pay the medical bills you are facing. That is called Medicaid Spend-Down.

In order to qualify for Medicaid Spend-Down, you must have a certain amount of medical bills. This is called your deductible. Each family typically has a different deductible, depending upon income. You should save all of your medical bills, including receipts for medical-related items, such as transportation to the doctor, durable medical equipment, home health care, and over-the-counter medications. You can even include previous medical bills that have not been paid in full. If you have Medicare, your premiums and co-pays can be added to the total. When you have enough in medical bills to meet your deductible, you may be eligible for Medicaid.

However, many people find they need Medicaid but have too many assets to qualify. In this case, families might be able to transfer assets in order to "spend down" to Medicaid eligibility. Not all transfers are acceptable, however, Medicaid can look at up to 60 months of your past financial history to determine where your assets went to see if you are then eligible.

Long-Term Care Partnership Program:

Under the Long-Term Care Partnership program, a qualifying long–term care insurance policy may protect the policyholder's or certificate holder's (also applied to group coverage) assets through a feature known as "asset disregard" under Michigan's Medicaid program. This feature permits individuals to protect assets from Medicaid's "spend-down" requirements for the purpose of determining Medicaid eligibility and during the asset recovery process.

If you already have a long-term care policy, you should contact the issuer to inquire about a Long-Term Care Partnership policy. If you do not have a long-term care policy you should contact a life/health producer, visit the DIFS' list of long-term care writers, or do a search on-line for companies that offer Long-Term Care Partnership-qualified long-term care insurance. Only a Partnership-qualified policy will earn the consumer asset protection.

The greatest and most unique benefit of a Long-Term Care Partnership policy is the Medicaid asset protection. The difference between a Partnership policy and a non-Partnership policy is the Medicaid asset protection.

This feature provides dollar for dollar asset protection; for every dollar that a Partnership policy pays out in benefits, a dollar of assets can be protected from the long-term care Medicaid resource limit. When determining long-term care Medicaid eligibility, any assets you have up to the amount the Partnership policy paid in benefits will be disregarded.

FOR EXAMPLE:

If your Partnership policy paid $2,000 in benefits, Michigan's Medicaid program would allow you to keep $2,000 in assets and still qualify for Medicaid assistance. The amount of assets you are able to protect under the Partnership is in addition to the $2,000 everyone is allowed to keep, including any assets your spouse may be allowed to retain.

LONG-TERM CARE FAQs, SHOPPING TIPS, AND ADDITIONAL INFORMATION

FREQUENTLY ASKED QUESTIONS

Does long-term care insurance pay medical bills?

No. A health insurance policy pays medical bills, while a long-term care insurance policy helps you live as you are instead of improving or correcting your medical problems.

Can I buy long-term care insurance if I have a pre-existing condition?

Yes; however if the company approves your application the insurance company may implement a six-month waiting period for any pre-existing health conditions you have. Your condition cannot be limited or excluded after this initial six-month waiting period.

Can my premium be increased on my long–term care insurance policy?

Yes. Long-term care rates are not guaranteed and may be subject to change by the insurance company. Rate increases must be filed for approval with the Department of Insurance and Financial Services (DIFS) and your long-term care insurance company must notify you at least 45 days prior to the effective date of the increase.

How do I file a claim with my long-term care insurance company?

Read your policy. Contact the insurance company directly to find out what is needed to begin the process. Ask the insurer if the facility or provider you want to use is authorized, or participating. Keep notes of who you talk to at the company.

What do I do if my claim has been denied?

The company will send you a denial letter. If you disagree, first try to resolve your claim with the insurance company. Contact DIFS to file a complaint if you are unable to resolve your claim by working with the insurance company. You may request a complaint form by calling toll free 1-877-999-6442 or visiting our website www.michigan.gov/difs.

Will the purchase of a qualified Long–Term Care Partnership policy automatically make me eligible for Medicaid?

No. Medicaid eligibility is determined by income and

asset tests. You still need to qualify for Medicaid in order for the Partnership-qualified policy to be used for asset protection.

Do I have to do anything to let Medicaid know that I have a qualified Long-Term Care Partnership policy?

You do not have to notify Medicaid when you purchase a Long-Term Care Partnership-qualified long-term care policy. However, if you must ever have to apply for medical assistance through Medicaid, you should have the following information available: the company that sold the policy, the policy number, the limits of the policy, including elimination period, daily benefit, and duration of the policy. This information will be recorded during the Medicaid application process.

Does a Partnership policy cost more than a non-Partnership policy?

Not necessarily, but it may. If you already have a long-term care policy that includes the appropriate level of inflation protection, is tax qualified, and contains the other required elements, the cost will not increase just because it is a qualified Partnership policy. If inflation protection has to be added to an existing policy, the premium is likely to increase by quite a bit.

Does the State of Michigan sell long-term care policies for the Partnership program?

No. The State of Michigan neither sells nor endorses any particular long-term care program. Private insurers have the ability to sell Partnership-qualified policies but no company is required to sell these policies. Companies will make the decision on whether to offer these policies in Michigan based on many factors such as other state experience with the product, their current experience with long-term care insurance, and the marketing goals of the company.

How much asset protection does a qualified Long-Term Care Partnership policy give?

That depends. Michigan's approach is a dollar-for-dollar approach. For each dollar spent on long-term care services, reimbursed by a long-term care policy, a dollar will be deducted from the consumer's asset recovery requirements. For instance, if you qualify for Medicaid and you are placed in a long-term care facility, the long-term care policy will pay for the stay. Let's say the policy paid a total of $300,000 while you were in a facility but benefits were exhausted. Medicaid would kick in and pay for continuing care. If you die, Medicaid will "disregard" the $300,000 that was paid through the long-term care policy when recovering the cost to the State for the care. If the total amount of care cost $600,000, the insured's estate would only be obligated to pay $300,000.

Is there a minimum amount of coverage that I must buy to qualify for asset protection under Michigan's Medicaid?

No. The Michigan enabling act does not prescribe the benefit level that qualifies a long-term care policy as a Partnership policy.

If I already have a long–term care policy, can that policy be grandfathered in as a Partnership policy?

Not automatically. The issuer must offer to replace the non-qualified Partnership policy for a qualified Partnership policy. Adjustments must be made to the policy if the required provisions were not included in the original policy, i.e. appropriate inflation protection for the consumer's age group. The company that sold the original policy may not market Partnership policies so you would have to decide whether you want to apply for a Partnership-qualified policy from a company that offers such policies or keep your non-Partnership qualified policy. There are risks associated with applying for a new policy such as being placed in a higher age group with higher premiums, denial of coverage due to medical conditions that have occurred since the purchase of the original policy, or less satisfaction with the new issuer.

What happens if I move to another state?

Michigan's Partnership program includes reciprocal agreements with other Partnership states. Always check with the state to see if that state's Medicaid program will honor the partnership policy.

Is a qualified Partnership policy tax deductible?

Yes. In order to be qualified as a Partnership policy, the policy must be a tax qualified policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

SHOPPING TIPS

- Check your current life insurance policy to determine if your life insurance policy contains any provisions that may offer long-term care options.
- A long-term care policy is an insurance product and should not be viewed as a savings program or be confused with estate planning.
- Michigan does not license assisted living facilities so make certain your policy does not specify benefit payments only for “licensed facilities.” If the policy does contain this provision, before purchasing the policy, obtain in writing from the company that the company waives this requirement as related to Michigan residents.
- Compare coverage provisions and prices through several agents and companies. Competition is a consumer’s best tool to secure the lowest premium rate.
- Take your time, ask questions of your agent and do not be pressured. Don’t be misled by advertising and don’t be misled that your medical history doesn’t matter. A physical may be required and there is nothing in the law that limits how far back in an individual’s medical history a company can review.
- Never pay an agent in cash. Your check should be made payable to the company issuing the long-term care policy.
- If you do not receive your policy within sixty (60) days, contact the company directly.
- Understand what “benefit triggers” the company will apply to determine when you become eligible for your benefits. This information can usually be found under the section in the policy entitled “Eligibility for the Payment of Benefits” or “Eligibility for Benefits.”

ADDITIONAL INFORMATION

Michigan Department of Insurance and Financial Services

The mission of the Michigan Department of Insurance and Financial Services is to provide a business climate that promotes economic growth while ensuring that the insurance and financial services industries are safe, sound and entitled to public confidence. In addition, the Department provides consumer protection, outreach and education services to Michigan citizens. DIFS encourages consumers to first attempt to resolve disputes directly with their financial service entity. If a resolution cannot be reached, our department can help try to resolve your dispute. For more information visit, **www.michigan.gov/difs**, or call the **Consumer Hotline at 877-999-6442**.

Insurance Producers should visit the Michigan Department of Insurance and Financial Services' website at **www.michigan.gov/difs**.

National Association of Insurance Commissioners – Insure U

A public education program created by the National Association of Insurance Commissioners (NAIC) to assist consumers with information about insurance issues. Insure U is designed to help insurance consumers as their lives and needs change, and to educate them about how to avoid being scammed. The program also reminds consumers of the tools and resources provided them by state insurance regulators. For more information visit **www.insureuonline.org**.

Michigan Department of Health and Human Services: **www.michigan.gov/MDHHS** or call the **Michigan Beneficiary Help Line at 800-642-3195**.

NOTES

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DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

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DIFS is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Visit DIFS online at: www.michigan.gov/difs
Phone DIFS toll-free at: 877-999-6442