Chapter 2: Long-Term Care

Corrections were made to this material through January of 2012. No subsequent modifications were made.

Note. Much of the material in this chapter was drawn from material prepared by Professor Richard Kaplan, the Peer and Sarah Pedersen Professor of Law at the University of Illinois. Professor Kaplan is an internationally recognized expert on U.S. taxation and tax policy who has lectured in these areas on three continents, testified before the U.S. Congress on several occasions, and written innovative course books on income taxation and international taxation.

FUNDING LONG-TERM CARE[1]

Prospective retirees have a wealth of information available to aid in planning for their retirement. However, many of the calculations involved in the determination of what constitutes sufficient retirement resources utilize very rough estimates of several critical factors. One factor that is often overlooked is the cost of future health care. Fidelity Investments estimates that a 65-year-old couple will need $230,000 to pay for medical expenses throughout retirement, **not including nursing home care.**[2] Prospective retirees are left largely on their own to consider what to do about this looming issue. Failure to adequately plan for long-term care (LTC) can potentially eclipse all the carefully constructed parameters of preretirement calculations.

As clientele age, tax practitioners are faced with issues other than the tax consequences of specific transactions. The purpose of this chapter is to offer resources and insight into questions elder clients ask their tax preparers. To that end, this chapter explores some of the corrective actions that should be considered by prospective retirees and their advisors in dealing with the funding of LTC.

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1. This section is drawn largely from an article by Richard L. Kaplan. *See* Kaplan, Richard L (2007). Retirement Planning's Greatest Gap: Funding LTC. *Lewis & Clark Law Review, 11,* (407); University of Illinois Law & Economics Research Paper No. LE07-019; Illinois Public Law Research Paper No. 07-14. SSRN. [http://papers.ssrn.com/sol3/papers.cfm?abstract_id=993179] Accessed on Sep. 13, 2011.

2. Assumes no employer-provided retiree health care coverage and life expectancies of 17 years for men and 20 years for women. Fidelity Investments. [www.fidelity.com/inside-fidelity/individual-investing/2011-rhcce] Accessed on Aug. 5, 2011.

MEDICARE

Subject to significant preconditions and restrictions, Medicare covers home care and nursing homes. It does not cover assisted living or any other alternatives for LTC.

Home Care

Medicare provides a range of services to enrollees who are confined to their homes. Eligibility for these services is restricted to persons who meet all of the following conditions.[3]

1. Are under a doctor's care and are getting services under a plan established and reviewed regularly by a doctor
2. Have a doctor's certification that one or more of the following are needed
   a. Intermittent skilled nursing care
   b. Physical therapy
   c. Speech-language pathology services
   d. Continued occupational therapy
3. Are cared for by a Medicare-certified home health agency
4. Have a doctor's certification that the person is homebound

Persons who need more than part-time or intermittent skilled nursing care are not eligible for the Medicare home health benefit. Part-time or intermittent skilled nursing care is generally defined as care of less than eight hours per day and no more than 28 hours per week. Hour and day limits can be extended in certain circumstances when the need for care is finite and predictable.[4]

Medicare covers the following home health services for eligible individuals.[5]

- Skilled nursing care
- Physical therapy, occupational therapy, and speech-language pathology services
- Medical social services
- Medical supplies

Nursing Homes

Medicare covers care in a skilled nursing facility (SNF) if all four of the following conditions are met.

1. The SNF must be approved by Medicare.
2. A patient must be admitted to the SNF within 30 days of discharge from a hospital.
3. The required hospital stay must last at least three days, not counting the day of discharge.
4. The patient must require skilled nursing care. These services must be needed on a daily basis for a condition that was treated during the preceding hospital stay.

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3. [www.medicare.gov/Publications/Pubs/pdf/10969.pdf] Accessed on Apr. 20, 2011.
4. 42 USC §1395x(m).
5. [www.medicare.gov/Publications/Pubs/pdf/10969.pdf] Accessed on Apr. 20, 2011.

Even if a person meets the above conditions, Medicare pays the entire cost of the SNF for only 20 days in a "spell of illness." A **spell of illness** begins with the day the individual is admitted to the nursing home and ends at the close of 60 consecutive days when the person has been out of the hospital, SNF, or other rehabilitative facility.[6]

Medicare covers the cost of an additional 80 days at an SNF, subject to a per-day deductible. For 2011, the deductible is $141.50 per day[7] and is adjusted annually for inflation. At the end of the 100-day benefit period, Medicare coverage ceases.

MEDICAID

Medicaid is funded jointly by the federal and state governments. As a result of the dual funding, Medicaid has both **federal and state rules** that establish eligibility and coverage. However, despite the variation in Medicaid services across the United States, there are some general patterns that are fairly consistent.

Home Care

Medicaid covers home health visits for functionally disabled elderly individuals and certain other older individuals.[8] A **functionally disabled elderly individual** is one who meets the following conditions.

1. Is at least 65 years old
2. Is receiving supplemental security income benefits
3. Has a functional disability, which means the individual:
   - **a.** Is unable to perform without substantial assistance at least two of the following three activities of daily living: toileting, transferring, and eating; or
   - **b.** Has a primary or secondary diagnosis of Alzheimer's disease.

The home care provided by Medicaid is more extensive than Medicare's and can include home health aide services and even some personal care services. Some states cover homemaker services, adult day care, and respite care for family caregivers.

Nursing Homes

Medicaid has no major restrictions on the scope of its nursing home coverage. However, it is restricted to people with minimal financial assets. The restrictions vary by state and depend on the applicant's marital status.

Unmarried Applicants. To qualify for the program, a Medicaid applicant without a spouse may own only a few assets. Persons with assets in excess of the limits must "spend down" their resources until they fall within Medicaid's stipulated allowance parameters. The federal allowances include the following.

- $2,000 in cash or market value of investments
- Automobile used for transportation by the applicant or household member
- Burial plot
- Up to $1,500 for burial expenses
- Life insurance policy with face value of $1,500 or less
- Residence with an equity value of $500,000 or less if the applicant expects to return to it

> **Note.** The Illinois allowances can be accessed at **www.dhs.state.il.us/page.aspx?Item=14874.**

6. 42 USC §1395x(a)(2) (2000).
7. [www.medicare.gov/publications/pubs/pdf/10050.pdf] Accessed on Apr. 20, 2011.
8. 42 USC §1396t (2000).

Once a person qualifies for Medicaid coverage for nursing home costs, essentially all of the person's income must be applied against the nursing home expenses. States permit the retention of a monthly allowance for personal needs, but this amount is usually $50 per month or less.

Example 1. Lucas is a Medicaid-qualified resident of Pleasant Valley Nursing Home. He receives social security benefits of $1,000 per month and a private pension of $930 per month. The personal needs allowance in his state is $30 per month; thus, the remaining $1,900 of his income is applied to his nursing home expenses. The Medicaid reimbursement rate for the Pleasant Valley facility is $100 per day, or $3,000 per month ($100 per day × 30 days). Medicaid pays $1,100 of the cost of Lucas's care ($3,000 cost − $1,900 paid from Lucas's income).

Note. Many familiar exclusions and exemptions from taxable income have no application to Medicaid. Income from tax-exempt sources is considered a countable resource that must be "spent down" before an applicant is eligible for Medicaid benefits.

Applicants with a Community Spouse. A "community spouse"[9] is defined as a spouse of the opposite sex who remains in the community while the applicant is in a nursing home. The phrase "community spouse" for Medicaid purposes is unrelated to the phrase "community property" as used to describe property laws in certain states.

The Medicaid restrictions are different for an applicant with a community spouse because it is recognized that the spouse needs a certain level of resources. However, the basic components of the Medicaid system mirror those described above for unmarried applicants, which are summarized as follows.

- Assets in excess of stipulated limits must be spent down to establish Medicaid eligibility.
- An applicant's income is applied almost entirely to the nursing home charges.
- Taxable income exclusions and exceptions are not relevant to Medicaid.

There are some protections that exist to avoid impoverishing the community spouse. The community spouse may retain the following assets.

- A residence, regardless of value
- An automobile, regardless of value
- A burial plot and burial expense arrangement
- A community spouse resource allowance (see below)

Community Spouse Resource Allowance. The community spouse resource allowance (CSRA) consists of cash, bonds, stocks, mutual funds, and other investments up to limits set by the applicant's state of residence. The CSRA must fall within a range established by the Medicaid statute and is adjusted annually for inflation. In 2010, the range nationwide was $21,912 to $109,560.[10]

Minimum Income Standard. States generally allow community spouses to keep whatever income is in their own names. Also, Medicaid allows some of the applicant's income to be transferred to the community spouse if the spouse's income falls below certain standards. This minimum income standard, like the CSRA, is set by the applicant's state from within a specified range. It is adjusted annually for inflation; in 2010, the range nationwide was $1,821 to $2,739 per month.[11]

Because the transfer of the applicant's income to the community spouse leaves less of the applicant's income available to pay nursing home costs, Medicaid pays a larger portion of the applicant's nursing home expenses.

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9. The term "community spouse" applies only to a person of the opposite sex of the Medicaid applicant because a federal statute known as the "Defense of Marriage Act" applies to all federal programs, including Medicaid. See PL No. 104-199, §3(a), 110 Stat. 2419 (1996) (amending 1 USC § 7).

10. [www.cms.gov/MedicaidEligibility/downloads/1998-2010SSIFBR122909.pdf] Accessed on Aug. 5, 2011.

11. Ibid.

Medicaid Restrictions

Medicaid has two major restrictions that further limit its viability as a funding source for LTC expenses. First, it penalizes applicants who transfer assets to family members and friends in order to accelerate their Medicaid eligibility. Second, Medicaid benefits are recovered from beneficiaries' estates after they die.

Transfer Penalties. In response to Medicaid's severe asset limitations and corresponding spend-down requirements, some people attempt to transfer resources to relatives before seeking Medicaid benefits. However, Medicaid imposes a transfer penalty that makes a person who transfers assets for less than fair market value (FMV) during the "look-back period" ineligible for Medicaid benefits for a certain period of time. The number of months of ineligibility is computed as follows:[12]

- The total uncompensated value of all assets transferred by the individual (or the individual's spouse) during the look-back period, **divided by**
- The average monthly cost to a private patient of nursing facility services in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application.

The starting date of the period of ineligibility is the date on which the Medicaid applicant would otherwise be eligible for Medicaid.

Look-Back Period. For transfers of assets made after February 7, 2006, the look-back period is 60 months from the date the individual is either institutionalized or applies for medical assistance under the state plan.[13]

> **Example 2.** Matilda gave $100,000 to her son 59 months before she would otherwise be eligible for Medicaid. The average private pay nursing home cost in Matilda's state of residence is $5,000 per month. Matilda is ineligible for Medicaid benefits for 20 months ($100,000 ÷ $5,000 monthly nursing home cost).

Exceptions to the Transfer Penalty. No period of ineligibility is triggered if assets are transferred by a Medicaid applicant to the following recipients.[14]

- Spouse of the individual (or to another person for the sole benefit of the individual's spouse)
- Child of the individual (or to a trust for the benefit of a child) who is blind or disabled
- Trust established solely for the benefit of a disabled individual under age 65

In addition, a Medicaid applicant may transfer their home to the following individuals without triggering a period of ineligibility.[15]

1. Spouse of the individual
2. Child of the individual who is either:
   a. Under age 21, or
   b. Blind or disabled.
3. Sibling of the individual who has an equity interest in the home and who was residing in the home for at least one year before the individual was institutionalized
4. Son or daughter who was residing in the home for at least two years prior to the date the individual was institutionalized and who provided caretaking services which permitted the individual to reside at home

12. 42 USC §1396p(c)(1)(E)(i).
13. 42 USC §1396p(c)(1)(B).
14. 42 USC §1396p(c)(2)(B).
15. 42 USC §1396p(c)(2)(A).

Federal law allows state Medicaid agencies to grant a waiver from the penalty period in the case of "undue hardship." **Undue hardship** exists if enforcement of the penalty period would deprive the Medicaid applicant of:[16]

- Necessary medical care, or
- Food, clothing, shelter, or necessities of life.

State Medicaid agencies are required to approve or deny an application for a hardship waiver within a reasonable time. Nursing homes may pursue the hardship waivers on behalf of a resident.[17]

Estate Recovery. States are required to recover Medicaid expenditures from whatever assets are owned by a Medicaid recipient at death. However, any recovery is made only after the death of the individual's surviving spouse and at a time when **both of the following are true.**[18]

1. The individual has no surviving child who is under age 21 or is blind or disabled.
2. In the case of a lien against an individual's home,[19] none of the following persons have lawfully resided in the home continually since the date of the individual's admission to the institution.
   a. Sibling of the individual who was residing in the home for at least one year prior to the individual's admission to the institution
   b. Son or daughter who was residing in the home for at least two years prior to the date the individual was institutionalized and who provided caretaking services which permitted the individual to reside at home

There is no de minimis level of assets that is beyond the scope of Medicaid's estate recovery provisions.

Asset Protection Options

The following section described these types of asset protection options.

- Immediate annuity
- Life estate
- Supplemental needs trust
- Caregiver agreement

Immediate Annuity. A Medicaid applicant can convert assets into an immediate annuity for the benefit of themselves or their spouses. An **immediate annuity** is one that is purchased with a single premium and requires distributions to begin within one year of the annuity's purchase.

16. [www.elderlawanswers.com/Elder_Info/Elder_Article.asp?id=2751] Accessed on May 27, 2011.
17. Ibid.
18. 42 USC §1396p(b)(2).
19. See 42 USC §1396p(a)(1) authorizing real estate liens on the residences of Medicaid patients who are living in nursing homes.

The purchase of an immediate annuity is not treated as the transfer of assets for less than FMV if the following conditions are met.[20]

- The annuity must be irrevocable and nonassignable.
- The annuity must be nontransferable.
- The annuity must be actuarially sound.
- The annuity must provide for payments in equal amounts during the term of the annuity.
- The state must be named as the remainder beneficiary for at least the amount of Medicaid benefits paid on behalf of the institutionalized individual. If the Medicaid recipient has a community spouse or a minor or disabled child, the state must be named as a secondary beneficiary.

The annuity must be disclosed by a Medicaid applicant.

Life Estate. A life estate is a form of joint ownership of property between two or more people. The person who holds the life estate has possession of the property during their lifetime. The other owner (remainder owner) takes possession after the death of the life estate holder.

Some states may use the narrow federal definition of "estate" and limit Medicaid estate recoveries to only those assets that pass through probate. Other states define "estate" in a broader context, which enables them to recover from some or all property that bypasses probate, such as a life estate.[21]

Deeding a remainder interest in a home constitutes a gift of the value of the remainder interest. Such a gift is counted against an applicant for Medicaid if it is made during the look-back period. The federal government publishes a table that lists the factors used in valuing a life estate and remainder interest from ages 0 to 109.[22]

> **Example 3.** Lionel is 70 years old and owns a home valued at $300,000. He is a widower and sets up a life estate for his home, naming his daughter, Leigh Anne, as the remainder owner. The factor for a remainder interest for a person aged 70 is .39478.[23] Lionel made a gift to Leigh Anne valued at $118,434 ($300,000 × .39478).
>
> Four years after setting up the life estate, Lionel suffers a major stroke and has to enter a nursing home. He is otherwise eligible for Medicaid assistance except that the gift to Leigh Anne was made during the look-back period. If the average cost of a private-pay nursing home in Lionel's state of residence is $5,750 per month, he will be ineligible for Medicaid benefits for 20.6 months ($118,434 ÷ $5,750).

Supplemental Needs Trust. Assets placed in a trust are exempt from Medicaid transfer penalties if the following conditions are satisfied.[24]

- The trust contains the assets of a disabled individual who is under age 65.
- The trust is established by a parent, grandparent, legal guardian, or court.
- The state receives all amounts remaining in the trust upon the death of the individual up to the amount of medical assistance paid under a state plan on behalf of the individual.

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20. 42 USC §1396p(c)(1)(F)-(G); [www.elderlawanswers.com/Elder_Info/Elder_Article.asp?id=2751] Accessed on May 27, 2011.
21. [http://aspe.hhs.gov/daltcp/reports/estaterec.htm] Accessed on May 27, 2011.
22. [https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140120!opendocument] Accessed on Jun. 8, 2011.
23. Ibid.
24. 42 USC §1396p(d)(4)(A).

A disabled individual can transfer their own assets into a supplemental needs trust (although the trust must be established by someone else) without incurring Medicaid transfer penalties.[25] A supplemental needs trust can be used to pay for goods and services that are not covered by Medicaid, thus improving the beneficiary's quality of life.

> **Caution.** The rules for supplemental needs trusts are complex and vary from state to state. The foregoing brief discussion is intended merely to aid the estate planner in identifying a potential option that must be carefully investigated under the relevant state statutes.

Although a carefully constructed supplemental needs trust may protect the beneficiary's assets for purposes of Medicaid eligibility, the assets of the trust may be included in the beneficiary's gross estate for federal estate tax purposes. In a recent letter ruling,[26] funds contributed to a supplemental needs trust as compensation for a decedent's personal injuries were includible in the decedent's gross estate under IRC §2036. However, the amount that the trustee was required to reimburse the state Medicaid program for medical assistance provided to the decedent was deductible under IRC §2053(a)(2) as a claim against the estate.

Caregiver Agreement. A caregiver agreement is generally a written contract between an elderly person who needs care and the caregiver, who is often an adult child or another family member. The agreement should specify, at a minimum, the duties to be performed, the amount of compensation to be paid, and the timing of the payments.

A properly executed caregiver agreement can compensate the family caregiver and, at the same time, reduce an individual's countable resources for Medicaid purposes. A caregiver agreement has to follow certain formalities for it to satisfy Medicaid authorities. For example, the caregiver cannot be paid an inflated rate in order to shift money out of the estate. Rather, local home-care agencies or geriatric-care managers should be contacted to determine the market value of the specific duties that the caregiver will perform.[27]

Taxpayers who make payments for **qualified LTC services** (defined later in this chapter) may itemize these payments as medical expenses. However, amounts paid for LTC services do **not** qualify for the deduction if paid to the spouse or a relative[28] of the individual unless the service is provided by a licensed professional.[29]

The caregiver must report the compensation as income. The payroll tax issues and reporting requirements applicable to home-care workers are discussed later in this chapter.

> **Caution.** Caregiver contracts may have serious tax and legal ramifications. When drawing up the contract, it is advisable to consult an attorney with expertise in this area.

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25. 42 USC §1396p(c)(2)(B)(iv).

26. Ltr. Rul. 200240018 (Jun. 24, 2002).

27. *The Wall Street Journal.* Silverman, Rachel Emma. (Sep. 6, 2006.) [http://online.wsj.com/article/SB115759786200356055.html] Accessed on Jun. 7, 2011.

28. The term "relative" refers to a person bearing a relationship to the individual as described in IRC §152(d)(2)(A)-(G).

29. IRC §213(d)(11)(A).

LONG-TERM CARE INSURANCE

LTC insurance is an alternative for individuals who either have insufficient funds to pay for their own nursing home expenses or too many assets to qualify for Medicaid. Information included in this section is based on information found in a publication produced by the National Association of Insurance Commissioners.[30]

INTRODUCTION

What Is Long-Term Care?

LTC involves a wide variety of services for people with prolonged physical illnesses, disabilities, or cognitive disorders, such as Alzheimer's disease. LTC is composed of many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently. LTC differs from traditional medical care because it is designed to help people maintain their level of functioning, as opposed to providing care or services designed to rehabilitate or correct certain medical problems. LTC services may include help with daily activities at home, respite care, home health care, adult day care, and nursing home care.

Persons with physical illnesses or disabilities often need hands-on assistance with the activities of daily living (ADLs). Persons with cognitive impairments generally need supervision, protection, or verbal reminders to accomplish everyday activities.

The delivery mechanisms for LTC services are changing very rapidly; however, **skilled care** and **personal care** remain the most common terms used to describe LTC and the level of care a person may need.

Skilled care is generally needed for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists. This care is usually provided 24 hours per day, is ordered by a physician, and involves a treatment plan. Skilled care is generally provided in a nursing home; however, it may also be provided by visiting nurses or therapists in other settings, such as the patient's home.

Personal care (also known as custodial care) helps a person perform ADLs, which include assistance with bathing, eating, dressing, toileting, and transferring. It is less intensive or complicated than skilled care and can be provided in many settings, including nursing homes, adult daycare centers, or at home.

There are different types of providers of LTC and various places where a person can receive this care. State laws governing the providers of LTC vary widely as do terms used to describe these providers. Individuals investigating LTC insurance options will become familiar with services provided by nursing homes, adult daycare centers, assisted-living facilities, and home-care agencies.

Long-Term Care Costs

LTC can be expensive, depending upon the amount and type of care needed and the setting in which it is provided. In 2011, the median cost of one year in a semi-private nursing home in Illinois was $54,750.[31] This cost varies widely across the country; California has a median cost of $77,745 and New York has a median cost of $114,975.[32]

If a person is visited by a home health aide three times per week for the entire year, the bill would equal about $18,000, based on national averages.[33]

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30. *Shoppers Guide to Long-Term Care.* [www.ltcfeds.com/documents/files/NAIC_Shoppers_Guide.pdf] Accessed on Jun. 10, 2011.
31. Compare Cost of Care across the United States. Genworth Financial. [www.genworth.com/content/products/long_term_care/long_term_care/cost_of_care.html] Accessed on Jun. 9, 2011.
32. Ibid.
33. [www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx#What] Accessed on Aug. 5, 2011.

Who Should Buy Long-Term Care Insurance?

Not everyone should buy an LTC insurance policy. For some, an LTC policy is an affordable and attractive form of insurance. For others, the cost is too great, or the affordable benefits are insufficient. An LTC policy is not a good option if it would cause financial hardship and make the buyer forgo other more pressing financial needs. Many people purchase LTC insurance who cannot afford to maintain the policy. Research conducted at the University of Illinois by McNamara and Lee shows that only 23% of those with LTC insurance in 1996 maintained their coverage for five years.[34] Paying LTC insurance premiums and then canceling the policy before it is needed indicates that inadequate information was obtained by the purchaser. Individuals, in consultation with their family members, tax advisors, attorneys, and financial advisors should carefully examine their needs and resources to decide whether LTC insurance is appropriate.

The need for LTC may occur gradually as a person needs more and more assistance with ADLs, such as bathing and dressing. For some individuals, the need can surface suddenly following a major illness, such as a stroke or a heart attack. Some people who have acute illnesses may need nursing home or home health care for only short periods of time. Others may need these services for many months or years.

It is difficult to predict who will need LTC, but studies provide information on the likelihood of needing such care. For example, one national source projects that approximately 9 million Americans over age 65 will need LTC services this year. They predict this will increase to 12 million by 2020. They also predict about 70% of individuals over age 65 will need some type of LTC services during their lifetimes.[35]

Men usually need care for shorter periods of time than women. Men need care for an average of 2.2 years compared to 3.7 years for women. Although 30% of those over 65 years of age will never need long-term care, 20% will need care for more than five years.[36]

Whether a person should buy an LTC insurance policy depends on age, health status, overall retirement objectives, and income. For instance, if the only source of income is a social security benefit or supplemental security income, LTC insurance should probably not be purchased. Individuals who have trouble stretching their income to meet other financial obligations — such as paying for utilities, food, or medicine — should probably not purchase LTC insurance policies.

On the other hand, people with significant assets may or may not need to consider buying an LTC insurance policy in order to save these assets. Many people buy an LTC insurance policy because they want to pay for their own care and not burden their children or the government with nursing home bills. However, individuals who cannot afford the premiums or cannot reasonably predict whether they will be able to pay the premiums in the future should probably not buy LTC policies.

People who have existing health problems that are likely to result in the need for LTC will probably not be eligible to buy a policy. Insurance companies have medical underwriting standards in place to keep the cost of LTC insurance affordable. In the absence of such standards, most people would not buy coverage until they needed LTC services.

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34. *Making an Informed Decision about Long-term Care Insurance: A Teleconference Seminar to Help Consumers.* Paul J. McNamara, Kathryn L. Sweedler, Katherine J. Reuter, Mary Ann Fugate. Oct. 2004. [www.ncsu.edu/ffci/publications/2004/v9-n2-2004-october/pa-1-informed.php] Accessed on Jun. 9, 2011.

35. [www.longtermcare.gov/LTC/Main_Site/index.aspx] Accessed on Jun. 9, 2011.

36. [www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Basics/Basics.aspx#risks] Accessed on Jun. 9, 2011.

TYPES OF POLICIES

Today, LTC insurance policies are not standardized like Medicare supplemental insurance. Companies sell policies with various combinations of benefits and coverage. A person may acquire a policy in a variety of ways, such as the following.

- Individually
- Through an employer
- Through a spouse's employer
- Through a child's employer
- Through membership in an association
- Through a life insurance policy

> **Note.** The University of Illinois Extension developed "A Long-Term Care Insurance Policy Comparison Tool" to aid in the selection process for LTC insurance. This tool is reproduced at the end of this chapter.

Individual Policies

Most of the policies sold today are sold to individuals. Many of these policies are sold through insurance agents, and some are sold through mail solicitations or direct marketing. Individual policies offer a wide variety of coverage; however, not all companies offer the same coverage. In order to find a policy that best meets an individual's needs, shopping among various companies and agents is highly recommended.

Joint Policies

Most LTC insurance companies offer an option to cover two individuals with a defined total set of benefits. These policies allow either of the covered parties to use any or all of the benefits as they qualify. Any benefits remaining after the first covered individual collects benefits are available to the second covered individual.

In essence, two individuals are pooling benefits and risks, which usually results in significant premium savings.

Employer Policies

An employer may allow employees to enroll in a group LTC insurance plan. The coverage provided by these group policies may be similar to what could be purchased individually from an agent or through direct-mail solicitation. Employer-sponsored policies usually give employees a choice of benefit periods, maximum payments, and elimination periods. Insurers may allow employees to keep the coverage after they leave the company. This is done by offering continuation of coverage or conversion options.

Many employers allow retirees, spouses, parents, and parents-in-law to buy coverage. Typically, an employee's spouses and relatives must pass the company's medical screening to qualify for coverage. Employees, however, may not be required to pass any medical examination.

If an employer offers such coverage, it is advisable to consider it carefully. An employer's group policy may offer options that employees will not find if they try to buy policies independently.

Association Policies

Many associations allow insurance companies and agents to offer LTC insurance to their members. These policies are similar to other types of LTC insurance policies. Like employer-sponsored policies, association policies usually give their members many choices. Association policies may offer nonforfeiture benefits and inflation protection. In most states, association policies must allow members to keep their coverage after they leave the association. However, a person should be cautious about joining an association for the sole purpose of purchasing any insurance coverage, especially LTC coverage.

Life Insurance Policies

Some life insurance companies offer access to the life insurance death benefit and cash value under certain specified conditions prior to death, such as terminal illness, permanent confinement in a nursing home, or for LTC. This is often referred to as an **accelerated benefit** provision. LTC benefits can be offered as a feature of an individual or group life insurance policy. Under these arrangements, a portion of the policy's death benefit is paid on a periodic basis when the insured individual needs LTC services. Policies may pay up to 100% of the death benefit for LTC, and some companies offer the option to purchase additional LTC coverage beyond the death benefit amount.

It is important to remember that the amounts used for LTC under this type of policy reduce the amount of death benefit a beneficiary will receive, as well as the cash value of the life policy. For example, if a person purchases a policy with a $100,000 death benefit and uses $60,000 for LTC, the death benefit of the policy is reduced to $40,000. If a person purchases life insurance to provide a benefit upon death for a specific need but uses this option for LTC needs, the benefit upon death may not cover the original need. However, if a person never uses the LTC benefit, the full death benefit stated in the life insurance policy is paid to the beneficiary.

Annuity Policies

Recently, some insurance companies have offered riders to their annuity policies that allow for increased annuity payments when an LTC event is triggered. For instance, if an individual is admitted to a nursing home for 60 or more days or loses two or more of their six ADLs, then the monthly annuity might increase by 50% or even 100%. The specific coverage differs between companies, but this hybrid approach to coverage is often a more attractive option to an individual than no coverage or the all-or-nothing coverage of a traditional LTC policy.

MEDICAID-INSURANCE PARTNERSHIP

Congress authorized state governments to create LTC partnerships in the Deficit Reduction Act of 2005. These arrangements allow people who own specially designated LTC insurance policies to be eligible for Medicaid payment of their LTC expenses after their insurance benefits are exhausted. In effect, a policyholder who uses all of their LTC insurance benefits is allowed to retain assets equal to those benefits and still qualify for Medicaid. Additionally, assets remaining at the person's death are exempt from Medicaid's estate recovery provisions to the extent of the LTC insurance benefits that the individual received.

> **Example 4.** Pearl has $125,000 of countable resources for Medicaid purposes. She also has a qualifying LTC insurance policy that will pay $100 per day for two years, totaling $73,000 ($100 per day × 365 days × 2 years). If Pearl utilizes all of these benefits, the policy will enable her to keep $73,000 of her countable resources while still qualifying for Medicaid. However, Pearl would still need to spend down her remaining $52,000 of assets ($125,000 − $73,000) because those assets are in excess of the insurance benefits paid.

Qualifying Insurance

To qualify for the Medicaid-insurance partnership program, an LTC insurance policy must contain the requisite consumer protections to ensure that its premiums are eligible for tax deductibility. The consumer protections incorporate model provisions established by the National Association of Insurance Commissioners (NAIC).[37] Most policies currently sold satisfy these requirements.

Partnership policies must include inflation protection if the policyholder is under age 76 when the policy is first obtained. Furthermore, if the insured is under age 61 at the time the policy is purchased, it must include compound annual inflation protection.[38]

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37. See 42 USC §1396p(b)(5).

38. 42 USC §1396p(b)(1)(C)(iii)(IV).

HOW DO LTC POLICIES WORK?

Covered Services

People who buy LTC policies must understand the coverage for the variety of LTC services available. Some policies cover only stays in nursing homes. Others cover only home-care services. Still others cover both nursing home and home care. In addition, many policies also cover services provided in adult daycare centers or other community facilities.

Many LTC policies only pay for care provided in licensed nursing facilities. Most policies on the market today do not distinguish among the types of nursing home care or the level of care that is provided. They pay for any care needed, as long as LTC is required and other eligibility requirements contained in the policy are met.

Home-care coverage varies. Some policies pay home-care benefits only for services performed in a person's home by registered nurses, licensed practical nurses, and occupational, speech, or physical therapists. Many policies offer a broader range of home-care benefits. For instance, the services of home health aides employed by licensed home-care agencies may be covered. These aides have less training than nurses who perform skilled care, and they generally help patients with personal care. Some policies pay for homemaker or chore worker services. This type of policy, though rare, pays for someone to come to the home to cook meals and run errands. Generally speaking, adding home-care benefits to the policy increases the cost.

> **Note.** Most policies do not pay benefits to family members who perform home-care services.

How Benefits Are Paid

Insurance companies generally pay benefits using two different methods: the expense incurred method and the indemnity method.

In the **expense incurred method,** when an eligible person submits claims, the insurance company either pays the insured or the provider up to the limits contained in the policy. The policy or certificate pays benefits only when eligible services are received.

The second type of benefit payment is the **indemnity method.** Under this method, once a person is eligible for benefits, the insurance company pays the insured person directly in the amount specified in the policy, without regard to the specific services received.

It is important to read the literature that accompanies the policy or certificate. Most recently purchased policies pay benefits by the expense incurred method. Expense incurred policies tend to be less expensive and may provide benefits for a longer period of time.

Where Is Service Covered?

With an LTC policy, it is not enough to know what services are covered; it is also important to know **where** services are covered. If the insured individual is not in the right type of facility, the insurance company may refuse to pay. Some policies cover care provided in any state-licensed facility. Others may limit the kinds of facilities where a person can receive care.

Many policies will not cover personal care unless it is provided in a licensed nursing facility. Other policies list the kinds of facilities that will **not** be covered. These often include homes for the aged, rest homes, personal care homes, and assisted-living facilities, although many states license these facilities to provide personal care. Some policies may explicitly define the kinds of facilities they will cover. Some may require the facility to care for a certain number of patients or require a certain kind of nursing supervision. It is important to check these requirements very carefully and pay particular attention to the types of facilities that provide services near the person's locale. It is also important to contact the insurance company before entering the healthcare facility to determine whether the stay will be covered.

Exclusions and Limitations

Insurance companies generally do **not** pay benefits if services are needed for a person who has:

- A mental or nervous disorder or disease, other than Alzheimer's disease;
- An alcohol or drug addiction;
- An illness or injury caused by an act of war;
- Received treatment that was already paid for by the government; or
- Attempted suicide or has intentionally self-inflicted injuries.

Note. Insurance carriers cannot exclude coverage for Alzheimer's disease in states that have adopted the NAIC's Long-Term Care Insurance Model Regulation. Individuals should contact their state's department of insurance to find out whether this applies in their state. Virtually all policies specifically say they will cover Alzheimer's disease. Individuals also should be aware of the connection between Alzheimer's disease and eligibility for benefits discussed later.

Scope of Coverage

The amount of coverage provided by a policy or certificate is expressed in different ways.

1. **Lifetime maximum benefits.** Most plans have a total maximum benefit payable over the policy's duration. The maximum benefit limit is generally expressed in language such as "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit." When examining a policy or certificate, it is important to carefully consider the total amount of coverage available. A few plans offer unlimited lifetime benefits. Often, these benefits are expressed in the marketing materials as benefit periods of one, two, three, or more years, or as the total dollar amount available. When considering which is better — a longer or a shorter benefit period — it is important to keep in mind that most nursing home stays are short and last three months or less. However, some illnesses last for several years, necessitating very long stays. Policies with longer benefit periods tend to be more expensive.
2. **Daily/monthly benefit amounts.** Benefits are often payable on a daily, weekly, monthly, annual, or other periodic basis. For example, in an expense incurred plan, a nursing home benefit might be paid on a daily basis in an amount up to $100 per day, while the nursing home might cost $300 per day. Some policies contain inflation protection for these amounts, and such policies usually involve a higher premium payment.

A person should understand the amount of coverage furnished by the policy or certificate. The type of service received will dictate the amount of coverage.

TAX INCENTIVES

In an effort to encourage people to buy LTC insurance, Congress made premiums for such insurance tax deductible. IRS Pub. 502, *Medical and Dental Expenses,* explains the requirements that LTC contracts must meet in order to be tax-qualified under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). LTC insurance contracts are generally treated as accident and health insurance contracts. An LTC insurance contract is an insurance contract that only provides coverage for qualified LTC services. The contract must:

- Be guaranteed renewable;
- Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed;
- Provide that refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract be used only to reduce future premiums or increase future benefits; and
- Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except when Medicare is a secondary payer or the contract makes per diem or other periodic payments without regard to expenses.

Qualified LTC services are:[39]

- Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance and personal care services; and
- Required by a chronically ill individual and provided according to a plan of care prescribed by a licensed healthcare practitioner.

Policies that meet these standards are eligible for tax treatment similar to that of health insurance premiums, including an adjustment to income for the self-employed. The premiums may also be deducted on Schedule A, *Itemized Deductions,* as a medical expense if they are paid by the individual.

Unlike health insurance premiums, there are **age-specific limits** on the amount of LTC insurance premiums that can be deducted. Any premiums in excess of these limits provide no tax benefit whatsoever. For taxable years beginning in 2011, the annual limits are as follows.[40]

Age Attained before End of 2011	Limitation on Premiums
40 or less	$ 340
41–50	640
51–60	1,270
61–70	3,390
Over 70	4,240

Example 5. Ruby is 65 years old and pays $4,000 for LTC insurance in 2011. She also pays $1,385 for Medicare Part B coverage. The limit on deductible LTC premiums for Ruby is $3,390 (see preceding chart). Ruby's 2011 adjusted gross income is $50,000. Her medical expense deduction is computed as follows.

LTC insurance premium	$3,390
Medicare Part B premium	1,385
Total medical expenses	$4,775
Threshold on medical expense deduction ($50,000 × 7.5%)	(3,750)
Deduction allowed	$1,025

Thus, although Ruby pays a total of $4,000 in LTC premiums, her medical expense deduction is limited to $1,025, part of which is attributable to the Medicare Part B premiums she pays. Ruby is single and in the 25% income tax bracket; therefore, her medical expenses reduce her taxes by $256 ($1,025 × 25%). If Ruby does not qualify to itemize her deductions, she will not receive any tax benefit from paying for LTC insurance.

As the above example illustrates, the small tax benefit, if any, derived from paying LTC premiums would not likely motivate anyone to purchase the insurance. However, the tax benefit will be higher if the taxpayer is self-employed because LTC premiums are deductible as self-employed health insurance.

Distributions from a Health Savings Account

Individuals with high-deductible health plans can make tax-deductible contributions to a health savings account (HSA). Distributions from an HSA that are used for qualified medical expenses are excludable from gross income. Persons enrolled in Medicare are not eligible to make contributions to an HSA; however, they can still receive tax-free distributions from their previously established HSAs to reimburse qualified medical expenses.

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39. IRS Pub. 525, *Taxable and Nontaxable Income.*

40. Rev. Proc. 2010-40, 2010-46 IRB 666.

Distributions from HSAs can be used to pay LTC insurance premiums up to the age-specific limits listed previously.[41] All HSA distributions must be reported on Form 8889, *Health Savings Accounts (HSAs)*.

Example 6. Edmund is 65 years old and has $15,000 remaining in an HSA that he established when he was 50. Edmund pays $4,000 in LTC premiums in 2011. He can take a tax-free distribution from his HSA to pay up to $3,390 (the age-specific limit from the preceding chart) of his LTC premiums.

Employer-Provided Coverage

Employer-paid contributions for coverage (premiums) for LTC services are generally deductible by the employer and are not included in the employee's income. However, contributions made through a flexible spending arrangement or cafeteria plan must be included in the employee's income. This amount is reported as wages in box 1 of Form W-2.[42]

Nondiscrimination Rules. Under IRC §7702B, an employer plan providing qualified LTC insurance is treated as an accident and health plan. Thus, the employer is subject to the provisions of IRC §105 under which the plan is only subject to nondiscrimination rules if it is self-insured.[43]

Note. The Patient Protection and Affordable Care Act added §2716 to the Public Health Service Act (PHSA). PHSA §2716 provides that a group health plan (other than a self-insured plan) must satisfy the nondiscrimination provisions of IRC §105(h)(2). However, these regulations do not apply to grandfathered health plans providing coverage on or before March 23, 2010. The IRS anticipates issuing guidance under PHSA §2716.[44] Nonetheless, it appears that LTC insurance will continue to be exempt from the nondiscrimination rules because the PHSA definition of group health plans excludes benefits that are exempt from HIPAA's portability requirements, which includes LTC insurance.

TAX TREATMENT OF BENEFITS

Generally, amounts paid under a qualified LTC insurance contract are excluded from gross income. However, the exclusion for payments made on a per diem basis under a qualified LTC insurance contract is limited to $300 per day in 2011.[45] **Per diem payments** are payments of a fixed amount on a periodic basis without regard to actual expenses incurred (indemnity method).

The excludable amount for any period is calculated by subtracting the reimbursement received (through insurance or otherwise) for the cost of LTC services from the **larger** of the following amounts.

- The cost of qualified LTC services during the period
- The per diem amount for the period

If the LTC contract pays under the expense incurred method, the benefits are not taxable as long as the taxpayer has incurred the specified amount of qualified expense.

If the taxpayer receives LTC benefits, Form 1099-LTC, *Long-Term Care and Accelerated Death Benefits,* is issued at yearend. The taxpayer files Form 8853, *Archer MSAs and Long-Term Care Insurance Contracts,* with Form 1040.

41. IRS Pub. 969, *Health Savings Accounts and Other Tax-Favored Health Plans.*
42. IRS Pub. 525, *Taxable and Nontaxable Income.*
43. See IRC §105(h).
44. IRS Notice 2011-1, 2011-2 IRB 259.
45. Rev. Proc. 2010-40, 2010-46 IRB 663.

Example 7. Myrtle was chronically ill throughout 2011 and received 12 monthly payments on a per diem basis from a qualified LTC insurance contract. She was paid $2,000 per month, for a total of $24,000. Myrtle incurred expenses for qualified LTC services of $150 per day, for a total of $54,750 (365 days × $150).

Myrtle's Form 1099-LTC and page 2 of Form 8853 follows.

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, ZIP code, and telephone no.	1 Gross long-term care benefits paid	OMB No. 1545-1519	
LTC Insurance Co. **99 Rocky Rd** **Anyplace, IL 60000**	$ **24000.00** 2 Accelerated death benefits paid $	2011 Form **1099-LTC**	**Long-Term Care and Accelerated Death Benefits**

PAYER'S federal identification number	POLICYHOLDER'S identification number	3	INSURED'S social security no.	
36-1234567	**111-00-1111**	☒ Per diem ☐ Reimbursed amount	**111-00-1111**	**Copy B** **For Policyholder** This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this item is required to be reported and the IRS determines that it has not been reported.

POLICYHOLDER'S name	INSURED'S name
Myrtle Smyth	**Myrtle Smyth**
Street address (including apt. no.) **111 Ivy Lane**	Street address (including apt. no.) **111 Ivy Lane**
City, state, and ZIP code **Urbana, IL 61801**	City, state, and ZIP code **Urbana, IL 61801**

Account number (see instructions)	4 Qualified contract ☐ (optional)	5 (optional)	☐ Chronically ill ☐ Terminally ill	Date certified

Form **1099-LTC** (keep for your records) Department of the Treasury - Internal Revenue Service

For Example 7

Form 8853 (2011) Attachment Sequence No. 39 Page 2

Name of policyholder (as shown on Form 1040): Myrtle Smyth

Social security number of policyholder ▶ 111-00-1111

Section C. Long-Term Care (LTC) Insurance Contracts. See **Filing Requirements for Section C** in the instructions before completing this section.

If more than one Section C is attached, check here . . . . . ▶ ☐

14a Name of insured ▶ Myrtle Smyth b Social security number of insured ▶ 111-00-1111

15 In 2011, did anyone other than you receive payments on a per diem or other periodic basis under a qualified LTC insurance contract covering the insured or receive accelerated death benefits under a life insurance policy covering the insured? . . . . . ☐ Yes ☑ No

16 Was the insured a terminally ill individual? . . . . . ☐ Yes ☑ No

Note: *If "Yes" and the **only** payments you received in 2011 were accelerated death benefits that were paid to you because the insured was terminally ill, skip lines 17 through 25 and enter -0- on line 26.*

17	Gross LTC payments received on a per diem or other periodic basis. Enter the total of the amounts from box 1 of all Forms 1099-LTC you received with respect to the insured on which the "Per diem" box in box 3 is checked			17	24,000
	Caution: ***Do not*** *use lines 18 through 26 to figure the taxable amount of benefits paid under an LTC insurance contract that is not a **qualified** LTC insurance contract. Instead, if the benefits are not excludable from your income (for example, if the benefits are not paid for personal injuries or sickness through accident or health insurance), report the amount not excludable as income on Form 1040, line 21.*				
18	Enter the part of the amount on line 17 that is from **qualified** LTC insurance contracts			18	24,000
19	Accelerated death benefits received on a per diem or other periodic basis. Do not include any amounts you received because the insured was terminally ill (see instructions)			19	
20	Add lines 18 and 19			20	24,000
	Note: *If you checked "Yes" on line 15 above, see **Multiple Payees** in the instructions before completing lines 21 through 25.*				
21	Multiply $300 by the number of days in the LTC period	21	109,500		
22	Costs incurred for qualified LTC services provided for the insured during the LTC period (see instructions)	22	54,750		
23	Enter the **larger** of line 21 or line 22	23	109,500		
24	Reimbursements for qualified LTC services provided for the insured during the LTC period	24	0		
	Caution: *If you received any reimbursements from LTC contracts issued before August 1, 1996, see instructions.*				
25	Per diem limitation. Subtract line 24 from line 23			25	109,500
26	**Taxable payments.** Subtract line 25 from line 20. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21. On the dotted line next to line 21, enter "LTC" and the amount			26	0

Form **8853** (2011)

Note. For per diem-based payments, the amount in box 1 of Form 1099-LTC is reported on line 17 of Form 8853. For reimbursement-based payments, it is reported on line 24.

CLASS PROGRAM[46]

The Patient Protection and Affordable Care Act (PPACA) establishes a new LTC insurance option, which is expected to be available in October 2012. The Community Living Assistance Services and Support (CLASS) program is a national voluntary insurance program for the purchase of community living services and for payment of institutional LTC services. The purposes of this program are as follows.

- Provide tools to individuals with functional limitations in order to allow them to maintain their personal and financial independence
- Establish an infrastructure to help address community living assistance services and support needs
- Alleviate burdens on family caregivers
- Address institutional bias by providing a financing mechanism that supports personal choice and independent community living[47]

Working adults can participate through an employment-based program. Spouses of workers can participate if they meet eligibility criteria. Self-employed individuals, along with individuals whose employers do not offer the CLASS program, can participate through an alternate sign-up method.

CLASS will be financed by voluntary payroll deductions or direct payments from individuals. At this point, premiums are expected to average approximately $120 per month.[48] Employees working for a participating employer will be automatically enrolled in the program unless they opt out.

Benefits are expected to average about $75 per day,[49] with the exact amount of benefit payments depending on the degree of loss of physical or mental function. Cash benefits will be paid to the participant according to the level of impairment. Participants are not eligible for benefits until they have contributed to the program for five years. Thus, the CLASS program is not designed to help people who are currently disabled and unable to work, or those who are already retired.

The PHSA mandates that the benefits provided must average at least $50 per day.[50] This $50 average is determined based on the reasonably expected distribution of anticipated claimants;[51] thus, at this point, it is impossible to know exactly how much money will be provided to any given recipient. On the other hand, there is no lifetime limit on the amount of cash benefits that a claimant can receive.

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46. This section is drawn largely from an article by Richard L. Kaplan. *See* Kaplan, Richard L. (2010, Jul.–Aug.). Financing Long-Term Care after Health Care Reform. *Journal of Retirement Planning,* p. 9; Illinois Program in Law, Behavior and Social Science Paper No. LE10-001. [http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1692288] Accessed on Jul. 14, 2011.

47. PPACA Sec. 8801, adding Sec. 3203 to the Public Health Service Act.

48. [http://web.extension.illinois.edu/countrysidecenter/blogs/eb141/20100713_3814.html] Accessed on Jun. 1, 2011.

49. Ibid.

50. PHSA §3203(a)(1)(D)(i).

51. Ibid.

CLASS benefits can be used for the full range of LTC services, as long as they are needed by a beneficiary "to maintain his or her independence at home or in another residential setting of their choice in the community."[52] These services include the following.[53]

- Home modifications
- Assistive technology
- Accessible transportation
- Homemaker services
- Respite care
- Personal assistance services
- Home care aides
- Nursing support

Beneficiaries can even use their cash benefits to pay family members for the caregiving assistance that they provide. This is true even if these services are provided without expectation of remuneration.

CLASS benefits can also be used to obtain "assistance with decision making concerning medical care, including the right to. . . formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care."[54] Thus, legal fees to prepare certain documents can be an acceptable use of CLASS benefits.

Eligibility

To be eligible for benefits under the CLASS program, both of the following must apply.[55]

1. The individual has a functional limitation that is expected to last for more than 90 days.
2. The person meets **either** of the following standards.
   - **a.** The individual requires substantial supervision to be protected from threats to health and safety because of cognitive impairment.
   - **b.** The individual is unable to perform either two or three ADLs without assistance from another person. ADLs include the following.
     - Eating
     - Toileting
     - Transferring (i.e., getting into and out of bed)
     - Bathing
     - Dressing
     - Control of continence

> **Note.** Many of the details of the CLASS program have yet to be developed by the Department of Health and Human Services (HHS) but are expected to be announced by October 2012.

52. PHSA §3205(c)(1)(B).
53. Ibid.
54. PHSA §3205(c)(1)(B).
55. PHSA §3203(a)(1)(C).

Eligibility for CLASS benefits also requires that the recipient has paid CLASS premiums for at least 60 months. The 60 months of payments need not be consecutive, but if payments have lapsed for more than three months since the person enrolled in the CLASS program, at least 24 months of premium payments must be consecutive.[56] Additionally, the person must have earned wages and/or SE income sufficient to earn a quarter of coverage under the social security program during at least three calendar years in the first 60 months of a person's enrollment in CLASS.

Example 8. At the time Gerard was diagnosed with multiple sclerosis, he had paid CLASS premiums for 56 months. Gerard will become eligible for CLASS benefits only if he continues to pay CLASS premiums for another four months.

Example 9. Matilda is only able to work sporadically because she suffers from chronic obstructive pulmonary disease. She can enroll in the CLASS program as long as she earns at least one quarter of coverage under social security for three years. Matilda will be eligible for CLASS benefits after paying premiums for 60 months.

Example 10. Matilda, from **Example 9,** enrolled in the CLASS program. After two years, her medical condition deteriorated and she is no longer able to work. She is not eligible for CLASS benefits because she did not make 60 payments nor did she earn one quarter of coverage in at least three calendar years after her initial enrollment in CLASS.

Premiums

The premiums for the CLASS program are not set by law but instead are to be determined by HHS. However, the law specifies that the CLASS program is intended to be self-sustaining, with no taxpayer funds being used to support program benefits. Furthermore, the premiums may vary only because of the enrollee's age and not because of their state of health.

Example 11. Veronica and Victor are both 50 years old. Victor has a cholesterol level of 295, is 100 pounds overweight, and has a family history of heart disease. Veronica is slender, has a cholesterol level of 150, and works out at the gym five days a week. Because Veronica and Victor are the same age, their CLASS premiums must be identical.

Example 12. Use the same facts as **Example 11,** except Veronica is 55 years old. Because Veronica is older than Victor, her CLASS premium may be higher than his.

CLASS premiums are intended to remain unchanged during the enrollee's period of enrollment; however, the premiums may be increased to maintain the solvency of the program.[57] No post-enrollment premium increases are allowed for individuals who meet all the following conditions.[58]

- Have attained age 65
- Have paid premiums for at least 20 years
- Are not actively employed

Individuals whose income does not exceed the poverty line may enroll in the CLASS program for a nominal premium of $5 per month, plus subsequent inflation adjustments. The nominal premium rate also applies to full-time students under age 22 who are actively employed.

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56. PHSA §3202(6)(A)(iii).
57. PHSA §3203(b)(1)(B)(i).
58. PHSA §3203(b)(1)(B)(ii).

Enrollment

The CLASS program is a federally administered social insurance plan that is similar to social security and Medicare but with three important distinctions. First, CLASS premiums are paid exclusively by the enrollee. No financial obligation is imposed on the employer.

Second, employers must choose to participate in the program. Employees of employers that decline to enroll in the CLASS program can still enroll in the program via an alternative procedure that has yet to be announced. This procedure will also be available to self-employed individuals.

Third, employees of participating employers are automatically enrolled in the program. Employees may then opt out of the program, if desired. Employees who opt out can subsequently enroll in the CLASS program during an open enrollment period, but these open enrollment periods must not occur more often than once every two years.[59]

Once an individual is enrolled in the CLASS program, there are serious disincentives to dropping the coverage. For example, if a person discontinues premium payments for more than three months and then rejoins the program, the premium amount will be based upon the person's age at the time they rejoin the program. As long as reenrollment occurs within five years of the initial enrollment, prior months of premium payments will count toward the 60 months that are required for benefit eligibility. However, the enrollee must pay premiums for at least 24 consecutive months before receiving benefits.

> **Example 13.** Gordon worked and paid CLASS premiums for two years before he lost his job and stopped paying the premiums. One year later, he got a new job and reenrolled in the CLASS program. Gordon's new premium is set at the rate that applies to enrollees of his current age. His prior CLASS payments count toward the required 60-month total, because his nonenrollment period was less than five years. Gordon must pay CLASS premiums for at least 36 additional months before he will be eligible for CLASS benefits.
>
> **Example 14.** Use the same facts as **Example 13,** except Gordon worked and paid premiums for four years prior to discontinuing his premium payments for a year. When Gordon reenrolls, he will need to pay CLASS premiums for an additional 24 consecutive months (rather than only 12 additional months) before he can receive CLASS benefits.

If a person discontinues CLASS premium payments for more than five years, a penalty is charged if that person re-enrolls in the program. The penalty amount is at least 1% of missed premiums since disenrollment occurred and is added to the age-adjusted CLASS premium amount that would otherwise apply. Furthermore, the CLASS premiums that were paid prior to a 5-year lapse are not counted in determining eligibility for CLASS benefits. In this situation, a re-enrollee must start the 60-month enrollment period anew in order to qualify for benefits.

> **Example 15.** Bethany paid CLASS premiums for three years before disenrollment. She re-enrolls in the CLASS program after seven years of nonenrollment. Bethany's new age-adjusted premium will be increased by a penalty based on her period of nonenrollment. She will need to pay an additional 60 months of premiums before she will qualify for benefits.

Only persons who are actively employed and receive wages or earn SE income are eligible to enroll in the CLASS program. For this purpose, **actively employed** means a person who:[60]

- Is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of employment, and
- Can perform all the usual and customary duties of the individual's employment on a regular work schedule.

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59. PHSA §3204(g)(1).

60. PHSA §3202(2).

Accordingly, current retirees cannot enroll in the CLASS program unless they can work at least part-time during the three initial years of their CLASS program enrollment.

Example 16. Opal enrolled in the CLASS program and paid premiums for 42 months before she retired. Opal must continue to pay CLASS premiums for 18 months to complete the 60 months that are necessary to be eligible for CLASS benefits.

Example 17. Wilton paid CLASS premiums for only 24 months before he retired completely. Even if he continues to pay CLASS premiums, he will not be eligible for benefits after 60 months of payments because he was not actively employed during the three initial years of his CLASS program enrollment.

Example 18. Use the same facts as **Example 17,** except Wilton worked part-time and earned $2,500 during his first year of retirement. Because this level of earnings qualifies as "actively employed," Wilton will be eligible for CLASS benefits after he pays 60 months of premiums.

CLASS PROGRAM VERSUS LTC INSURANCE

Several key factors must be considered when deciding whether an individual should enroll in the CLASS program or purchase LTC insurance. It should be noted at the outset, however, that an individual is not required to choose between the two options. **An eligible person can enroll in the CLASS program and also purchase LTC insurance if they can afford to pay two sets of premiums.**

Some persons may not have the choice between the two options. **Enrollment in CLASS is open to all eligible individuals regardless of their medical profile.** On the other hand, LTC premiums are determined based on the risks associated with a given individual; accordingly, such insurance may be prohibitively expensive or even completely unavailable to certain persons.

Scope of Benefits

CLASS benefits can be used for a wider range of services than those covered by LTC insurance. For example, only some of the newer LTC policies cover homemaker services. And if LTC insurance covers payments to family caregivers at all, it is typically restricted to caregivers residing with the care recipient or with specific professional credentials. Additionally, there is no lifetime or aggregate limit for CLASS benefits, while LTC insurance usually has predetermined limits in terms of days or dollars.

On the other hand, the benefit level under the CLASS program will most likely cover only a minimal amount of expensive LTC arrangements such as nursing homes and assisted living facilities. Individuals who are concerned about covering the cost of an extended nursing home stay may be better advised to focus on LTC insurance and opt out of the CLASS program.

Some individuals may prefer the home-based care alternatives that the CLASS program is intended to cover. Of course, some of these individuals could add a home-care rider to their LTC insurance policy, but such riders would significantly increase the cost of the insurance. Alternatively, some individuals may choose to enroll in the CLASS program for the lower-cost home healthcare services and also obtain LTC insurance without a home-care rider.

Access to benefits is very different for the two alternatives. Once a person has paid the premiums for an LTC insurance policy, they can collect benefits if they satisfy the policy's eligibility conditions. An enrollee in the CLASS program, on the other hand, is not eligible for benefits until they have been enrolled in the program for at least 60 months, regardless of whether they meet the other stipulated eligibility standards. This means that even a person who requires assistance with all six ADLs (listed previously) will receive no CLASS benefits during the first five years of enrollment in the program. LTC insurance also has elimination or waiting periods, but these periods are typically much shorter than five years.

Ease of Acquisition

The CLASS program is clearly superior with respect to the process of obtaining insurance. Individuals that work for employers that participate in the CLASS program will be automatically enrolled in the program. Individuals that either work for employers that do not participate in the CLASS program or are self-employed will be required to access the alternative payment mechanism, which has yet to be announced. Because the CLASS program does not permit medical underwriting, the lengthy questionnaires and medical records reviews that LTC insurance requires do not apply.

Similarly, there are no benefit options to select when enrolling in the CLASS program. CLASS benefits are paid in terms of dollar amounts, with the specific services determined at the time the services are needed by the individual based on that person's level of impairment and national projections of functional limitations.[61] On the other hand, LTC insurance requires the purchaser to select from a confusing assortment of nonstandardized options that makes comparison shopping among various insurers difficult. However, LTC insurance does offer greater predictability in terms of the benefits that it provides.

Individual LTC policies are more accessible in that they can be obtained at any time. The CLASS program only permits enrollment during a biennial open enrollment period.[62]

Solvency

A key concern for purchasers of LTC insurance is whether their insurance carrier will be solvent or even exist at the time they have claims. LTC insurance depends on the company's financial health, and insurers exit the business regularly. State governments administer guaranty funds for LTC insurance companies, but the projected benefits are subject to statutory limits and often restrict payouts to policyholders who reside in the sponsoring state.

There is no comparable solvency risk for the CLASS program. It is unlikely that the federal government would allow promised benefits to not be paid in full and on a timely basis.

Premium Stability

One persistent problem with LTC insurance is the practice of increasing premiums on existing policies without offering increased benefits. Although rate increases cannot be applied to individual policyholders, they can, and often are, applied to entire **classes** of policyholders. Accordingly, many policyholders who face huge premium increases often are forced to cancel their policies, thereby losing their LTC coverage at a time when they are increasingly likely to need it.

The CLASS program also allows premiums to be increased to ensure the solvency of the program. It may be especially susceptible to such increases because of the absence of medical underwriting which makes "adverse selection" of enrollees a potentially serious problem. **This means that the CLASS program may find that many — if not most — of its enrollees have a higher than average likelihood of requiring LTC services at some point. In that situation, the CLASS program will need to raise its premiums to maintain its self-sufficiency.** The increased premiums may then induce some of the healthier CLASS enrollees to leave the program, which would leave a less healthy pool of enrollees to shoulder the program's costs. A debilitating spiral of successive premium increases could then ensue.

Other Features

Spousal Coverage. LTC insurance is available to anyone who meets the medical qualifications, and many policies offer premium discounts for couples. On the other hand, enrollment in the CLASS program is limited to those who are actively employed, as explained earlier. Thus, a spouse who is not in the workforce cannot participate in the CLASS program. In contrast to social security and Medicare, the CLASS program does not provide any benefits to an enrollee's spouse.

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61. PHSA §3203(a)(1)(D).

62. PHSA §3204(g)(1).

Loss of Benefits Due to Nonpayment of Premiums. Many LTC insurance policies have a provision which offers some coverage under a lapsed policy. These provisions usually stipulate that the policy has been in effect for a certain number of years and that only a portion of the policy's benefits are payable. Nonetheless, this provision means that a lapsed LTC policy is not a total loss.

In contrast, no benefits are payable if an enrollee discontinues participation in the CLASS program. As explained earlier, an individual can re-enroll in the program, but a late penalty may apply and at least 24 consecutive months of CLASS premiums are then required to become eligible for CLASS benefits.

TAX ISSUES FOR HOME-CARE WORKERS

The need for elder care of all types will increase as the population ages. Home healthcare has been encouraged by favorable payment provisions passed by Congress in the last decade. However, the payroll tax issues associated with home healthcare workers can be confusing. This section explains the rules regarding which home healthcare workers are subject to domestic employment rules and outlines the steps that must be taken to comply with the law.

IRS Pub. 926, *Household Employer's Tax Guide,* provides the following definition of a household employee.

> ***Do You Have a Household Employee?***
>
> *You have a household employee if you hired someone to do household work and that worker is your employee. The worker is your employee if you can control not only what work is done, but how it is done. If the worker is your employee, it does not matter whether the work is full time or part time or that you hired the worker through an agency or from a list provided by an agency or association. It also does not matter whether you pay the worker on an hourly, daily, or weekly basis, or by the job.*
>
> **Example 19.** Blanche recently had hip-replacement surgery. She is widowed and lives alone. She pays Monique to come into her home to cook, do light housework, and provide personal-care services 25 hours per week. Monique follows Blanche's specific instructions about the duties she performs. Blanche provides the household equipment and supplies that Monique needs to do her work. Monique is Blanche's household employee.

Household work is defined as work that is done in or around a home. Some examples of persons who do household work include the following.[63]

- Babysitters
- Caretakers
- Cleaning people
- Domestic workers
- Drivers
- Health aides
- Housekeepers
- Maids
- Nannies
- Private nurses
- Yard workers

IRS Pub. 926 also provides the following guidance on workers who are **not** considered household employees.

> ***Workers who are not your employees.*** *If only the worker can control how the work is done, the worker is not your employee but is self-employed. A self-employed worker usually provides his or her own tools and offers services to the general public in an independent business.*
>
> *A worker who performs child care services for you in his or her home generally is not your employee. If an agency provides the worker and controls what work is done and how it is done, the worker is not your employee.*

63. IRS Pub. 926, *Household Employer's Tax Guide.*

Example 20. Jerome is single and needs some assistance while he recuperates at home after open-heart surgery. Jerome contacted Bountiful Healthcare to arrange for his care at home. Bountiful runs a home healthcare business and offers their services to the general public. They provide their own supplies and hire and pay any helpers that are needed. Neither Bountiful nor their helpers are Jerome's household employees.

Bountiful issues Forms W-2 to its employees; submits reimbursement requests for its charges to Medicare, Medicaid, or insurance providers; and generally does everything that a business would do in providing services to the public.

The deciding factors used to determine whether a household employment situation exists include the following.

- **Where Duties Are Performed.** If services are provided in the senior citizen's home, the worker may be a household worker if the worker is not employed by an agency.
- **Who Controls the Hours and Terms of the Care.** If an agency establishes the hours, schedules the workers, and pays them, then the workers are not considered household workers.
- **Whether the Worker Is Hired by Multiple Persons.** If the worker is hired by several persons, then the worker probably owns a business, advertises for clients, and runs a 1-person home health operation.

REPORTING REQUIREMENTS FOR HOME-CARE EMPLOYEES

IRS Pub. 926 specifies the payroll reporting requirements for household employees. The following table, found in this publication, explains when individuals must pay social security and Medicare taxes and when they must pay unemployment taxes (FUTA).

Table 1. **Do You Need To Pay Employment Taxes?**

IF you ...		THEN you need to ...
A–	Pay cash wages of $1,700 or more in 2011 to any one household employee. Do not count wages you pay to— • Your spouse, • Your child under the age of 21, • Your parent (see page 5 for an exception), or • Any employee under the age of 18 at any time in 2011 (see page 5 for an exception).	Withhold and pay social security and Medicare taxes. • The taxes are 13.3% of cash wages. • Your employee's share is 5.65% (for 2011 only). (You can choose to pay it yourself and not withhold it.) • Your share is 7.65%.
B–	Pay total cash wages of $1,000 or more in any calendar quarter of 2010 or 2011 to household employees. Do not count wages you pay to— • Your spouse, • Your child under the age of 21, or • Your parent.	Pay federal unemployment tax. • The tax is usually 0.8% of cash wages. After June 30, 2011, the tax is scheduled to decrease to 0.6% of cash wages. • Wages over $7,000 a year per employee are not taxed. • You also may owe state unemployment tax.
Note. If neither A nor B above applies, you do not need to pay any federal employment taxes. But you may still need to pay state employment taxes.		

These taxes are reported on Schedule H, *Household Employment Taxes,* (filed with the individual's Form 1040) or Form 941, *Employer's Quarterly Federal Tax Return,* Form 940, *Employer's Annual Federal Unemployment (FUTA) Tax Return,* and state forms if applicable.

> **Note.** Liability for state employment taxes and workers' compensation may exist even though a person is not required to pay FICA or FUTA taxes.

APPENDIX: A HELPFUL LTC PLANNING RESOURCE

The following tool is available on the University of Illinois Extension's Long-Term Care website at **www.longtermcare.illinois.edu.** This website has in-depth information, strategies, and activities to use in planning for and managing LTC needs.

Long-Term Care
talking ▸ deciding ▸ taking action

A Long-Term Care Insurance Policy Comparison Tool

This tool is designed to help you compare up to three different long-term care insurance policies. You can get most of the information directly from the outlines of coverage which you should have received. Additional information can be gathered from the agent or can be calculated.

		Policy 1	Policy 2	Policy 3
Overview of the Company and Policy				
1	Name of the Insurance Company			
2	Agent's Name			
3	Is the company licensed in Illinois?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4	What is the company's insurance rating? (Ratings are unique to the rating firm and are not comparable across rating agencies.)			
	Moody's			
	Standard and Poor's			
	A.M. Best			
	Weiss			
	Fitch			
5	Is the policy tax-qualified?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
6	What is the premium for this policy?			
	Monthly?			
	Yearly?			
Waiting Periods				
7	What are the waiting periods for this policy?			
	Assisted living facility care?	days	days	days
	Nursing home care?	days	days	days
	Home health care?	days	days	days

continued

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		Policy 1	Policy 2	Policy 3
8	Is the waiting period in service days or calendar days?			
	Is the waiting period cumulative or consecutive?			
	How long is the wait for pre-existing conditions?			
What Does the Policy Cover?				
9	Covers care received in any licensed facility?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	If no, what is not covered?			
10	Care sites covered			
	Adult day care centers?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Assisted living facilities?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Other care sites?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
11	Home health care benefits			
	Skilled nursing care delivered in the home?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Personal care delivered by home health aides?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Homemaker services?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Any other covered home care benefits? (list)			
Length of Benefit Periods and Amount Covered				
12	Per day coverage amounts (daily benefit)			
	Nursing home care?	$	$	$
	Assisted living facility care?	$	$	$
	Home care?	$	$	$
	Home care delivered by a family member or friend?	$	$	$
13	Benefit period			
	Length of benefit period	years	years	years
14	Limits on the days per year or visits per year?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Home health care (days or visits) limits?			
	Nursing home care limits?			
	Assisted living facility care limits?			

		Policy 1	Policy 2	Policy 3
15	Is there a lifetime limit on the benefits the policy will pay?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Nursing home care limits?	$	$	$
	Assisted living facility care limits?	$	$	$
	Home health care limits?	$	$	$
Policy Triggers or Qualifying Conditions				
16	How does the policy qualify you to be eligible to receive benefits?			
	Activity of Daily Living (ADL) limitations	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Physician certification or letter (your physician)	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Another health care provider or physician	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Prior hospital stay	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Alzheimer's or cognitive impairment	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Inflation Protection				
17	Does the policy include inflation protection?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	Is the inflation protection simple or compound?			
	What is the rate of increase?			
	When do increases stop?			
Other Policy Features				
18	Is there a discount if your spouse purchases a policy?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	How much?			
19	Does the policy offer a non-forfeiture benefit?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Additional Notes				

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