



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

WRITING THE CHECK

1999

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This article appeared in the ***Assisted Living Today*** (Volume 6, Number 6, pages 36-39). For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was John Cutler.

WRITING THE CHECK

John Cutler

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

July/August 1999

The opinions and views expressed in this article are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services.

Since President Clinton's announcement in January of this year to launch long-term care initiatives, long-term care has enjoyed the spotlight. This reaction, and the favorable response of Congress, bodes well for the future. But the processes by which these and other ideas get carried into law are difficult and time consuming. As a result, the types of care and services, and the ways to pay for them, will not radically change in the near term.

Approximately nine out of 10 residents in an assisted living facility are private pay; that is, they pay out of pocket for their own care. For the rest, costs are paid by Medicaid (MediCal in California) and supplemental security income (SSI), With Medicaid paying for the health care and SSI paying for room and board.

Even though assisted living, in most places, may cost only half as much as a nursing home, it still is a considerable sum, and the average has been creeping up even when compared to the price tag of a full-fledged nursing home.

Typical assisted living residence costs are anywhere from \$620 a month to \$995 on the low end, according to research for the U.S. Department of Health and Human Services (HHS). On the high end, it ranges from \$1,639 a month to \$3,565. A person can reasonably expect to pay at least a \$1,000 a month, and probably more, in most parts of the country. In nursing homes, however, the average country-wide costs are about \$4,000 per month or \$48,000 per year.

Types of facilities and costs vary greatly within the assisted living industry. One popular model, for example, is the continuing care retirement community (CCRC) where the resident pays a lump sum at the beginning or perhaps a combination of front-end and monthly payments (sometimes called fee for service). For the class of CCRCs that ask for a lump sum, the entrance fee could be as low as \$30,000 or as high as \$500,000. Then there are the monthly fees, ranging from \$500 to \$2,000. More typically, a person can expect to have to deposit somewhere between \$50,000 and \$200,000 (in California, for example) and pay another \$1,000 or so a month.

With freestanding assisted living, on the other hand, a resident typically pays month to month, without a lump sum payment. A security deposit is often required, which may be equivalent to a month or two of fees. In addition, some residences bundle their services into one fee, while others offer services a la carte where residents can choose and pay for only those services they require.

GOVERNMENT ASSISTANCE

The idea that Medicare will pay for assisted living or nursing home care is a popular misconception. Medicare pays for acute health services, not ongoing long-term care. Only in limited circumstances where you might be going from a hospital to a skilled nursing facility (SNIT) will Medicare pay for this type of care. Even if Medicare pays for home health care, it's a situation of limited coverage for a limited time.

The other government program of note is Medicaid, which may indeed pay for some assisted living. However, you will either have to be "poor" or spend down your assets to get to that level in order to qualify. In this case, "poor" means you meet a definition set by your state as to how much income and assets you have. It usually is a percentage of the federal poverty guidelines.

Medicaid is a joint federal-state program developed in the mid-1960s to help low-income individuals pay their medical bills. Over the years, Medicaid has expanded to also help people with long-term care needs, including nursing homes and sometimes home health care and assisted living.

To receive assistance from Medicaid for long-term care services, a person must meet certain income and asset limitations, have a need for such services, and get a signed statement from a physician that the service is medically necessary. Because these requirements vary so much from state to state, just think of this in terms of having only a few thousand dollars in assets (meaning bank accounts, stocks, etc.) and being limited as to how much income you can receive per month to qualify and stay qualified. Some states are more generous than others and many have multiple levels of eligibility, which can quickly become confusing.

While Medicaid is still designed to serve lower-income people, it is now possible to become Medicaid eligible with incomes as high as two-and-a-half times the federal poverty level in most states. (In some states, you could have even higher incomes and be eligible on a month-to-month basis.) The amount paid also may vary by where you live in the state, and how severe you score on an assessment test that measures your ability to handle activities of daily living (bathing, eating, toileting, etc.) or on cognitive ability.

Also note that Medicaid only reimburses for services. The room and board portion of the rate must be paid by the resident from Social Security income, pension, or other sources. Another problem is that existing federal rules make it easier to get Medicaid reimbursement when going into a nursing home than into an assisted living facility.

Still, it's unlikely that you will be able to use Medicaid to cover assisted living, even if you wanted to. However, ALFA has been working for several years on plans to make it easier for people in need of long-term care services to get assistance from Medicaid. These plans would expand coverage of non-nursing home services. Generally, people in need of long-term care still would have to meet the eligibility criteria but would be issued payment certificates that could be used to purchase service from any approved long-term care provider.

In addition, one of President Clinton's long-term care initiatives announced in January will help the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS) work together to make sure that

people who qualify for both HUD assistance and HHS assistance (meaning Medicaid) can get into assisted living facilities using their HUD vouchers.

PAYING FOR IT YOURSELF

Because these government options aren't entirely within one's control or extensive enough for most people's needs, it is likely you or your loved one will be drawing on your own existing resources, or on insurance, instead of the government. These resources include savings, investments, a home, and various insurance policies (mainly life insurance and long-term care insurance).

One of the most obvious options for paying for an assisted living facility involves a prospective resident selling his or her own home. This option, if there is no spouse at home, is obvious since a move into an assisted living facility means a change of residence and therefore makes selling the home logical if it is not needed anymore. The Taxpayer Relief Act of 1997 changed the rules on the sale of a home and how much of the profits you could keep tax free. After May 6, 1997, profits on home sales are tax free up to \$250,000 (\$500,000 for a couple) regardless of the person's age. Also, the value of an estate that will pass tax free at death goes up (in stages) from \$600,000 to \$1 million by the year 2006.

But there's another option. A reverse mortgage allows you to tap the value in the home if you are not in position to sell because there is still a spouse at home or you want to pass it along to your children. Unlike a home equity line of credit, a reverse mortgage provides payments to you each month, assessed against the future sale of the house. One version of a reverse mortgage is the Home Equity Conversion Mortgage (HECM), a Federal Housing Administration (FHA) program, which is offered through conventional lenders but has more consumer protection features. For example, HECM products were the first to use the concept of disclosing the "total loan cost" now required of all lenders.

Reverse mortgages vary greatly by locale. However, financial institutions in your area can provide information on how much your house is worth and how much they will pay you each month if you choose a reverse mortgage. One caveat: Make sure you are comfortable with the date for the house's final sale. Some lenders will allow a person (or spouse) to remain in the home until death, but others will set a time for the sale of the house so the mortgage can be repaid.

If you have it, using your life insurance may be an option if it is a "universal" or other comprehensive life insurance product, as opposed to "term" products that cover you year to year and do not have a portion that grows. While you may be familiar with borrowing against the value of insurance and that might be an option, some newer and perhaps better choices also are available, as follows:

- Beyond taking out a loan, another way to get at the value is to "accelerate" your life insurance, meaning get it ahead of time (before death). Four out of five insurers have such accelerated death benefit (ADB) clauses, according to research by LIMRA International and the American Council of Life Insurance. Unfortunately most will trigger this feature only for terminal illness as opposed to situations where you need it for long-term care coverage.

There also may be limits on how much can be accelerated or whether it is going to be made as a lump sum or paid out over a course of years. Even with these limits, you get substantially all the value of the policy if you qualify, which can be a great help if you no longer need the protection.

- Still another option, and one you could take after, or instead of, an acceleration is to "viaticate" the policy, or sell it. A few large insurance companies and many smaller brokers make a market in viaticals. Because this sort of sale and purchase is more open and unregulated than an acceleration, you likely will get less value for your policy. If you don't use the insurance for its original purpose and cannot accelerate the policy, this may be better than any other alternative.

To find out more about viaticals, contact either your state insurance or your state securities commissioners. Just a reminder: Because this is life insurance, it is meant to pay out upon death. Obviously, if you choose to get the insurance money ahead of time, it will not be available for the original purpose for which you bought it, such as to provide for a spouse's need upon the insured's death.

Another caveat: A person typically does not get as good a value for accelerating or viaticating the life insurance unless they have a terminal illness and are within two years of death, or have a severe chronic condition. Tax laws passed in 1996 as part of the Health Insurance Portability and Accountability Act (HIPAA) limit tax-free treatment of policies unless made for terminal illness (meaning 24 months or less until death) or severe chronic illness. Using the same rules that apply to long-term care insurance, that refers to problems with at least two ADLs or having significant cognitive problems. If you get the money and don't qualify under HIPAA, you may have to pay taxes on the distribution as if it were ordinary income.

- Long-term care insurance is an option for baby boomers and others who wish to plan early for possible needs in the future (see sidebar). A relatively new idea in the past 10 years, long-term care insurance is designed specifically for taking care of long-term health needs such as moving into an assisted living facility. (Indeed, many financial planners will make the purchase of long-term care insurance part of the plan.)

With such great odds of needing care--as many as one in three Americans are likely to need some degree of significant help when they are older--it makes sense to insure against these future needs. A comprehensive long-term care

insurance policy will cover home health care, assisted living, and nursing home stays.

SHOULD YOU BUY LONG-TERM CARE INSURANCE?

You wouldn't think of not having auto or homeowners' insurance, or life insurance if you have your kids. Yet one of your biggest risks is that at some point you will need care for an illness or an injury that puts you out of action for a long period of time, or permanently. While many are familiar with disability insurance--most important for those in the workforce--long-term care insurance is available to cover illnesses or injuries that become particularly evident with age.

More than 100 large and mid-size companies sell long-term care insurance. Mostly these policies are sold through individual agents, but you also can get long-term care insurance from large associations. Many employers now offer it as well.

The key for the consumer is to buy a policy from a company that will be around in the future. Read *A.M. Best*, *Weiss*, and other similar publications to identify strong companies. Next, determine how much coverage to buy and what is right for you. Policies should definitely cover home and home health care (unless you are only interested in catastrophic "nursing home only" coverage). Coverage should be available for a range of services and types of care, including making sure that assisted living will be covered as well as nursing homes.

Buy enough coverage per day to pay for the worst-case scenario. That means, on average, the insurance would have to pay \$100 to \$120 per day if you triggered it. If you do buy less, make sure you have other funds to cover the difference. If you move into an assisted living residence costing \$80 a day and your insurance daily benefit only covers \$50 a day, you'll need \$30 a day from other sources. That \$30 a day adds up to almost \$11,000 in the course of just one year.

You'll also have to decide how long that \$100 a day, or whatever you decide, should extend. Some people think they should buy what is called "lifetime" coverage, meaning the insurance keeps paying as long as you are in claim status. For some people, that could mean 10 to 12 years or more if they have Alzheimer's or a related dementia. On the other hand, it costs more for this additional coverage, so a policy that covers you for, say, four years after you go into claims status might be adequate for most people.

With the newer "pool of money" policies, if you have a four-year policy but do not use all that daily benefit, you get credit for it and can stretch those four years of coverage to five or six or more.

Another major decision is inflation protection. If you are younger (and this includes people in their 60s), make sure that whatever daily dollar amount you buy will keep up with inflation. The typical figure for keeping up with inflation is 5 percent (compounded), as opposed to simple inflation, or none at all. The agent or company you work with can walk you through the particulars.--JC

EXPLORE ALL THE OPTIONS

Whether you're considering assisted living for you or your spouse, or if you're a child of aging parents, it pays to explore all options. As is true of any financial or health planning, the earlier this is done, the better the likely results. But these decisions are often only made by (or for) the resident in the weeks and months before moving out of his or her home.

Whether the assisted living facility becomes the new home often depends on how well the move is made. And this part of the process will go smoother if the financial picture has been well considered.

RESOURCES

- If you have general questions about assisted living, contact the Assisted Living Federation of America at 703/691-8100, 10300 Eaton Place, Suite 400, Fairfax, VA 22030, <http://www.alfa.org>.
- For information about Medicaid, contact the Health Care Financing Administration (HCFA), which runs Medicaid in Washington, D.C., or one of its regional offices (or at the local Social Security office), or your state Office on Aging, HCFA's toll-free number is 800/638-6833. Information from HCFA also is available on the Internet at <http://www.hcfa.gov> and <http://www.medicare.gov> for Medicare issues.
- Counseling and information are available in most states from either the Office on Aging or the state insurance department. Trade groups such as the American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA) can provide information on private insurance options. Consumer groups, such as United Senior Health Cooperative (USHC), typically offer informative publications. The American Association of Retired Persons (AARP) also has publications on reverse mortgages, long-term care insurance, and other matters. All of these groups are located in Washington, D.C.

John Cutler works in the office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services. His office has responsibility for policy and research in several areas and is in the midst of a large study of assisted living facilities. Before joining HHS, Cutler spent eight years with the American Association of Retired Persons, with responsibility for regulatory and compliance matters. The comments in this article are solely those of the author and do not necessarily reflect the opinion of the Department of Health and Human Services.

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

RETURN TO:

Office of Disability, Aging and Long-Term Care Policy (DALTCP) Home
[\[http://aspe.hhs.gov/office_specific/daltcp.cfm\]](http://aspe.hhs.gov/office_specific/daltcp.cfm)

Assistant Secretary for Planning and Evaluation (ASPE) Home
[\[http://aspe.hhs.gov\]](http://aspe.hhs.gov)

U.S. Department of Health and Human Services Home
[\[http://www.hhs.gov\]](http://www.hhs.gov)