Long-Term Care Planning:
Colorado Options

LOCAL HELP FOR PEOPLE WITH MEDICARE

SHIP
Senior Health Insurance Assistance Program
Colorado Division of Insurance

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Department of Regulatory Agencies
Division of Insurance

The SHIP (Colorado Senior Health Insurance Assistance Program) is a counseling program for Medicare beneficiaries and their families who wish assistance in understanding Medicare benefits, coverage gaps, billing concerns, Medigap, Medicare Health Plans, long-term care insurance and other health insurance options.

Services are provided through a statewide network of organizations that recruit counselors, publicize services, and operate the local programs. Many counselors donate their time and expertise.
Counselors will not recommend or endorse specific insurance policies, but will assist consumers with information to make informed insurance choices.

<u>All services are provided without charge.</u>

Colorado Senior Health Insurance Assistance Program (SHIP) volunteers can help you:

- Organize, understand and process medical bills
- Assist with private health insurance claims
- Identify gaps in Medicare coverage and options to fill them
- Evaluate Medicare supplement insurance options
- File Medicare appeals
- Understand your hospital and Medicare rights
- Provide you with reference information and referral sources

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To contact the SHIP program at the Colorado Division of Insurance, call 303-894-2946.

LONG-TERM CARE PLANNING: COLORADO OPTIONS

WHAT IS LONG-TERM CARE?

Nursing homes? That's what most people think. Actually, long-term care describes a much broader range of health and personal care needed by those who are chronically ill or aged. A person's need for services changes over time and usually increases with age or as an illness progresses. People who initially need part-time assistance at home —perhaps a homemaker or the delivery of meals — may gradually need more extensive support services such as adult day care. Additionally, a time may come when loved ones can no longer be managed at home and must be move to a residential care facility, such as a personal care boarding home or an assisted living community. Ultimately individuals who are unable to care for themselves or are totally incontinent will need around-the-clock care provided in a nursing home.

Frightened by horror stories about middle-income families spending life savings to pay for long-term care, especially nursing home services, consumers, justifiably, are concerned about how to protect themselves. Compounding these worries is the fear that when they die there will be nothing left for their families.

WHY PLAN FOR LONG-TERM CARE?

Sixty (60) percent of people who turn age 65 will need long-term care as they grow older and one in five who reach age 65 will spend more than two (2) years in a nursing home. As our population ages the need for long-term care will increase, particularly for women. Twenty-two (22) percent of men and 41 percent of women can expect to have a nursing home stay longer than 3 months. At age 65, fourteen (14) percent of men and 31 percent of women are likely to have a nursing home stay longer than one year. Women are at most risk of a very long stay — 13 percent reportedly may have stays exceeding five (5) years. Only 4 percent of men will have nursing home stays exceeding five (5) years. Older adults are most likely to begin using nursing home care around age 85.

An individual's genetic predisposition (especially Alzheimer's disease), health status, marital status, and availability of family members or friends to provide help are important factors in determining the likelihood that a person will need to pay for long-term care services and how long those services will be required. If you don't have family or friends to help, you are much more likely to end up in a nursing home.

If this compelling information didn't get your attention, consider the other benefits of planning ahead for the financing of long-term care. Planning in advance forces you to assess your financial assets. It also makes you consider legal issues, such as durable powers of attorney, durable powers of attorney for health care that outline your health care preferences, and optionally, living wills. In addition, it gives you control over the type of care options you will receive when you need assistance. With advance plans in place you may be able to remain at home or in less restrictive settings in your time of need. Making plans about future care certainly lifts the burden of crisis planning from your family.

So why don't people plan ahead? Some may be unaware of the risks and costs or may be in denial because they don't trust information sources. They may be paralyzed into inaction by "it'll never happen to me" or "let the chips fall where they may" philosophies. They may believe that long-term care insurance is too complicated and unaffordable. Or, they may have other planning priorities, such as college tuition or immediate health care needs. They may view retirement as a period of good health and recreation and prefer to plan toward that end. Some simply cannot bring themselves to discuss the unpleasant subject of future dependency. Even adults who have experienced “crisis planning” when placing their parents in nursing homes fail to think of their own vulnerabilities and delay investigating private financing options for long-term care.

The key to overcoming planning barriers is to learn more about financing options to pay for long-term care — options such as long-term care insurance, reverse mortgages, life insurance, annuities, etc. Thinking of your worst-case scenario helps you personalize your planning. Yes, it’s going to take hard work to gain this knowledge but the result is worth the effort if it gives you the independence you deserve. It’s better to plan now than have other people making decisions for you.

WHAT DOES LONG-TERM CARE COST?

Long-term care is expensive. The national average for 2008 is $68,255/year or $187/day for a semi-private room. See the document in this publication for the Colorado average costs. The table shows costs for nursing home, assisted living, home health aides and homemaker services.

WHO PAYS FOR LONG-TERM CARE?

Medicare is the federal health insurance program for people over 65 and some disabled individuals. Many people erroneously believe Medicare will pay for their long-term care. Medicare does have a limited benefit for home care and nursing facility care; however, it only pays if you need a very complex level of skilled care and it limits the nursing home benefit period to 100 days.

Medicaid is the state/federal assistance program that covers medical care for eligible needy people. Colorado long-term care Medicaid helps eligible individuals pay for services in the home, in assisted living communities, and in nursing homes. To be eligible, you must have very limited income and assets. Many people eventually use up their savings paying for care and have to apply for Medicaid. In 2004, Medicaid dollars covered approximately 42 percent of this country’s nursing home expenses, down from 47 percent in 2001.

Private reserves, often assisted by family, cover the rest. Increasing numbers of consumers are purchasing long-term care insurance, which pays benefits when long-term care is needed. This type of insurance can protect savings for your spouse and heirs and give you more choices about the type of services and settings in which to receive long-term care.

SHOULD I RELY ON MEDICAID TO PAY FOR MY LONG-TERM CARE?

If you have limited assets or cannot afford long-term care insurance premiums without cutting back on food or medicine, you’ll probably have to rely on Medicaid assistance. If you have a substantial nest egg, you’ll have to spend a large portion before becoming eligible for Medicaid. Recent changes in the law will place a much heavier burden on Medicaid applicants and their families in the future.

The Budget Deficit Reduction Act of 2005 tightened regulations for long-term care Medicaid eligibility. The law changed rules for asset transfers, extending the “look-back” period from 36 months to 60 months; changed the handling of trusts, annuities and life estates; and excluded anyone with home equity of $500,000 or more from receiving long-term care services through Medicaid.

In 2007, in order to quality for long-term care assistance through Medicaid, a single person must have a gross monthly income below $1,869 ($2,704 for a couple) and resources of $2,000 ($3,000 for a couple) or less (including savings, checking, IRA's, etc). If the income is above this level, but below the average cost of nursing home care, the applicant may still qualify by setting up a qualifying trust (Miller trust). Any funds left in the trust at the time of the person's death pass to the state. Although the value of a home (if below $500,000) and your car are exempt when applying for Medicaid, the state can recoup expenses from the estate when the person dies.

The rules are different for couples when one spouse needs long-term care services. Spousal impoverishment laws protect the spouse living in the community. In 2007, the community spouse can keep a maximum of $101,640 of the couple's assets, not counting the home and car. Under these rules the household income is evaluated and the spouse remaining in the community is allowed a minimum of $1,711 per month and up to $2,541 per month if costs, such as mortgage or rent, are high. This may mean that part of the nursing home spouse's income is allowed to help the community spouse. Couples should realize that when the Medicaid recipient dies, estate recovery laws allow the state to recover costs if there is no spouse or dependent living in the home.

Medicaid laws are stringent in order to prevent you from artificially impoverishing yourself in order to qualify for assistance. If you've transferred considerable assets within five (5) years before applying for Medicaid you may be ineligible for Medicaid until your penalty period expires. The length of the penalty period depends on how much you've transferred.

Although many people needing long-term care depend on Medicaid, it limits their choice of facilities, as well as the ability to leave an inheritance to heirs.

WHAT IS A LONG-TERM CARE PARTNERSHIP PROGRAM AND IS IT AVAILABLE IN COLORADO?

Colorado's Long-term Care (LTC) Partnership is a public-private venture designed to encourage and reward Colorado's residents for planning ahead for future long-term care needs. Partnerships are an alliance between the private insurance industry and the state government to help Colorado residents plan for future long-term needs without depleting all of their assets to pay for care. Colorado launched its Partnership on January 1, 2008. The Colorado Department of Health Care Policy and Financing is the lead agency in developing the LTC Partnership.

A LTC Partnership policy allows consumers to protect personal assets in the event they must apply for Medicaid assistance to pay LTC costs. Colorado is using the "dollar-for-dollar" model; that means that LTC Partnership policy holders who apply for Medicaid coverage are able to maintain their assets equal to the benefits paid under the LTC Partnership policy.

The federal Deficit Reduction Act of 2005 (DRA) outlined specific requirements for LTC Partnership policies. Based on the requirements, Colorado LTC Partnership policies require inflation protection in most policies. To learn more about Partnership policies, you can get information at the Partnership website at www.coloradoltcpartnership.org

By federal law, Colorado is not allowed to add the LTC partnership provisions to current policies. Current long-term care insurance policy holders who wish to obtain Partnership policies should contact their agent, carrier, or the carrier of their choice regarding issuance of a new Partnership qualified policy.

LTC Partnership policies are not for everyone. However, for many consumers with significant assets to protect, Partnership policies represent viable options to state estate recovery processes in the event those consumers must rely on Medicaid assistance with LTC in the future. For additional information, consumers should talk with their financial planner, insurance agent or a SHIP counselor.

SHOULD I BUY LONG-TERM CARE INSURANCE?

If you have a comfortable income and a significant amount of savings and investments you should consider purchasing long-term care insurance. *Consumer Reports* recommends that a consumer with $20,000 in annual income and at least $50,000 in savings and investments should consider such protection. Advocates also advise consumers not to pay more than 7 percent of their income toward long-term care premiums.

Long-term care insurance can help pay for a variety of long-term care services, ranging from help with activities of daily living — such as bathing, eating and dressing — to 24-hour skilled nursing care. Long-term care insurance helps to pay for these services in a variety of settings, such as home care, assisted living and nursing home. Unlike major medical health insurance that pays a percentage of costs, most long-term care policies pay up to a maximum daily amount selected by the applicant.

This type of insurance is appropriate if you have assets that you want to protect, can afford the premiums and want to be in charge of the type of future care you receive. A *Shopper's Guide to Long-Term Care Insurance,* published by the National Association of Insurance Commissioners, is an excellent source of information. When you are talking with an insurance agent about a LTC insurance policy, they must provide this booklet. You can also contact the Colorado SHIP program at 303-894-2946 for this book.

Consumer interest in long-term care insurance is on the rise. According to the Health Insurance Association of America, over nine (9) million long-term care insurance policies were purchased by 2003. More than 74,000 Coloradans are covered by long-term care insurance.

In 2002, over 20 million federal and U. S. Postal Service employees and annuitants, members and retired members of the uniformed services and qualified relatives were offered an opportunity to purchase group long-term care insurance under the Federal Long-Term Care Insurance Program. If you are eligible for the federal program, you can find out more information at www.opm.gov or by calling 1-800-582-3337.

WHAT ARE SOME ABCs OF BUYING LONG-TERM CARE INSURANCE?

If you plan to buy long-term care insurance, envisioning your worst-case scenario can help you make decisions about how to customize your policy. A couple, for example, may need enough cash to pay in full for the nursing home so the other spouse can live at home on the couple's savings. A widow may need enough to supplement her Social Security income in an attempt to preserve her savings for her heirs. Take into consideration your parent's longevity and your lifestyle. Here are some basics to remember:

- Buy an integrated policy that will cover your care in a variety of settings, i.e., nursing home, assisted living and your home.
- Don’t buy more coverage than you need. For example, if you can contribute $1,000 a month towards the cost of care from your pension, you can reduce the amount of benefit you buy.
- Most consumers buy coverage for 2 to 5 years.
- Selecting a 90-day or a 180-day deductible period will lower your premiums, but selecting a 90-day deductible means that at today’s rates you will have to pay almost $15,300 (based on average private-pay rate in Colorado) in care costs before the policy begins making payments and this amount could at least double over the next 15 or 20 years.
- Buy inflation protection that increases your daily benefit by 5 percent compounded annually. (Individuals in their late seventies and older may find it less expensive to select simple interest or a higher daily benefit instead of inflation protection.)
- Buy when you are healthy. If you already suffer from a serious illness, such as Alzheimer’s or Parkinson’s, you won’t be able to buy insurance. But if you contract these diseases after your policy is in force, you are protected. Don’t hide health problems. Your policy can be canceled if you don’t reveal a medical problem on your application.
- It pays to buy at a younger age. Any future premium increases would be based on your issue age. In other words, if you buy at a younger age, your premium increase will be proportionally less. The older you are when you first buy a long-term care policy, the more expensive it is, and after age 75 or 80 the benefit options are limited. Average premiums range from $1,500 to $3,000 a year and up depending on benefits selected.
- If premiums increase so you cannot afford the policy, you have the right to downgrade or reduce policy benefits at any time. This would reduce premiums and could prevent your having to cancel the policy in the future if your financial situation deteriorates.
- **Don’t be pressured into a hasty decision. Do your homework. Compare policies. Buy a policy that bests fits your needs.**

HOW DO I CHOOSE A GOOD LONG-TERM CARE INSURANCE COMPANY?

Key to the decision-making process is selecting a sound company that is financially solvent. Most consumer experts recommend doing business with companies that have high marks from several rating services. Even so, if you buy from a company that hasn’t done its actuarial homework, your rates could skyrocket in the future as policyholders file claims. Colorado’s guaranty fund offers some protection to residents if their company fails, but the value of your policy may be worth considerably more than the state’s maximum payment. You can research financial soundness, but it’s harder to predict customer service. Will your company process your claims quickly and accurately?

By calling the following financial rating companies and asking for the ratings desk you can get free verbal rating information for up to 5 companies. Weiss Research does not give free verbal information, charging $15 per company for a report. Or you can visit the company's web site or your local library for information. Be sure to ask for an explanation of each company's ratings. An "A" rating from one company will not mean the same thing as an "A" rating from another company. (See Exhibit 1 for an explanation of ratings and definitions

- A.M. Best : 908-439-2200 or www.ambest.com
- Moody's: 212-553-0377 or www.moodys.com
- Standard & Poor's: 212-438-2000 or www.standardandpoors.com
- The Street.com (formerly Weiss Research): 1-800-9222 or www.weissratings.com

DOES COLORADO REGULATE LONG-TERM CARE INSURANCE?

The Colorado Division of Insurance regulates long-term care insurance policies issued in this state. The Long-Term Care Act of 1990 prohibited new policies from including burdensome provisions as in many earlier policies. Policies purchased before July 1991 may lack important features now required in all policies.

Federal provisions pertaining to long-term care partnerships, may, in the future, expand Colorado options in long-term care. Federal law now allows States to expand new partnership programs to increase the role of long-term care insurance. Any changes to Colorado's long-term care regulations require legislative action. For this reason, changes will not occur in the State immediately.

Colorado has adopted almost all of the National Association of Insurance Commissioners' (NAIC) model regulations regarding long-term care insurance. There are two exceptions. One is the provision requiring insurers to offer a non-forfeiture benefit to consumers (although most do anyway to comply with a federal standard). The other exception is the recent NAIC model "rate stability" guideline in which insurance companies must certify adequacy of their premium rates under "moderately adverse" circumstances which makes it more difficult for insurers to raise rates in the future.

You may view Colorado LTC regulations on the Colorado Division of Insurance website at www.dora.state.co.us/insurance. Select "Information for Industry." Then choose "Regulations and Bulletins" and then "Regulations by Number" and find regulation 4-4-1. You, also, may visit the Division of Insurance site and select "Information for Consumers" and then "Senior Health/Medicare" and then "Long Term Care" for more information on LTC in general.

WHAT DECISIONS WILL I HAVE TO MAKE TO BUY A LONG-TERM CARE POLICY?

When you buy long-term care insurance not only will you have to decide from which company to buy your policy, you'll need to undergo a health screening, decide what options to include, and decide whether or not to buy a tax qualified policy. You should consider the following options when buying a long-term care insurance policy:

- Covered Services
- Maximum Benefit
- Elimination Period

- Benefit Triggers
- Inflation Protection
- Premiums
- Waiver of Premiums
- Health Underwriting
- Tax Treatment

WHAT ARE LONG-TERM CARE COVERED SERVICES?

With the increase in alternatives to nursing home care, it is important to consider purchasing a policy that will pay for benefits in a variety of settings. Perhaps, with some adaptations you can stay in your own home. Perhaps, you will need to move to an assisted living facility or other type of residential setting. Seek flexibility in policy language that anticipates new care settings in the future and be aware of the type of facility licensing the policy requires. Long-term care insurance may cover some or all of the following services:

- Nursing home
- Assisted living or alternate care facility or other community facility
- Skilled and personal care in the home
- Adult day care
- Home modification and supportive equipment benefit
- Hospice
- Respite care
- Caregiver training
- Care coordination/care management services
- Bed reservation
- Restoration benefit
- Survivorship benefit

WHAT ARE THE LONG-TERM CARE INSURANCE POLICY'S MAXIMUM BENEFITS?

Colorado Medicaid calculates $5,092 a month or over $61,000 a year as the average private-pay rate for nursing home care in Colorado. Prices in Denver are usually higher than rural areas of Colorado. Assisted living, depending on the level of care needed, the location and type of facility, costs between $2,250 - $2,500 per month or more. Adult day care averages about $60 per day and the cost of hiring a home health aide is approximately $15-26 an hour. The average length of stay in a nursing home is about 2.5 years.

Long-term care policies pay benefits according to either an expense-incurred or indemnity method, both of which are based on a daily, weekly or monthly limit. Generally these limits are $50 to $250 a day or $1,500 to $7,500 a month. Expense-incurred (favored by most companies) means the company pays benefits based on your expenses up to the limits of your policy. Some companies have begun to express their payment in terms of "prevailing expenses," which means they'll pay up to your policy limit with the expenses you incur not to exceed the "going rate" in your area. It's possible that the "going rate" may not be enough to cover your actual expenses and you'll have to subsidize the balance. Companies that use the indemnity method pay the dollar amount you've selected directly to you, regardless of costs incurred. Payment may differ according to the type of setting in which you receive care. Many policies pay a percentage of the maximum benefit for home care, assisted living or adult day care.

Some companies offer a policy with pooled benefits that cover all long-term care services specified in the policy. A single policy may even cover more than one person, such as a husband and wife. In other words as benefits are used, they are subtracted from a single pool of money.

Policies state your total amount of coverage differently. Some state your maximum benefit in terms of years, typically ranging from 2 to 6 years or lifetime, others in terms of a maximum dollar amount. Policies may pay different amounts for different types of services and may have separate pools of money that must be used toward each type of care. Make sure you understand the policy's definitions. For example, if the lifetime maximum is expressed in terms of years, you could use up your total years before the company has paid the total dollar amount you expected. On the other hand, if the policy deducts benefits for all services from a single pool of money, care could extend beyond the stated number of years of the policy.

HOW LONG IS THE LONG-TERM CARE POLICY'S ELIMINATION PERIOD?

An elimination period is a waiting period (or deductible). You select a certain number of days during which, although you're eligible for benefits, the insurer doesn't make payment and you're responsible for the charges. A longer elimination period lowers your premium.

Typically, choices for the elimination period are "no days", 20, 30, 60, or 90 days, although some policies offer a longer period. Sometimes people assume that Medicare automatically pays for the first 100 days of care in a nursing home. This is not true, as the Medicare benefit requires a complex level of skilled care in order to be eligible. Some companies make you meet only one elimination period in your life-time (better), others could require a new elimination period if you are discharged and then re-enter a facility after a specified number of days have elapsed.

WHAT TRIGGERS LONG-TERM CARE INSURANCE BENEFITS?

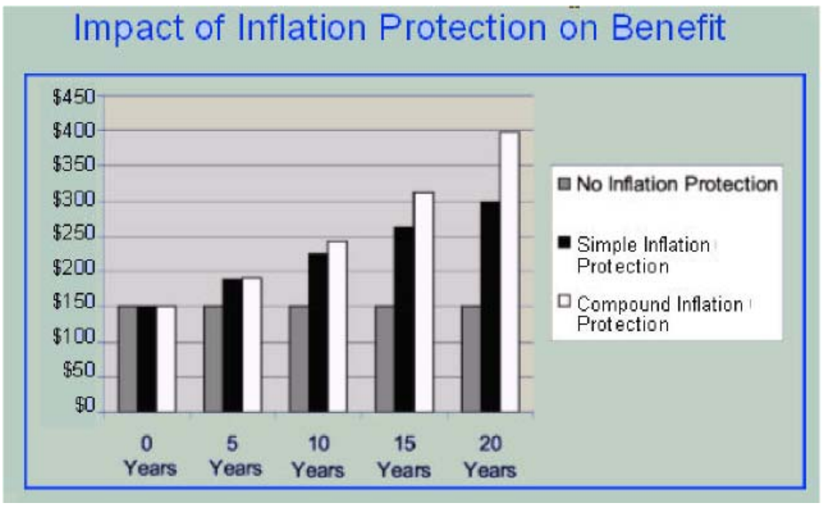
Older generations of nursing home policies require a physician to certify your nursing home stay is "medically necessary." Most policies on the market today pay benefits if the insured is cognitively impaired or not able to perform two (2) or more activities of daily living (ADL). The six (6) important ADL's include dressing, bathing, remaining continent, toileting, eating, and transferring from a chair or bed. Bathing, usually, is the first ADL that a person cannot perform.

Cognitive impairment refers to mental status and is important because many people who enter nursing homes suffer from Alzheimer's disease or senile dementia. Tax-qualified policies have a uniform definition of the deficits required to trigger benefits. Refer to the section, "Is The Long-Term Care Policy Tax-Qualified", for these definitions.

WHAT IS INFLATION PROTECTION IN LONG-TERM CARE INSURANCE?

Although inflation protection increases your premium, it is an extremely important option that increases your daily benefit over time to keep up with increasing costs of long-term care. The benefits you select today could be woefully inadequate in the future if you don't take into account the impact of inflation.

You can buy automatic inflation protection, which increases the daily benefit each year by a fixed percentage (usually 5 percent) using either simple or compound rates. It is typically offered either for the life of the policy or for a fixed number of years. Or, periodically you may be offered an opportunity to increase your benefits. However, if you turn down the option when it is offered, you may not be given the chance again.



HOW MUCH ARE LONG-TERM CARE INSURANCE PREMIUMS?

The Colorado Division of Insurance regulates pricing to that extent that actuarial projections meet the required 60% loss ratio. It's important to compare prices among companies since there is tremendous variation, although purchasing the least expensive policy may not be the best decision. The younger you are, the lower the premiums. Premiums are based on your age at the time of purchase and don't increase because you attain certain birthdays or because your health status changes. They can increase (and most likely will), but only for the entire group of people who purchased that policy.

A substantial premium increase can present a dilemma. Imagine that you've owned a policy for 10 years and you're notified that everyone in Colorado is getting a premium increase of 25 percent. You are no longer in excellent health and, of course, you're 10 years older. You can't really afford the increase, but can't replace the policy, because due to your poor health, you know you wouldn't be approved for a new policy, plus you'd have to pay a higher issue age premium based on your advanced age. To avoid a premium increase companies offer you an option to reduce some of your benefits. Before purchasing a policy you should review a company's premium increase history over, at least, a 10-year period.

Insurers may offer a non-forfeiture benefit, an optional feature that is meant to cut your losses if you cancel your policy or let it lapse. It adds significantly to your premium and may not give you substantial enough returns, since only your premium dollars are available to pay for services.

IS THERE A WAIVER OF LONG-TERM CARE INSURANCE PREMIUMS?

If you have this option, you won't have to pay premiums while you are receiving benefits. Some companies make you wait 60 or 90 days before waiving premiums; others waive them as soon as they begin to pay benefits.

WILL I HAVE TO UNDERGO UNDERWRITING TO BUY A LONG-TERM CARE POLICY?

Not everyone who wants to buy a policy will be approved. Insurance companies "underwrite" long-term care insurance. This means that before issuing you a policy the insurer will check your medical history thoroughly. It's important to give accurate information about your medical history. Individuals who already have been diagnosed with Alzheimer's disease, dementia, multiple strokes, Parkinson's disease, insulin-dependent diabetes, or other serious chronic conditions will almost always be rejected. That's why it's important to apply when you are healthy. Sometimes a group or employer may offer members or employees a policy with no health underwriting (known as guaranteed issue) or modified underwriting.

IS A LONG-TERM CARE INSURANCE POLICY TAX-QUALIFIED?

Since January 1997, long-term care insurance policies, under the Health Insurance Portability and Accountability Act (HIPAA), that meet certain consumer protection and benefit trigger standards are given favorable federal tax treatment. If you purchase a tax-qualified policy you may be eligible for tax deductions if you file an itemized return and your medical expenses exceed 7.5% of your adjusted gross income. Benefits paid by a tax-qualified policy are generally not taxable as income, whereas benefits from a non-tax-qualified policy <u>may</u> be taxable as income.

Qualified policies pay benefits for a "chronically ill individual who cannot perform at least two (2) activities of daily living without substantial assistance from another individual for a period of at least 90 days due to a loss of functional capacity, or, who requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment." Policies purchased prior to that date are automatically grandfathered as tax-qualified.

Colorado allows a state income tax credit equal to 25 percent (up to a maximum of $150 per individual policy) of premiums paid for long-term care insurance by individuals with taxable income less than $50,000 ($100,000 for joint returns).

ARE THERE ALTERNATIVE FINANCING OPTIONS FOR LONG-TERM CARE?

In addition to purchasing long-term care insurance, there are other options that provide funds to help pay for care. These include using your home's equity: including lender insured or FHA-insured reverse mortgages; reverse mortgages, annuities; selling your home and leaseback arrangements. There are also life insurance policies that provide accelerated death benefits; life settlements; viatical settlements and limited pay long-term care insurance policies. Some individuals use trusts, including Medicaid disability trusts and charitable remainder trusts. Finally, you have the option of self-insuring or borrowing funds through special purpose loan arrangements. Following are brief summaries of these options. Keep in mind that they are complicated issues that require the help of experienced professionals.

USING YOUR HOME'S EQUITY

REVERSE MORTGAGES

Since there are no health screens, reverse mortgages are appropriate for older consumers who owe very little on their homes and have a lot of equity. The funds can be used to buy long-term care insurance or, if the individual doesn't qualify for insurance, to pay for care. Loans do not adjust for inflation so it is possible that long-term care costs may exceed the amount received through the reverse mortgage. If the homeowner needs to go to a nursing home, the home would have to be sold and the loan repaid. This may leave little or nothing to cover nursing home expenses and the consumer would have to plan for Medicaid. There are currently six (6) types of reverse mortgages available to people age 62 and older. Two (2) of these mortgages are government insured; one (1) is offered by Fannie Mae and three (3) are proprietary programs which are owned by Lehman Brothers. The most popular reverse mortgage is the FHA annual program. A reverse mortgage allows a senior to immediately liquidate a portion of his/her home's equity and never have to make a monthly mortgage payment as long as the home is occupied as the primary residence.

The amount of money a person can receive is based on age, interest rate, value of the property, life expectancy to 100, and choice of program. The house does not need to be free and clear in order to obtain a reverse mortgage and, in fact, in many circumstances the reverse mortgage will only pay off the current mortgage. However, this could easily free up hundreds of dollars a month for the borrower. It is still the borrower's responsibility to pay property taxes and hazard insurance.

The borrower has options as to how he or she would like to receive the proceeds from a reverse mortgage. These include:

- lump sum;
- monthly payments to the borrower;
- line of credit; or
- combination of the above.

When the last person on the note no longer occupies the home as a primary residence, the note is due and payable. The heirs may choose to sell the home or choose to obtain their own loan and keep the home. In either case the reverse mortgage is paid off and all remaining equity goes to the heirs, estate, or borrower. In the unlikely event that the home sells for less than is owed, FHA's insurance will pay the difference. A reverse mortgage may be the only lien on the property. Once a reverse mortgage has been closed, a home equity line of credit cannot be obtained.

SELLING YOUR HOME?

Single individuals without heirs or couples who are willing to change their lifestyle might consider selling their home and using the proceeds to pay for care or to purchase long-term care insurance. Obviously, it is most advantageous to sell your home when it is at its highest market value.

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An investor purchases your home and you continue to live in it, renting it on a long-term lease. When you no longer live in the home the investor possesses the property. This frees the renter from home maintenance costs and property taxes. The proceeds from the sale can be used to finance long-term care or to buy insurance. If your children become the investors and purchase your home, it can remain in the family. However, it is important to consider potential taxes on the proceeds you collect from the sale, as well as the fact that you may lose public assistance. Also, if the property is neglected, you may find it difficult to live there.

The Budget Deficit Reduction Act of 2005 mandated rule changes governing promissory notes, loans or mortgages when an individual applies for long-term care assistance through Medicaid. The value of a promissory note, loan or mortgage established after April 1, 2006 is counted as a resource unless it meets certain criteria:

- It has a repayment term that is based on the individual's life expectancy.
- It provides for payments to be made in equal amounts during the term of the loan – no deferred or postponed or balloon payments.
- It prohibits the cancellation of the balance due upon the death of the lender.

Under rules mandated by the Budget Deficit Act of 2005, purchasing a life estate interest in an individual's home is considered to be a "transfer without fair consideration" unless the purchaser lives in the home for at least one year after the purchase date. The prior rules contained no such provision.

You may check with your County Department of Human Services as to how rule changes under the Budget Deficit Reduction Act may impact you.

LIFE INSURANCE

ACCELERATED DEATH BENEFIT

A tax-free cash advance on your life insurance policy's death benefit is another option to finance needed care. Eligibility to draw a cash advance is determined by a poor health condition, such as a terminal illness; life-threatening diagnosis (e.g., AIDS); permanent confinement to a nursing home or permanent functional loss. The payment amount varies according to your contract provisions. For activity of daily living loss, a typical monthly benefit might be 2 percent of the face value for nursing home and 1 percent for home care. So, for example, with a $200,000 face value, you would collect $4,000 a month for nursing care and $2,000 for home care. The problem is that since benefits are more limited than typical long-term care insurance policies, the amount may not be sufficient to cover costs.

Inflation protection is offered infrequently. If you use the death benefit up entirely, there is nothing left for survivors. It's important to make sure there are funds to pay premiums on the life insurance policy to keep it from lapsing. This type of arrangement may affect your eligibility for Medicaid.

LIFE SETTLEMENTS

If you are a female age 74 or older or a male age 70 or older, and no longer have the need for a life insurance policy, you might consider selling it for its present value. The use of the proceeds is not restricted; therefore, you could pay for long-term care or buy a long-term care insurance policy. Since there are tax consequences, depending on the income status of the individual, this may not be the best option for everyone. If you are considering a life settlement, you should check with a qualified professional before making a decision.

VIATICAL SETTLEMENTS

In this arrangement your life insurance policy is sold to a third party for a fraction (50% or less) of the death benefit. The proceeds are tax-free, however, you must be terminally ill to use this option. It might be suitable for someone who doesn't qualify for long-term care insurance. Often the settlement is insufficient to cover long-term care needs. Only half of applicants are approved for viatical settlements and there are many requirements regarding the face value, how long the policy has been owned and more. Finally, beneficiaries would no longer receive a death benefit. If you are considering a viatical settlement, you should check with a qualified professional before making a decision.

SINGLE PAY LIFE/LONG- TERM CARE INSURANCE POLICIES

A lump sum deposit purchases a death benefit and at least double the amount becomes available for long-term care expenses. If long-term care is needed immediately, the policy could pay as much as four years of benefits at 2 percent per month of the long-term care amount. The longer the policy is held without a claim, the more accumulation and the longer the benefit period becomes. In order for the benefit to be meaningful you would have to invest a large lump sum, in the range of $100,000 for a 60-year old couple. If long-term care is imminent the benefit may not be sufficient. Inflation protection may be included in the lump sum, or paid separately and require ongoing funding.

LONG-TERM CARE ANNUITIES

Deferred annuities may be available in some states. One type is designed for those 85-years and older who can satisfy broad health questions. It includes two funds, one for long-term care expenses and the other, a regular cash fund. The long-term care expense fund grows at a higher interest rate for a specified period while the regular cash fund grows at 3 percent. The long-term care fund allows for immediate use of the funds for licensed long-term care services. Actual expenses are paid up to a monthly limit for a minimum of 36 months. If they are never used, the money can be passed to beneficiaries. You need to plan for inflation because depending on the length of needed care and the amount of the annuity the benefit could be insufficient to cover expenses. Consult a professional advisor to consider the tax implications.

An immediate annuity is available to an individual who is uninsurable or already receiving long-term care. A single-premium payment is converted into monthly income, guaranteed for the life of the policyholder. Since it is medically underwritten, a person who is impaired may receive a higher monthly income that a healthy person with a regular annuity. The pay-out schedule is based on age and gender. A beneficiary would receive a portion of the money if the policyholder died earlier than the insurance company expected. Again, it is important to plan for inflation in order to cover costs. Tax treatment is complicated and professional advice should be sought.

The Budget Deficit Reduction Act of 2005 made a number of changes in the way annuities are handled when an individual applies for long-term care assistance through Medicaid. The law requires that the purchase of an annuity after February 8, 2006 be treated as a transfer of assets without fair consideration unless the annuity meets certain criteria. You should contact a qualified professional or your County Department of Human Services for details.

TRUSTS

Trusts are legal arrangements by which assets are transferred from one party to another for the benefit of a third party.

The Budget Deficit Reduction Act of 2005 changed many of the rules for the handling of trusts when an individual applies for assistance through Medicaid for long-term care. If you are considering establishing a trust prior to applying to Medicaid for assistance, you should check with a qualified professional or your County Department of Human Services to determine how such a trust would impact your application.

MEDICAID DISABILITY TRUST

A Medicaid disability trust is the only type of trust exempt from Medicaid transfer rules. Its purpose is to enhance the life of a disabled person while maintaining eligibility for public programs. It can be set up for a disabled person under the age of 65 by a parent, grandparent or legal guardian. Any Medicaid benefits paid are recoverable by the state upon the death of the disabled individual. The trust is managed by a nonprofit entity that maintains a separate account for each beneficiary. The assets are pooled for management and investment purposes. Upon the death of the beneficiary, the state must be reimbursed for Medicaid payments made on behalf of the disabled individual. Disabled persons can be over 65 and may fund the trust themselves. Since Medicaid benefits must be reimbursed, not all money is sheltered. It is important to seek legal counsel in your state to set up this type of trust.

CHARITABLE REMAINDER TRUST

When a large sum of money is gifted to a public charity at fair market value the grantor receives a payment from the trust based on the current market value. The payment could be used to fund long-term care expenses. The grantor receives a tax deduction based on the market value of the gift and the charity receives the balance of the trust funds upon the grantor’s death. This trust is subject to a 5-year look-back period for Medicaid eligibility purposes.

SELF-FUNDING

Those who have planned and saved considerable assets can pay for their own care. There are, however, a lot of unknowns in planning the amount you will need, such as the future cost of care and the length of time you will need it.

CONTINUING CARE RETIREMENT COMMUNITIES (CCRC)

CCRCs provide a full continuum of services that include housing, health care, and social services all in the same location allowing a person to “age in place.” There are typically entrance fees and monthly payments, and fees are subject to periodic increases. Depending on the contract, home care may not be provided. Usually you must be healthy to enter a CCRC and have enough in assets to afford the entrance and monthly fees. A percentage of the entrance fee may or may not be refundable if the resident dies or moves. It is important to do business with reliable communities to assure that living conditions remain stable in the future.

SPECIAL PURPOSE LOANS

Known as Deferred Payment Loans, these low interest loans are provided by government agencies to low to moderate-income people. They don’t have fees and premiums like reverse mortgages. The onetime lump sum payment can be used for home improvements such as ramps or grab bars, not for long-term care costs. With modifications to the home a person may be able to stay in the home longer. Since there are income qualifications, this type of loan is not for everyone. The loan is due when you move from the house, including to a nursing home.

GLOSSARY

Activities of Daily Living (ADL) means bathing, continence, dressing, eating, toileting, and transferring. Many long-term care insurance policies use the inability to perform a certain number of ADL's (such as 2 of 6) to decide when to pay benefits.

Adult Day Care describes licensed or state-certified, non-residential day care that provides 6 to 12 hours of care per day; maintains and monitors a written plan of care for each client, provides assistance with activities of daily living; and has a client to staff ratio of at least 1 staff member for every 8 clients.

Alternate Plan of Care refers to payment of benefits for appropriate long-term care services that are not specifically mentioned in the policy if the insured, the insured's doctor, and the insurance carrier agree to the care.

Assisted Living Facility is a residential living arrangement that provides individualized personal care and health services for people who need help with their activities of daily living but who do not necessarily need the level of care provided by nursing homes.

Bathing means washing oneself by sponge bath, either in a tub or shower, including the task of getting into or out of the tub or shower.

Bed Reservation Feature refers to payment of daily benefits to reserve accommodations in the nursing home during a period of hospitalization.

Benefit Triggers is a term used by insurance companies to describe the criteria and methods they use to determine when you are eligible to receive benefits.

Caregiver Training describes training of a designated person, agreed to by the insurance company, in the proper use and care of supportive equipment, medical aids, assistance with activities of daily living or other supportive needs of the insured. It does not include informal care provided by a caregiver.

Care Management Services refer to a professional nurse or social worker that may arrange, monitor, or coordinate long-term care services. Also referred to as coordination services.

Chronically Ill Individual is a term used in a tax-qualified long-term care contract to describe an individual who has been certified by a licensed health care practitioner as: being unable to perform without substantial assistance from another individual at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity; or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(1) Substantial assistance includes hands-on assistance or standby assistance.
- (a) Hands-on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL.
- (b) Standby assistance means the presence of another person within arm's reach of the chronically ill individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

(2) Substantial supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety.

Cognitive Impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Continence means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Elimination Period is a deductible period, that is, the length of time the individual must pay for covered services before the insurance company will pay.

Home Care Services mean medical and non-medical services provided to ill and disabled persons in the home. They include nursing services, physical, occupational, respiratory, and speech therapy services, homemaker services, assistance with activities of daily living, personal care services, and adult day care services. There may be licensing or certification restrictions on the agencies or individuals that provide these services.

Home Modification and Supportive Equipment/Supportive Services Benefit describes home modification and rental, lease, purchase, and installation of supportive equipment that is used to provide covered long-term care services. It might include lifeline alerts, informal caregiver training, medical equipment or devices, medical transportation, "Meals-on Wheels," and other services or devices to support the needs of people living with disabilities at home.

Hospice describes skilled or unskilled care of a terminally ill patient through a home health or community hospice organization.

Inflation Protection is an option in long-term care insurance to increase benefit levels to keep up with expected increases in the costs of future care.

Non-forfeiture Benefit describes an optional feature intended to cut your losses if you let your long-term care policy lapse. If your policy lapses within the grace period, after being in force for at least three years, it will remain in force with a reduced policy limit that is equal to the sum of the premiums you have paid.

Restoration Benefit restores the initial maximum policy benefits if after using your long-term care benefits you go 180 days without needing or receiving long-term care. This is a fairly illusory benefit.

Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring means moving into or out of a bed, chair or wheelchair.

Underwriting refers to the process of examining, accepting or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

ABOUT THE S & P RATINGS

Standard and Poors is a private company, and the ratings are their opinions. The Colorado Division of Insurance does not endorse these ratings, and is making them available for the convenience of consumers. Ratings were obtained from an Internet search of Standard and Poors website: www.standardandpoors.com; 'pi' ratings are based on an analysis of published financial information and additional information in the public domain. They do not reflect in-depth meetings with an insurer's management and are, therefore, based on less comprehensive information.

AAA (Highest rating): An insurer rated: 'AAA' has EXTREMELY STRONG financial security characteristics.

AA: An insurer rated 'AA' has VERY STRONG financial security characteristics, differing only slightly from those rated higher.

A: An insurer rated 'A' has STRONG financial security characteristics, but is somewhat more likely to be affected by adverse business conditions than are insurers with higher ratings.

BBB: An insurer rated 'BBB' has GOOD financial security characteristics, but is more likely to be affected by adverse business conditions than are higher rated insurers.

BB: An insurer rated 'BB' has MARGINAL financial security characteristics. Positive attributes exist, but adverse business conditions could lead to insufficient ability to meet financial commitments. An insurer rated 'BB' or lower is regarded as having vulnerable characteristics that may outweigh its strengths.

CCC: An insurer rated 'CCC' has VERY WEAK financial security characteristics. Adverse business conditions will likely impair its ability to meet financial commitments.

NR: An insurer rated 'NR' is NOT RATED, which implies no opinion about the insurer's financial security.

ABOUT THE A.M. BEST RATINGS

A.M. Best is a private company, and the ratings are their opinions. The Colorado Division of Insurance does not endorse these ratings, and is making them available for the convenience of consumers. Ratings were obtained from an Internet search www.ambest.com. Under Review (u) Rating Modifiers are assigned to Best's Ratings to identify companies whose rating opinions are Under Review and may be subject to near-term change.

A++ and A+ (Superior): Assigned to companies that have, in Best's opinion, a superior ability to meet their ongoing obligations to policyholders.

A and A- (Excellent): Assigned to companies that have, in Best's opinion, an excellent ability to meet their ongoing obligations to policyholders.

B++ and B+ (Very Good): Assigned to companies that have, in Best's opinion, a good ability to meet their ongoing obligations to policyholders.

B and B- (Fair): Assigned to companies that have, in Best's opinion, a fair ability to meet their ongoing obligations to policyholders but are financially vulnerable to adverse changes in underwriting and economic conditions.

C++ and C+ (Marginal): Assigned to companies that have, in Best's opinion, a marginal ability to meet their ongoing obligations to policyholders but are financially vulnerable to adverse changes in underwriting and economic conditions.

C and C- (Weak): Assigned to companies that have, in Best's opinion, a weak ability to meet their ongoing obligations to policyholders but are financially vulnerable to adverse changes in underwriting and economic conditions.

D (Poor): Assigned to companies that, in Best's opinion, may not have an ability to meet their current obligations to policyholders and are financially extremely vulnerable to adverse changes in underwriting and economic conditions.

E (Under Regulatory Supervision): Assigned to companies (and possibly their subsidiaries or affiliates) that have been placed by an insurance regulatory authority under a significant form of supervision, control or restraint, whereby they are no longer allowed to conduct normal ongoing insurance operations. This would include conservatorship or rehabilitation, but does not include liquidation. It may also be assigned to companies issued cease and desist orders by regulators outside their home state or country.

F (In Liquidation): Assigned to companies that have been placed under an order of liquidation by a court of law or whose owners have voluntarily agreed to liquidate the company. Note: Companies that voluntarily liquidate or dissolve their charters are generally not insolvent.

S (Rating Suspended): Assigned to rated companies that have experienced sudden and significant events affecting their balance sheet strength or operating performance whose rating implications cannot be evaluated due to a lack of timely or adequate information.

Exhibit 1: Colorado-Licensed Companies Marketing Long-Term Care Insurance			
Companies Revised January 2009			
Company	Financial Strength		National Market Share
	S&P Rating	AM Best Rating	
Allianz Life Insurance Company of N.A.* (800) 950-7372	AA	A	2.51%
American Fidelity Assurance Company (800) 654-8489	Api	A+	Not Reported**
American General Life Insurance Co. (800) 231-3655	A+	A	Not Reported**
Assurity Life Insurance Company (800) 869-0355	--	A-	Not Reported**
Auto-Owners Life Insurance Company (303) 694-0940	Api	A+	0.01%
Bankers Life & Casualty Co.* (800) 621-3724	BB+	B+	4.79%
Berkshire Life Insurance Company of America (800) 819-2468	--	A++	0.37%
Combined Insurance Company of America (800) 490-1322	A	A	0.26%
Country Life Insurance Company (800) 345-2436	Api	A+	Not Reported**
Equitable Life & Casualty Insurance Co.* (800) 352-5170	BBpi	B++	2.02%
Genworth Life Insurance Co. of NY* (800) 543-2901	AA-	A+	17.52%
Great American Life Insurance Company (800) 880-2745	A	A	Not Reported**
Guarantee Trust Life Insurance Company (Not Available)	Bpi	B+	0.00%
John Hancock Life Insurance Co.* (800) 377-7311	AAA	A++	10.83%
Knights of Columbus (866) 610-8402	AAA	A++	Not Reported**
LifeSecure Insurance Co.* (800) 582-7702	--	--	Not Reported**
Massachusetts Mutual Life Insurance Co.* (888) 505-8952	AAA	A++	1.08%

* Companies marketing Long Term Care Partnership policies in CO.
**Not all LTC data os required to be filed in Colorado, per the NAIC Annual Statement Instructions.

Exhibit 1: Colorado-Licensed Companies Marketing Long-Term Care Insurance			
Companies Revised January 2009			
Company	Financial Strength		National Market Share
	S&P Rating	AM Best Rating	
MedAmerica Insurance Co.* (800) 544-0327	A-	A-	1.02%
Metropolitan Life Insurance Co.* (800) 308-0179	AA	A+	8.62%
Minnesota Life Insurance Co.* (local agents)	AA-	A+	0.01%
Mutual of Omaha Insurance Co.* (800) 775-6000	AA-	A+	2.19%
National States Insurance Company (800) 868-6788	--	B-	0.07%
New York Life Insurance Co. (800) 710-7945	AAA	A++	1.14%
Northwestern Long Term Care Insurance Co. (local agents)	AAA	A++	1.45%
Physicians Mutual Insurance Co.* (800) 228-9100	--	A	0.75%
Provident Life and Accident Insurance Co. (800) 633-7490	A-	A-	0.32%
State Farm Mutual Automobile Insurance Co.* (local agents)	AA	A++	2.28%
The Prudential Insurance Co. of America* (800) 732-0416	AA	A+	0.64%
Transamerica Life Insurance Co.* (800) 227-3740	AA	A+	0.67%
United Health Care Insurance Co.* (800) 545-5205	A+	A	Not Reported**
United of Omaha Life Insurance Co.* (800) 775-6000	AA-	A+	0.19%
United Teacher Associates Insurance Co. (800) 880-8824	--	A-	0.86%
UNUM Life Insurance Co. of America* (800) 784-8686	A-	A-	3.76%

* Companies marketing Long Term Care Partnership policies in CO.
**Not all LTC data os required to be filed in Colorado, per the NAIC Annual Statement Instructions.

EXHIBIT 2- Cost of Long Term Care, 2008 Averages and Percentage Increases				
LONG TERM CARE SERVICES	**2008 Annual Rate Averages**			**Five Year Annual Growth (CO Median Only)**
	National	**Denver**	**CO-Outside Denver**	
Nursing Home (Semi-Private Room)	$68,255.00 **($187 Day)**	$66,527.00 **($182 Day)**	$64,058.00 **($176 Day)**	4.5%
Nursing Home (Private Room)	$76,285.00 **($209 Day)**	$72,359.00 **($198 Day)**	$75,259.00 **($206 Day)**	4%
Assisted Living (One-Bedroom Unit)	$36,096.00 **($3,008 Month)**	$40,703.00 **($3,392 Month)**	$37,621.00 **($3,105 Month)**	7%
Home Health Aide (Medicare Certified Agencies)	$38 Hour	$36 Hour	$33 Hour	**Not Available[1]**
Home Health Aide (Non-Certified, but Licensed)	$19 Hour	$21 Hour	$19 Hour	4%
Homemaker Services (Non-Certified, but Licensed)	$18 Hour	$19 Hour	$18 Hour	3.5%

[1]Growth rate information is not available for this set of services due to the variance in responsibilities fulfilled by this kind of provider (Medicare-covered services as well as services not covered by Medicare). The contrasts in services offered would create a skew in accuracy based on the way the information in the publication is compiled.

Source: Genworth Financial 2008 Cost of Care Survey. Visit http://www.genworth.com/costofcare for more information.