Basic Long-Term Care Planning

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About the Author

David L. McGuffey is in private practice with the Elder Law Practice of David L. McGuffey in Dalton, Georgia. Mr. McGuffey limits his practice to Elder Law. This means he helps elders and their caregivers, as well as persons with disabilities. Much of his practice is devoted to helping elders find, get and pay for good long-term care. Mr. McGuffey is certified as an Elder Law Attorney by the National Elder Law Foundation and as an Elder Law Specialist by the Tennessee Commission on Continuing Legal Education and Specialization. He is also certified as a Civil Trial Specialist by the Tennessee Commission on Continuing Legal Education and Specialization.

Mr. McGuffey was admitted to the Georgia Bar in 1993, the Tennessee Bar in 2000 and the Michigan Bar in 2003. He attended Georgia State University (B.A., 1987; J.D., 1993). He is a member of: the National Academy of Elder Law Attorneys; the American Bar Association, the Association of Trial Lawyers of America (now the American Association for Justice) and various local bar associations. He is the current Chair of the State Bar of Georgia's Elder Law Section and a past chair of the Tennessee Bar Association's Elder Law Section. He is the immediate past Chair of AAJ's Nursing Home Litigation Group, and holds memberships in other groups associated with elder advocacy. Mr. McGuffey is a member of the Board of Directors of the Northwest Georgia Health Care Partnership and the Northwest Georgia office of Georgia Alzheimer's chapter. He is a member of the advisory committee for Peachtree Estates Assisted Living Facility, Ross Woods Adult Day Care and has been invited to serve on the Ethics Advisory Committee for Alexian Brothers in Chattanooga. The Elder Law Practice is a member of the Life Care Planning Law Firms Association.

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Introduction and Background

The essence of being an Elder Law Attorney is caring about and helping the elderly. And the essence of long-term care planning is helping clients with chronic conditions identify, get and pay for good long-term care.

Often, Elder Law Attorneys focus on a single aspect of long-term care planning, to wit: Medicaid Planning. Professionals who are Elder-focused, rather than asset-focused, will take a broader view. They will assist clients in identifying and getting good care because that task is at least as important, and often more so, than simply paying for care.[1]

Among the issues professionals face in counseling clients/patients about long-term care is a persistent paternalistic attitude among long-term care professionals. It is not uncommon for professionals to focus on doing something to or for a person against his or her will for his or her own good.[2] Choices made by persons other than the elder should not be given undue weight. For professionals counseling elders about long-term care, two issues predominate: one is communicating with the elder early enough to ascertain the elder's choice before incapacity prevents the expression of choice, and two, preserving sufficient assets to purchase the desired choice.

In the context of legal services, paternalism has no legitimate place. Rule 1.2(a) of the Model Rules of Professional Conduct provides, in part, that a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued.[3] Ethicists refer to this aspect of the planning model as *autonomy*. Legal and medical professionals might call it *informed consent* and *self-determinatio*n.[4] "One way to elicit this information is to have the [client] prepare a document that encompasses his [or her] values and expectation."[5]

A variant element in the planning process that mimics paternalism cannot be overlooked and must be accounted for. As professionals, we do not navigate an ideal world; we must live in the real world. Reality tells us that third parties, such as adult child caregivers, may not want to or be able to participate in an elder's plan of care. Thus, an elder's choice may be circumscribed by the choices third parties make about how they will (or will not) participate in a care plan. Because our long-term care "system" remains a market place, "the ultimate way to

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1 We would always rank care issues as more important than financial issues but for the fact that, in the United States, health care is a commodity, not a right. Without financing, an individual may be denied treatment.

2 R. Kane and R. Kane, *What Older People Want From Long-Term Care, And How They Cane Get It*, 20 Health Affairs 114, 115 (2001).

3 http://www.abanet.org/cpr/mrpc/rule_1_2.html. Rule 1.4 describes a lawyer's duty to communicate with his or her client.

4 *Better Elder Care: A Nurse's Guide to Caring for Older Adults* 472 (Springhouse 2002).

5 Id.

maximize choice is to ensure that people have the cash to purchase the services they prefer."[6]

Our Aging Population

The population of persons 65 or older has doubled three times since 1900. Today, one in eight U.S. citizens is over 65 years of age. More than 6,000 Americans celebrate their 65th birthday each day.[7] The number of people in the United States over age 65 is projected to nearly double in the next quarter century, growing to more than 71 million people by 2030.[8]

In 2002, older people made up 13% of the U.S. population, yet accounted for 36% of all hospital stays, 49% of all days of hospital care, and 50% of all physician hours. The average 75-year-old suffers from three chronic conditions and takes five prescription medications.[9]

Frail older adults are one of the most vulnerable groups in the nation. Disproportionately female, widowed, and in their 80s and 90s, most older people with disabilities living outside of nursing homes have little education and limited financial resources. Given the scarcity of public financing for home-based care, about three-quarters of frail older people receiving assistance rely exclusively on unpaid caregivers. Yet providing help to these older Americans can be a substantial burden on spouses, children, and friends. As a result, some frail older adults do not receive the help they need.[10]

Acute Care versus Long-Term Care

Although there is significant overlap, acute care and long-term care are treated differently in the United States. In acute care, physicians, nurses, and insurance companies choose and deliver treatment. Long-term care concentrates on helping individuals to function as well as possible; it demands intense involvement by family members, particularly spouses and adult children (typically wives and daughters), as providers and decision-makers. Families are often equal beneficiaries of long-term care interventions, because the care for the elderly person who is disabled is an important respite for the family caregiver.[11]

Long-term care needs emerge from chronic medical conditions that occur at birth or during developmental stages, such as arthritis, diabetes, dementia, cerebral palsy, and prolonged mental illness, or that result from accidents that cause

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6 Kane, supra.

7 *See* www.silverbook.org.

8 Recommendations on the Future of Long-Term Care in Oregon (May 2006), at http://www.oregon.gov/DHS/spwpd/ltc/fltc/report1.pdf.

9 www.silverbook.org.

10 R. Johnson & J. Wiener, *A Profile of Frail Older Americans and Their Caregivers* (Urban Institute, Feb. 2006), http://www.urban.org/UploadedPDF/311284_older_americans.pdf.

11 R. Stone, *Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century* (August 2000), available at http://www.milbank.org/0008stone.

conditions like traumatic brain injury and paraplegia. Long-term care is not merely an extension of acute care. Because it continues at length and mainly involves low-tech supportive services, it becomes an integral part of the life of the elder with a disability.[12]

The distinctions between acute care and long-term care have become more apparent due to the research at Improving Chronic Illness Care, a national program of The Robert Wood Johnson Foundation. Their research into the chronic care model for the delivery of long-term care services appears at www.improvingchroniccare.org.

Skilled versus Non-Skilled Care

Another distinction relates to the level (or type) of care needed. When continual skilled care becomes necessary, some informal caregiving options become problematic. For example, an adult caregiver child who is trying to provide her mother with homemaker services may not be able to coordinate the administration of IV medications. When skilled care becomes necessary, choice regarding the care setting depends on the available resources.

> "Custodial care" is the provision of services and supplies that can be given safely and reasonably by individuals who are neither skilled nor licensed medical personnel. The medical necessity and desired results of skilled care must be clearly documented by a written treatment plan approved by a physician.
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> "Skilled care" is the provision of services and supplies that can be given only by or under the supervision of skilled or licensed medical personnel. Skilled care is medically necessary when provided to improve the quality of health care of patients or to maintain or slow the de-compensation of a patient's condition, including palliative treatment (hospice). Skilled care is usually provided in a skilled nursing facility (a nursing home), although it can be provided in a less restrictive setting where sufficient resources are available to fund home care.

What Is Long-Term Care and the Long-Term Care Continuum?

When we refer to the long-term care continuum, we are recognizing that an individual's level of independence changes over time; individuals who need care typically undergo transitions as their needs become more complex. An individual's journey along the continuum of care typically begins when his or her independence declines. A loss of independence is typically marked by the need for assistance with two or more activities of daily living. ***The key to maintaining a good quality of life is spending the money to get the right services at the right time***. In other words, whether we have Medicaid

[12] Id.

or not, the Elder's needs should be addressed and resolved to the greatest extent possible. A failure to resolve these care needs simply places the Elder in danger. Planning along the entire long-term care continuum is not limited to Medicaid (or even to assets); in our office, we call this sort of planning "Life Care Planning."[13]

> Among persons age 65 years and over, arthritis, and heart disease and other circulatory conditions were the two most frequently reported causes of activity limitation in 2002–03. The next most commonly reported cause of activity limitation was diabetes for those 65–84 years and vision problems and senility for those 85 years and over. [14]

Conditions Causing a Loss of Independence

The overall health of an older person is determined by a composite of the person's lifestyle, physical health, social support network, coping skills, and cognitive abilities. When anyone of these co-related systems breaks down, the elder's well-being suffers. For example, the loss of a spouse (or the death of an adult child), combined with inadequate coping skills may lead to debilitating depression, resulting in self-neglect. Social situations that make an individual more likely to need long term care include homelessness, living alone with no immediate support system, required care that family and friends cannot provide, and lack of support systems in the community.

Commonly, older people experience conditions associated with advancing age, such as hearing loss, vision loss, loss of bone density, loss of mobility, and other age-related functional declines that hinder ability to perform activities of daily living. Among these, the greatest physical contributors to lost independence are: visual impairment, dementia, mental impairment, mobility impairment and incontinence. [15]

Impairment does not mean that long-term care is required. Long-term care is defined by functional need so care becomes necessary often after these chronic conditions take their toll on the elder's health or after general frailty makes self-care impossible.

Visual Impairment

According to the National Eye Institute, the four main causes of visual disability among the aging are cataracts, glaucoma, diabetic retinopathy, and age-related

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[13] For more information on what we mean by life care planning, *see* http://www.tn-elderlaw.com/lcpprogram.html.

[14] Centers for Disease Control, *Health, United States, 2005* at page 10, available at http://www.cdc.gov/nchs/data/hus/hus05.pdf.

[15] A general discussion of how seniors in America lose independence is in *Independence for Older Americans: An Investment for Our Nation's Future*, http://www.agingresearch.org/brochures/independence/welcome.html.

macular degeneration (AMD). More information on visual disability is available at http://ihcrp.georgetown.edu/agingsociety/pubhtml/visual/visual.html.

Dementia and Mental Impairment

Dementia is an umbrella term used to describe the loss of cognitive or intellectual function. Many conditions can cause mental impairment, including Alzheimer's disease, Lewy-Body Dementia, Parkinson's disease, Creutzfeldt-Jakob, Huntington's disease, and vascular disease. Additional information about different forms of dementia is at http://www.mayoclinic.com/health/dementia/AZ00003.

Mobility Impairment

Osteoporosis and arthritis are among the major causes of loss of independence due to mobility impairment. The Centers for Disease Control projects that 59.4 million people, almost 20 percent of the population, will suffer from arthritis over the next twenty years. Osteoarthritis is the most common form of arthritis affecting persons age 45 and over.

Incontinence

Urinary incontinence is one of the nation's greatest health care problems. It affects as many as 25 million Americans, the vast majority of whom are women, and often leads to disability and dependency. Urinary incontinence is a leading cause of nursing home admissions; approximately half of nursing home residents suffer from it.

Long-Term Care Services

Older people have two goals in their health management. The first goal, like that of young people, is to prevent illness and maintain good health. The second is to manage the changes associated with aging, sometimes managing degrees of disability, in order to prolong independence and activity. For this reason, true long-term care planning does not begin with Medicaid because Medicaid has an institutional bias toward nursing home care – and most people do not "want" to live in a restrictive environment like a nursing home.

This section describes some of the options available to people who need assistance. Although several of these options are interchangeable, for the most part they begin at home and become more restrictive as care needs are met in institutional settings.

For those clients who want to avoid "spending all of their money paying for nursing home care," there is one clear solution – don't go. Instead, spend the money necessary to get care at home – this will maintain health longer and make it less likely that an event occurs requiring a nursing home placement. Of course, the planning goal should always be to keep the client in the least restrictive setting possible for as long as possible rather than planning for the setting most likely to secure Medicaid benefits. In light of Medicaid's bias

toward institutional care, pure Medicaid planning could, in many instances, be unethical if it accelerates the nursing home admission.

Homemaker Services and Personal Care Services

There are many agencies that provide homemaker and/or personal care services for seniors. These services are usually available 24 hours per day/seven days a week. The caregivers may be licensed or unlicensed and may be bonded. Many companies also do background searches on their employees. Services include self-care assistance such as help with bathing, eating, dressing and toileting or household assistance which includes housekeeping, laundry, meal preparation, shopping and bill paying. Other services such as transportation, sitter/companion and medication monitoring are available. These assist an individual with personal and household needs, such as cleaning, laundry, and food preparation. These services are often available from the same agencies that provide health care in the home. Others, like Meals on Wheels, specialize in food preparation or some other homemaker service. For further information, contact your Area Agency on Aging.[16]

Home Health Care

Home health agencies provide skilled nursing and rehabilitative care such as physical, occupational and speech therapy. Personal services such as assistance with bathing and grooming are also available. And, if a physician determines that someone is in need of home health care, services to complement the health care services such as assistance with housekeeping or grocery shopping are also available.

Case Management Services

Case managers are available to help determine and coordinate the care and services needed by elderly individuals and others. Contact the Area Agency on Aging, or contact the National Association of Professional Geriatric Care Managers.[17]

Respite Care

Respite care offers relief for home caregivers by allowing overnight accommodations as well as medical and social supervision in a nursing home or an assisted living facility. Studies show that the family members who become round-the-clock caregivers often become resentful, guilty, irritable, depressed and generally fatigued due to the stressful situation. There may be times when the family is unable to provide care. The duration is usually limited to a week and is paid with private funds.

Potential financing options are the same as above, except that Medicaid provides little or no assistance and Medicare coverage is typically provided only as an ancillary benefit to hospice coverage.

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16 http://www.n4a.org/.

17 http://www.caremanager.org/.

Adult Day Care

These programs provide social activities, meals, assistance with personal needs, health education and supervision in a safe environment on a temporary basis. Most centers are open Monday through Friday during normal business hours and allow full-time caregivers an opportunity to continue their daily work routine while providing supervision and care for the elderly person.

Alternate Family Care Homes

Alternate family care homes offer individuals who are no longer able to live alone an opportunity to move in and share the home of a caretaker who is capable of providing needed assistance and supervision. They provide a home-like environment where participation in the family and community is encouraged. These homes are typically supervised by a "sponsor agency" which will vary from State-to-State. Individuals typically participate in the planning of their treatment, access shared areas of the home such as the kitchen and living room, and make choices regarding services and life-styles. Alternate family care emphasizes a uniquely individualized approach to care and promotion of an individual's sense of autonomy, privacy, and self-esteem.

Homes for the Aged

These facilities are designed to provide a place where people who are able to care for themselves with little or no help, may receive room, board and limited personal services. Someone who lives in the home must be physically and mentally capable of finding his or her way out of the building in case of an emergency without the assistance of another person. They are neither staffed nor licensed to provide medical care. Neither Medicare nor Medicaid pays the cost of homes for the aged.

Assisted Living Residences

Assisted living is a long-term care option for seniors who need more assistance than is available in a retirement community, but who do not require the heavy medical and nursing care provided in a nursing home. These facilities provide a higher level of care than homes for the aged and they are allowed to help administer medications to the resident. They may offer care with bathing, dressing, grooming and incontinence care. Residents who live in assisted living are required by state regulations to be able to transfer independently and perform certain other tasks as outlined in State specific regulations. Neither Medicare nor Medicaid pays for assisted care living services, with the exception of a limited number of Medicaid waiver programs.

Continuing Care Retirement Communities (CCRCs)

Continuing care retirement communities (CCRCs) offer seniors long-term contracts that guarantee lifelong shelter and access to specified health care services. In return, residents usually pay a lump-sum entrance fee and regular monthly payments. Depending on the contract, the entrance fee may be nonrefundable, refundable on a declining basis over time, partially refundable, or fully refundable. CCRC residents enjoy an independent lifestyle with the

knowledge that if they become sick or frail, their needs will continue to be met. These communities provide a continuum of care from independent housing through skilled nursing care.

Nursing Homes

The job of a nursing home is to provide 24-hour nursing care to those who are chronically ill or injured, have health care needs as well as personal needs and are unable to function independently. There are approximately 17,000 nursing homes in the United States with approximately 1.2 million residents.[18] The team of care givers in a nursing home includes the administrator, a physician who serves as the facility's medical director, registered nurses, licensed practical nurses, certified nursing assistants, a dietitian, activity coordinator, social worker and house keeping staff.

Nursing homes typically provide two levels of care, which are intermediate case and skilled care. Intermediate care provides the resident with non-skilled care (activities of daily living).

> Estimates from the three major national surveys of the older population examined are in substantial agreement that about 6.5 percent of persons age 65 or older--about 2.2 million persons--live in some type of residential care other than settings for special populations such as the mentally ill or mentally retarded. The estimates indicate that most--about 1.45 million--live in nursing homes, but more than 750,000 live in alternative residential care settings. See U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (DALTCP) and the Urban Institute (4 Jan 2006, online Apr 2006).[19]

Skilled care which is normally paid by Medicare (at least initially) provides the residents with more extensive services such as physical, occupational, speech or respiratory therapy. Nursing homes may have an Alzheimer's Unit. This is a distinct part of the home that cares for those residents who have dementia. The unit is secured and residents are not able to leave the area. There are special state regulations which apply to the Alzheimer's Unit.

The CMS *Guide to Choosing a Nursing Home* is at: http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf. In addition, a checklist that can be used when inspecting nursing homes is available at: http://www.medicare.gov/Nursing/Checklist.pdf.

Hospice Care

Traditionally hospice is provided at home for the terminally ill. Hospice care focuses on palliative rather than curative care. It addresses not only physical needs and pain management but also psychological, spiritual and emotional needs for residents, family members and friends. Hospice care is provided through an interdisciplinary, medically directed team. This team approach to care for dying persons typically includes a physician, a nurse, a home health aide, a

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18 The CDC's National Nursing Home Survey is at: http://www.cdc.gov/nchs/nnhs.htm.

19 http://aspe.hhs.gov/daltcp/reports/2006/3natlsur.htm.

social worker, a chaplain and a volunteer. Hospice requires a doctor's order with a prognosis of 6 months. For those who qualify, hospice services are paid for by Medicare and the room and board at the nursing home is paid for privately or by Medicaid. The resident liability which is paid monthly to the nursing home is discontinued. Many times the family benefits more from the services than the resident.

The Olmstead Decision

The Olmstead case[20] was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated setting appropriate.

The Supreme Court ruled that "Unjustified isolation . . . is properly regarded as discrimination based on disability." It observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA, States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors: the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the

[20] *Olmstead v. L. C.*, 119 S.Ct. 2176 (1999).

provision of services affects the ability of the State to meet the needs of others with disabilities.

Preserving Choice with Long-Term Care Insurance

Prior to considering Medicaid eligibility, it would be prudent to determine whether the client is insurable. Of course, if an adult caregiver child contacts you while the discharge planner is in the midst of assisting with nursing home placement, insurance will not be an option. Insurance may be an option for clients with more foresight and who begin their planning while they remain insurable. In the absence of insurance, there are two general methods of financing the cost of long-term care: private funds or benefits programs fund the cost if the client is eligible for benefits.

Turning Traditional Planning on its Head

Traditional Medicaid planning is focused on securing Medicaid eligibility. However, if planning commences before the client's health declines, the risk of paying for long-term care might be shifted to an insurance company. In many cases, the benefits funded through insurance will be more generous than those provided by Medicaid. Further, additional time is purchased through the use of LTC insurance to engage in long-term care planning, including Medicaid planning. What must be remembered is that if the planner waits until the client meets the Medicaid medical eligibility criteria, the client is not insurable.

What Does Long-Term Care Insurance Cost?

Like all other insurance, actual cost depends on individual factors considered during the underwriting process. However, with the understanding that it is a broad generalization, one website[21] estimates premium costs as follows:

Entry Age	Minimal Coverage *	Generous Coverage **
40	$ 55 / year	$ 1300 / year
45	$ 75 / year	$ 1400 / year
50	$ 80 / year	$ 1500 / year
55	$ 105 / year	$ 1700 / year
60	$ 150 / year	$ 2600 / year
65	$ 220 / year	$ 3400 / year
70	$ 355 / year	$ 5000 / year
80	$ 605 / year	$ 7900 / year
85	$ 1065 / year	$ 11900 / year

[21] http://www.prepsmart.com/prems-long-term-care.html.

*** Minimal Coverage** = Facility Only / $50 per day Maximum Daily Benefit / 2 year Benefit Period / 90 day elimination period / no 5% Inflation Adjustment

**** Generous Coverage** = Includes Integrated Home Care @ 100% / $140 per day Maximum Daily Benefit / Lifetime Unlimited Benefit Period / 90 day Elimination Period / 5% Inflation Adjustment

Federal Income Tax Consequences

The Internal Revenue Code grants favorable tax treatment to long-term care insurance in an attempt to encourage older persons to purchase insurance. Premiums for "qualified long-term care contracts" qualify as a deduction for medical expenses[22] subject to requirement that only medical expenses in excess of 7.5 percent of adjusted gross income are deductible.[23] Qualified long-term care policies are treated as if they are an accident and health insurance plan; the premiums for which are deductible.[24]

Only premiums for "qualified" long-term care insurance are deductible[25] and there is a limit based on the age of the insured as to the amount of premiums that can be deducted (indexed for inflation). For 2008 the limits per individual[26] (not per tax return) were:

Attained age before the close of the tax year	Maximum deduction
40 or less	$310
More than 40 but not more than 50	$580
More than 50 but not more than 60	$1,150
More than 60 but not more than 70	$3,080
More than 70	$3,850

A "qualified" long-term care insurance policy must:

- provide no other insurance protection other than for qualified long-term care services (though combined life insurance and long-term care insurance policies can qualify[27]);
- be guaranteed renewable;
- must provide for a cash surrender value or any right to borrow money; and
- must satisfy various consumer protection provisions.[28]

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22 I.R.C. § 213(d)(1)(D).
23 I.R.C. § 213.
24 I.R.C. § 7702B(a)(3).
25 I.R.C. § 7702B(a).
26 REV. PROC. 2005-70, at http://www.irs.gov/pub/irs-drop/rp-05-70.pdf.
27 I.R.C. § 7702B(e).

The consumer protection provisions required by the IRC are those of the Model Long-Term Care Insurance Act created by the National Association of Insurance Commissioners. The provisions include guaranteed renewability, limit non-coverage of preexisting conditions to those occurring within six months of the start of coverage, no conditioning benefit payments on prior hospitalization, prevention of unintended lapse of the policy, and limits on what conditions can be excluded from coverage.[29]

Where To Find Information About Long-Term Care Insurance

There is a wealth of information about long-term care insurance on the internet. One of the most comprehensive non-legal articles (meaning anyone should be able to understand it) found while preparing this article is at: http://www.longtermcarelink.net/eldercare/long_term_care_insurance.htm.

Things to look for when counseling an individual about long-term care insurance include:

- What are the financial ratings of the Company?
    - Standard & Poor's http://www.standardandpoors.com/RatingsActions/index.html
    - Moody's http://www.moodys.com
    - Duff & Phelps http://www.duffllc.com
    - Weiss http://www.weissratings.com
    - A.M. Best Company http://www.ambest.com
- How long have they been in the LTC field?
- What is their history of rate increases?
- Is there an inflation rider?
- favorable benefit triggers which must be met before the insurer starts paying for care
- few exclusions (Alzheimer's cannot be excluded in Tennessee)
- expenses that are paid regardless of where you receive care
- deductibles that are satisfied only once and various deductible periods
- fair premiums that you can afford over the coming years
- comprehensive care in your home, assisted living, or skilled nursing environments
- benefit levels that are adequate for your region
- choice of the doctor who will certify your need for care (rather than someone hired by the insurance company)
- benefits for homemaker services, in-home medical equipment, and safety devices
- weekly or monthly maximums (rather than daily maximums) for in-home care
- waiver of premiums in the event that you need care

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[28] I.R.C. §§ 7702B(b)(1)(A) through (F).

[29] Treas. Reg. § 1.7702B-1.

Quality of Care

As legal professionals, we should not presume that every client will get the benefit of his or her bargain with the long-term care community. While our goal is to help clients get good care, reality is that some clients will get sub-standard or negligent care.

Part of our job is to position ourselves to identify what good care is, and what is is not. Absent a medical background, this likely requires hiring professionals who can educate us and help us monitor the care being provided. When clients receive substandard or negligence care, we should be prepared to (i) assist clients in proactively altering their care setting; and (ii) holding caregivers accountable in appropriate circumstances.

Counseling Clients About Long-Term Care

The following list of issues should be considered in counseling a client about a Long-Term Care Plan:

- The most important first step is to speak with your client if they are still capable of expressing a preference. Sometimes this is not possible because clients wait until they are in the midst of a crisis before assistance is sought. However, the ideal is to begin planning with the client while the client is still capable of expressing personal choices and directing his or her plan.
- Get detailed financial, family and professional advisor information. This can be a useful collection of information about the client, his or her plans, finances, and who will assist them;
- Get copies of or prepare appropriate legal documents: Among the documents clients should have are an Advance Directive for health care, a Durable Financial Power of Attorney, a Living Will; testamentary, estate trust documents such as a Last Will and Testament or Living Trust.
- Get a geriatric evaluation of present and likely future care needs, as well as where those services might be available. A determination of what role family members and friends can be expected to play in helping provide for a portion of these long-term care services;
- Do not presume that every client should circle the wagons to defend against asset depletion. Some clients have sufficient funds to put their assets to work. A financial planner's expertise, including an estimate of the client's risk tolerance, may be appropriate;
- Consider involving a tax professional, such as an accountant, to get an evaluation of tax issues related to income, capital gains, sale of the home and other real estate, and medical expense deductions for long-tem care expenses;
- Consider the client's eligibility for long-term care insurance;
- Do not overlook the role for the client's home as the location of future long-term care services, as well as a source of financing care in other settings. Will combined housing with family members be feasible for this client?
- Evaluate the appropriateness of the client's current Medicare, Medigap and other health insurance coverage. Can the client's Medigap coverage be upgraded without problems of medical underwriting? Does the client have

health, accident or other insurance products that should be dropped given their premium costs and likely benefits?

- What are the client's current financial management abilities? Does the client need assistance? Who is available to help the client manage money if the client becomes incapacitated by accident or illness? Is the client living within his or her current budget? What sources of income, assets, and insurance benefits would be utilized if the client's budget needed to include substantial long-term care expenses?
- How does the client want to balance finances to accommodate current financial needs, future long-term care needs, and potential bequests to family, charities and others?
- Does the client own financial or insurance products that are not a good value because of their cost and likely payout? Should some of these products be abandoned because of their low value? Did the client purchase those products as the result of unprofessional sales pressure, fraud or undue influence? If so, what remedies are available to the client?
- Has the client received long-term care services that were low quality, negligent or abusive? If so, what remedies are available to the client?
- If the client directly hires individuals to provide services in the home—depending on whether the client treats the person as an employee or an independent contractor—what are the associated supervision, tax, insurance and liability issues?
- A due-diligence statement on the appropriateness of Medicaid eligibility for the client should be considered. What would be the financial impact of the spouse or partner if the person applied for Medicaid? If the person dramatically changed assets, and Medicaid no longer covered the service, would the person still have the ability to access quality care? If the person does qualify for Medicaid, what will be the impact of the Medicaid estate recovery on the surviving family members? What conclusion can be reached for this person about his or her access to quality care with or without Medicaid?
- If the person uses private funding for long-term care services without resort to Medicaid, how will those services be funded? What is a realistic evaluation of the person's assets and the cost to liquidate them? Can a Geriatric Care Manager help estimate private long-term care expenses, supervise care and control long-term care costs? Can the individual's existing assets, as well as the financial position of family members be leveraged to help make available sufficient revenue to fund long term care expenses?