CSA

Society of
Certified Senior Advisors®

BASICS

Things you need to know about:

Social Security

Medicare Supplements

Medicare

Medicaid

In-Home Care

Long-Term Care Insurance

Foreword

Basics answers some of the most often-asked questions about Social Security, Medicare, Medicare Supplements, Medicaid, senior housing, in-home care and long-term care insurance. It doesn't cover every subject you need to know, but it covers some of the subjects you should know

This booklet was the idea of our Certified Senior Advisors (CSA) who have taken take the time to learn about the complexity of aging and how to help seniors find the tools to navigate that journey. If CSAs don't have the answer to your question, they'll at least know where to help you find the answer. So no matter what your need may be, whether as a family member of a senior or a senior yourself, its always good to find a professional who has the CSA credential behind their name. It's their knowledge that's behind this booklet.

Ed Pittock, CSA

President
Society of Certified Senior Advisors

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Social Security

The Social Security Retirement Program, started in 1935, was designed as a financial "safety net" for retired workers and their families. There are five major segments: Retirement, Disability and SSI, Survivor's Benefits, and Medicare.

Retirement

When people reach retirement age, Social Security income provides a foundation on which they can build a secure retirement. It is intended to supplement other income sources including work income, pensions, savings and investment gains.

Most financial advisors recommend that, at retirement time, people have about 70 percent of their pre-retirement income in order to maintain their standard of living. For the average worker, Social Security benefits replace approximately 40 percent of pre-retirement income. Social Security retirement income is the entire source of income for one out of five seniors and about 96 percent of all workers are covered by Social Security.

The benefit comes from the Old-Age, Survivors and Disability Insurance (OASDI) funds through the federal government. The Social Security retirement program has undergone important changes—and it is anticipated that further changes will be necessary to keep the system solvent and functioning. No one knows at this time what those changes might be, but this guide explains the program as it currently exists.

How do I qualify for Social Security?

To qualify for Social Security benefits, a worker earns credits when he or she works in a job and pays Social Security taxes. The number of credits required to receive retirement benefits depends on when you were born. If you were born in 1929 or later, you need 40 credits.

Credits are calculated as follows: one credit is earned in covered employment, for a maximum of four credits per year. With four credits per year for 10 years (40 credits) the worker is "fully insured."

If workers stop working before they have enough credits to qualify for benefits, the credits remain on their Social Security record. If they return to work later, more credits can be earned to qualify. No retirement benefits can be paid until they have the required number of credits.

When workers reach **full retirement age**, they can receive full retirement benefits. The full retirement age used to be 65, but now it varies based on the year of birth.

Birth Year	Full Retirement Age
1937	65
1938	65 & 2 months
1939	65 & 4 months
1940	65 & 6 months
1941	65 & 8 months
1942	65 & 10 months
1943-54	66
1955	66 & 2 months
1956	66 & 4 months
1957	66 & 6 months
1958	66 & 8 months
1959	66 & 10 months
1960 and later	67

Reduced retirement benefits can be collected as early as age 62 (with 40 credits), and benefits will be approximately 25% less. If benefits are collected later than full retirement age, they will be increased slightly.

A spouse who has not worked or who has low earnings can be entitled to as much as one-half of the retired worker's full benefit. If you are eligible for both

your own retirement benefits and for benefits as a spouse, Social Security will always pay your own benefits first.

It is important to remember that although Social Security retirement age now varies depending on your birth year, Medicare eligibility remains at age 65.

Are my retirement benefits figured on my last five years of income?

No. Retirement benefits are calculated on earnings during a lifetime of work under the Social Security system. For most current and future retirees, your 35 highest years of earnings will be averaged. If you have fewer than 35 years of earnings, years of zero earnings are averaged in to bring the number of years to 35.

How can I find out how much Social Security income I will receive?

The benefit computation is complex and there are no simple tables that tell you how much you will receive. However, there are several ways to determine an estimate of your retirement benefits:

1. Social Security sends a yearly Social Security Statement to everyone age 25 or older who has paid Social Security taxes and has not yet received benefits. A Social Security statement should arrive about three months before your birthday each year.

   Statements can be requested by calling the Social Security Administration and asking for a form SSA-7004, Request for Social Security Statement, or by downloading the form at **www.socialsecurity.gov/online/ssa-7004.html** on the Internet. You can also use the Benefits Planner at **www.socialsecurity.gov/planners** to estimate your benefits.

2. Read "Your Retirement Benefit, How it is Figured,"

a publication that walks you through the formula for computing your retirement benefit. You can view this publication on the Internet at **http://www.socialsecurity.gov/pubs/10070.html.**

Do I have to apply for Social Security benefits?

Yes. Apply for benefits about three months before the date you want your benefits to start. Most information can be obtained over the phone by calling 1 800-772-1213 or by visiting the website **www.socialsecurity.gov .**

Can I still receive my benefits if I am working?

If you reached your Full Retirement Age, you can earn any amount and receive full Social Security retirement benefits.

If you are under the Full Retirement Age when you start receiving Social Security payments, $1 in benefits will be deducted for each $2 you earn above the annual limit. The earnings limit changes yearly.

In the year you reach your Full Retirement Age, $1 in benefits will be deducted for each $3 you earn above a different limit, but only counting earnings before the month you reach Full Retirement Age. The earnings limit changes yearly.

Does my investment income count toward earnings?

Non-work sources of income do not count as wages for the earnings test. Non-work sources of income include:

- inheritance payments,
- pensions,
- income from investments,
- IRA distributions,
- interest, or
- other sources as determined by the Social Security program

The only criterion for Social Security eligibility is the loss of earnings, not the failure to have investment income.

Do I have to pay income tax on my Social Security income?

Some people have to pay federal income taxes on their Social Security benefits. This usually happens only if you have other substantial income (such as wages, self-employment, interest, dividends and other taxable income that must be reported on your tax return) in addition to your benefits. No one pays federal income tax on more than 85 percent of his or her Social Security benefits based on Internal Revenue Service (IRS) rules.

If you:

- **file a federal tax return as an "individual" or file a joint return and have combined income***
  - between the annual limits (see **www.socialsecurity.gov** for annual changes), you may have to pay income tax on 50 percent of your benefits.
  - Depending on higher income levels, up to 85 percent of your benefits may be taxable.

- **are married and file a separate tax return,** you probably will pay taxes on your benefits

Each January you will receive a Social Security Benefit Statement (Form SSA-1099) showing the amount of benefits you received in the previous year. You can use this Statement when you complete your federal income tax return to find out if your benefits are subject to tax.

Although you're not required to have federal taxes withheld from your Social Security benefits, you may find it easier than paying quarterly estimated tax payments. For more information about your taxes, see Internal Revenue Service (IRS) Publication 554, "Tax Information for Older Americans," and Publication 915, "Social Security Benefits and Equivalent Railroad Retirement Benefits." Both publications have worksheets to help you figure out whether your benefits would be taxable. You can call the IRS at 1 800-829-3676 to ask for copies of these publications.

* Combined income is the sum of your adjusted gross income on your 1040 tax return, plus nontaxable interest, plus one-half of your Social Security benefits.

Are retirement benefits available to a surviving spouse, children, or a divorced spouse?

When a person who has worked and paid Social Security taxes dies, certain members of the family

may be eligible for survivors benefits (a widow or widower, unmarried children up to 18, disabled children of any age, dependent parents at least age 62.) Up to ten years of work is needed to be eligible for benefits, depending on the person's age at the time of death.

You can work and still collect survivor's benefits, depending on your age and income.

Disability and Supplemental Security Income (SSI)

This benefit is a distribution of cash in the event of interruption of employment, including disability and unemployment, when people become severely disabled and are unable to perform substantial work. The benefit is based on the beneficiary's work record only. The beneficiary must be "fully insured" under Social Security rules.

There is a five-month waiting period for Social Security disability benefits and the benefits continue until a beneficiary is able to return to work or until retirement age if the individual cannot return to work.

For more information call 1-800-772-1213 or contact your local Social Security office for an appointment to apply.

Survivors Benefits

When a person who has worked and paid Social Security taxes dies, certain members of the family may be eligible for survivors benefits. Up to ten years of work is needed to be eligible for benefits, depending on the person's age at the time of death. Widows and widowers can receive Social Security benefits at age 60, or at age 50 if they are disabled.

Social Security survivors benefits can be paid to:

- A widow or widower – full benefits at full retirement age, or reduced benefits as early as age 60
- A disabled widow or widower – as early as age 50.
- A widow or widower at any age if he or she takes care of the deceased's child who is: under the age of 16 or disabled and receiving Social Security benefits
- Unmarried children under 18, or up to age 19 if they are attending high school full time. Under certain circumstances, benefits can be paid to stepchildren, grandchildren or adopted children.
- Children at any age who were disabled before age 22 and remain disabled.
- Dependent parents age 62 or older.

For details on how divorce, remarriage and retirement affect survivor's benefits, go to **http://www.socialsecurity.gov/ww&os2.htm**

Resources:

www.socialsecurity.gov

Working with Seniors textbook, Society of Certified Senior Advisors, 2009.

Medicare

What is Medicare?

Medicare is the federal health insurance program for people 65 years of age or older, certain younger people with disabilities, people with permanent kidney failure, and people with Lou Gehrig's Disease (ALS).

Get the most from your Medicare benefits by learning what Medicare covers and by taking advantage of all that Medicare has to offer.

Medicare has the following parts:

Medicare Part A (Hospital Insurance) helps cover inpatient hospital care. Part A also helps cover skilled nursing facility care (following a 3-night hospital stay and discharge to a Medicare approved skilled nursing facility). Medicare also covers hospice and home health care if certain conditions are met.

Medicare Part B (Medical Insurance) helps cover medically necessary services like doctors' services and outpatient care. Part B can also cover some preventive services to help maintain health and to keep certain illnesses from progressing.

Medicare Part C (Medicare Advantage Plans) combines Part A, Part B, and sometimes Part D (prescription drug) coverage. Part C Medicare Advantage Plans are health plans offered by private companies and approved by Medicare

Medicare Advantage Plans always cover emergency and urgent care, and all services that original Medicare covers except hospice care. (Original Medicare covers hospice care even if you have a Medicare Advantage Plan.)

Medicare Advantage Plans may also offer extra coverage such as vision, hearing, dental and/or health and wellness programs. Each plan can charge different out-of-pocket costs and may have different rules for how to get service.

Medicare Part D (Prescription Drug Coverage) may help lower prescription drug costs and help protect against higher costs in the future.

Do I need to enroll in Medicare?

If you are receiving Social Security benefits when you turn 65, Medicare Part A starts automatically.

If you are not collecting Social Security, you need to sign up for Medicare about three months before you reach age 65. You are eligible for premium-free Part A if you are age 65 or older and you or your spouse worked and paid Medicare taxes for at least 10 years.

If you are covered by an employer group health insurance plan, you might want to delay enrollment into Part B of Medicare. If you elect to delay enrollment in Part B, you can sign up later during a Special Enrollment Period or a General Enrollment Period. You will want to consult with Social Security prio to deferring your enrollment.

How are Medicare Part B premiums paid?

Part B premiums are deducted monthly from your Social Security, Railroad Retirement or Civil Service Retirement check. Premium amounts can change yearly; you can verify premium amounts at **www.medicare.gov.**

Medicare

If you do not receive monthly payments from Social Security, Railroad Retirement or Civil Service Retirement, then Medicare will send you a bill every three months.

What should I know about Medicare Advantage Plans?

There are different types of Medicare Advantage Plans including:

- Health Maintenance Organizations (HMO) Plans
- Preferred Provider Organizations (PPO) Plans
- Private Fee-for-Service (PFFS) Plans
- Medical Savings Account (MSA) Plans
- Special Needs Plan (SNP)
- Point of Service (POS) Plans
- Provider Sponsored Organizations (PSOs) Plans

It is important to know that Medicare Advantage Plan benefits can change annually, and if needed you can go back to traditional Medicare.

How does the Part D (Medicare prescription drug coverage) plan work?

Enrollment is optional for people who receive Medicare benefits, but you must enroll in Part D to receive it. The drug plan covers most brand name and generic drugs. Like other insurance, you pay a monthly premium, a deductible, and a share of the costs of your prescriptions. Monthly premiums and annual deductibles vary depending on the plan.

After you satisfy your deductible, you pay a percentage of your drug costs up to a certain amount. After that amount, you pay 100% of your drug costs until you have spent a certain yearly total. After that total is met, for the rest of that year, you will pay a minimal percentage of your drug costs. Cost maximums, yearly maximums and percentages may change; go to: **www.medicare.gov** for more information.

I am retired and on Medicare. If I go back to work, will my earnings affect my Medicare eligibility?

Medicare eligibility is not based on income or resource levels. Your Medicare eligibility will not be affected by how much income you earn after retirement.

What does Medicare pay for long-term care?

Medicare pays for skilled care. It does not pay for non-skilled, custodial care in your home or a facility. Custodial care is personal care that provides help with (1) the Activities of Daily Living such as bathing, dressing, eating, transferring (getting in or out of a bed or chair), toileting or maintaining continence or (2) the effects of a cognitive impairment such as Alzheimer's or dementia, when the person is no longer safe to be alone.

To qualify for Medicare coverage in a skilled nursing facility, you must first meet the qualifications of a three-night hospital stay. After that, the care must be short-term, up to 100 days for recovery or rehabilitation. After the first 20 days, the patient will be responsible for part or all of the costs.

Resources:
Centers for Medicare and Medicaid Services (CMS),
www.cms.hhs.gov
www.medicare.gov
www.aarp.org

Working with Seniors textbook, Society of Certified Senior Advisors, 2009.

Medicare Supplements

What are Medicare Supplements?

Original Medicare pays for many, but not all health care services and supplies. A Medigap policy sold by private insurance companies can help pay some of the heath care costs ("gaps") that Original Medicare doesn't cover, like copayments, coinsurance and deductibles, and medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, both plans will pay their share of Medicare-approved amounts for covered health care costs. Medicare doesn't pay any of the costs for a Medigap policy.

Buying Medigap insurance is an important process which should include weighing your priorities, comparing policies, and balancing coverage with affordability.

How do I know if a policy is legitimate?

Every Medigap policy must follow federal and state laws designed to protect you, and it must be clearly identified as "Medicare Supplement Insurance." Medigap insurance companies can sell you only a "standardized" Medigap policy identified in most states by letters, Plans A through N. All plans offer the same basic benefits but some offer additional benefits so make sure to review them in order to choose the plan that meets your needs.

Do I need Medicare to get a Medigap policy?

You must have Medicare Part A (hospital coverage) and Part B (medical insurance) in order to purchase a Medigap policy, but you do not need a Medigap policy if you have Medicare Part C, the Medicare Advantage plan (HMO).

Can I be canceled if I have a lot of health problems?

As long as you pay your premium, your Medigap policy is guaranteed renewable. It is automatically renewed each year and will continue year after year, as long as your premium is paid. Premiums may increase each year.

Can I get a Medigap policy that also covers my spouse?

You and your spouse must buy separate Medigap policies. Your Medigap policy won't cover any health care costs for your spouse.

Why should I buy a Medigap policy?

Medigap policies can lower your out-of-pocket medical costs and can provide increased health coverage over that provided by Medicare.

What are some examples of things that are not covered by Medigap policies?

Medigap policies do not cover things such as custodial level of long-term care, routine vision or dental care, hearing aids, and private-duty nursing.

How much do Medigap policies cost?

Each insurance company sets its own premiums, and the cost of Medigap policies can vary widely. There can be big differences in the premiums that insurance companies charge for the same coverage, primarily due to the different ways insurance companies set their prices. Although initial price is important, you should ask how long a plan has been available when choosing a plan. Newer plans may cost less initially but there may be significant renewal rate increases. Investigate carefully and thoroughly when choosing a Medigap plan.

When should I buy a Medigap policy?

It is important to buy your Medigap policy during your Medicare Open Enrollment period, which starts on the day you are covered under Medicare Part B, or the first of the month you turn age 65 if you are already on Medicare Part B.

During the six-month open enrollment period, an insurance company can't:

- Deny you any Medigap policy it sells;
- Make you wait for coverage to start;
- Charge you higher premiums because of health problems.

If you buy a Medigap policy during the open enrollment period, and you had health insurance coverage for at least six months prior, the company can't apply a pre-existing condition waiting period to you.

You can submit an application for a Medigap policy prior to your Medicare Part B effective date or prior to turning age 65. In most states, you can apply up to 90 days ahead of the requested effective date. Some states allow you to apply up to six months ahead of that time.

Where can I go for more information?

For additional information on Medigap policies, including why you would want to buy a Medigap policy and information about what Medigap policies cover, please read the federal government publication, available at www.medicare.gov, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." This publication answers frequently asked questions about Medigap policies:

Resources:

www.healthinsuranceindepth.com
www.medicare.gov
www.aarp.org

Working with Seniors textbook, Society of Certified Senior Advisors, 2009.

Medicaid

What is Medicaid?

Many people confuse Medicare and Medicaid. Medicaid is a "means-tested program," available to those who meet their state's general, medical and financial eligibility requirements. Medicaid provides medical care to the poor – adults, children and pregnant women living under the federal poverty level. It is funded jointly by the states and the federal government. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds.

While Medicaid provides a critical safety net for many seniors, the decision to rely on Medicaid entails some risks. Good financial planning can help the family determine if Medicaid funding for long-term care is a reasonable alternative to purchasing an appropriate long-term care insurance policy. A long-term care insurance policy can provide peace of mind while permitting the senior to remain at home for care or go to a facility and not erode the principal of their estate assets.

Medicaid was established in 1965 at the same time as Medicare under Title XIX of the Social Security Act. It was designed to assist low-income families in providing health care for themselves and their children. It also covers certain other individuals who fall below the federal poverty level. It covers hospital and doctor's visits, prenatal care, emergency room visits, prescription drugs, and other treatments. Medicaid also pays for custodial long-term care where Medicare does not. Within broad national federal guidelines, each state:

1. establishes its own eligibility standards;
2. determines the type, amount, duration, and scope of services;
3. sets the rate of payment for services; and
4. administers its own program.

Medicaid is the biggest financer of long-term care in the US. More than two-thirds of Medicaid spending for long-term care is on institutional services (nursing homes). The Deficit Reduction Act of 2005 made it more difficult for people with higher incomes and assets to become eligible for Medicaid benefits for long-term care. Each state determines new limits based on federal guidelines.

Seniors who fall below the federal poverty level (in both assets and income) usually don't have the income or the assets to purchase long-term care insurance or pay the costs of long-term care on their own. Seniors who qualify for Medicaid benefits through a medically needy determination are those who face medical bills, including long-term care expenses, in excess of their ability to pay. An attorney who understands planning for the possibility of needing Medicaid benefits should be consulted.

Can I keep my house and still use Medicaid?

Medicaid does not count all assets when determining eligibility. Seniors may keep some assets. These assets are called non-countable assets and include a home if a healthy spouse or disabled dependent child is living in the home. If not, then the home must be under a set value as determined by each state. Medicaid does not count the value of basic household

a car, or burial plots. A Medicaid beneficiary cannot keep other assets which are considered countable assets, such as stocks, bonds, investments, and retirement plan assets. According to federal law, an unmarried applicant for Medicaid may retain non-countable assets plus no more than a minimal amount in countable assets (each state determines its own criteria within these limits). Before Medicaid benefits begin, an applicant must consume or eliminate the amount of countable assets above this limit.

How much income can I have and still qualify for Medicaid?

Each state has different income eligibility requirements. Medicaid counts Social Security income, defined benefit pensions, alimony, and income from immediate annuities as income. Most income counted by Medicaid will be applied toward nursing home and other care costs, and then Medicaid makes up the difference between the total cost and available income. The effect is essentially a huge copayment for services.

Income decisions are complicated for married individuals, and some states set an individual income threshold for Medicaid eligibility. Once again, consult an elder law attorney in order to make the best decisions about Medicaid.

What is Medicaid Planning?

Families who face long-term care decisions and wonder how to pay the high costs of care, may be able to transfer countable assets so they are inaccessible to both the Medicaid applicant and the Medicaid program by either giving them away or placing them in a trust. Medicaid will look back to review all financial transactions to determine eligibility. You should seek advice from an expert such as an attorney specializing in elder law.

Will my family have to pay back Medicaid for my medical or long-term care costs?

Federal law requires states to seek recovery for Medicaid benefits by placing a claim against the probate estate of the deceased beneficiary. States may also seek to recover non-countable assets (such as the home) and/or non-probate assets such as jointly owned property, living trusts, etc. For these reasons, it is extremely important for the family to obtain competent legal advice about how assets can be affected by the Medicaid program.

There are financial tools, such as irrevocable trusts and some annuities (where the beneficiary is the state), that can be used to preserve assets. Effective and safe use of these measures also requires the assistance of a knowledgeable professional. Further, establishing and executing powers of attorney (financial and medical) is critical to the success of Medicaid planning in case a senior suddenly becomes incapacitated.

Will Medicaid pay for home health care if I don't go into a nursing home?

This will depend on the type of care needed and the state in which you reside.

Resources:

www.medicaid.gov

Working with Seniors textbook, Society of Certified Senior Advisors, 2009

Long-Term Care Insu

Long-term care is a family issue. When someone needs care, multiple family members typically get involved in the major decisions about where care will be given, by whom and how to pay the cost. Long-term care insurance provides the money and management for your long-term care so your family members don't have to.

What is long-term care insurance?

Long-term care insurance pays for services to help people who are unable to perform certain Activities of Daily Living (ADLs) without assistance. Long-term care insurance is available as individual insurance or through an employer-sponsored or association plan. You must be healthy to apply, and the premiums are based on your age at the time the policy began. In some cases, insurance carrier underwriters may approve an applicant with chronic health problems that are well managed.

The decision of whether you or someone you love needs long-term care is done by a health professional who certifies that care is needed based off meeting either one of two criteria: (1) that the individual will be unable to perform some of the ADLs without assistance for 90 days or more. This inability to perform ADLs could be from an accident or illness; ADLs include:

- Transferring from a chair or bed
- Toileting and associated hygiene
- Bathing
- Dressing
- Eating
- Maintaining Continence (control of bowel or bladder)

Or (2) that assistance is needed due to a cognitive impairment, which means the deterioration or loss of intellectual capacity that requires continual supervision, such as Alzheimer's disease, Parkinson's or dementia.

How does the insurance work?

Comprehensive insurance plans include choices of where care will be given: at home—mostly by family members with paid professionals assisting; in adult day care; in an assisted living facility; or in a nursing home. The choice for the location of care is made at the time care is needed with guidance from a care coordinator, nurse or social worker hired through the insurance company. This is an important benefit of the insurance plan because expert guidance may be necessary.

Long-term care plans are designed with only a few decisions to be made, and a licensed insurance professional can guide you. Knowing the cost of home care and facility care in your community before you purchase insurance will be helpful as you design a

long-term care plan. Some of the decisions you may have to make include the following:

- Most carriers offer an Elimination Period or Waiting Period the first time you access your policy benefits. This means you are responsible for long-term care costs and premiums until after the period is over. It is similar to a deductible on other types of insurance and will keep the cost of premiums at an affordable level. A period of 60-90 days of care is common.

- Once the Elimination Period has been satisfied the plan will pay a daily, weekly or monthly maximum amount for your care, depending on the policy. This maximum will be deducted from a lifetime maximum pool of money in your plan, based on the amount chosen. Generally the pool of money is hundreds of thousands of dollars for you to use right away or in the future.

- The cost of care at home or in a facility is continuing to rise and there is an inflation protection feature offered in the insurance plans to give you a more meaningful benefit in the future. This feature adds to the premium cost.

What other riders or options are available?

- Individual plans offer spouse discounts when one or both are approved.
- Those individuals with good health ratings may be offered plans at a discount.
- Bed reservation is common to hold a bed in a facility when you are temporarily away.
- The option to get a return of premiums you've paid may be available for an additional premium cost in order to provide money (amount based on premiums paid in) to your estate if your policy is still in force at the time of your death.

Is Alzheimer's disease covered by long-term care insurance?

Most long-term care insurance policies will cover Alzheimer's and other organic cognitive disabilities. Check the policy contract to be certain. An insurance company will not issue a new long-term care insurance policy to someone already suffering from Alzheimer's.

What is a federally tax-qualified long-term care policy?

Most policies sold today are tax-qualified. If you itemize deductions on your tax return, you may be allowed to deduct a portion of the premium costs (eligible amount) as a medical expense. (Deductions are subject to a percent of adjusted gross income limitation.) The eligible amount is based on your age. Also, the benefits in a reimbursement or indemnity insurance plan are tax-free, to a certain level.

Do long-term care insurance premiums increase each year?

The younger you are when you first buy a policy, the lower your annual premium will be. Insurance companies can raise rates, but only for everyone in the

same pool of insured. The company cannot target individual policyholders for special rate increases despite the number of claims someone may make. Policies are guaranteed renewable which means that you cannot be cancelled because your health deteriorates or you make claims, as long as premiums are paid.

What is not covered by long-term care insurance?

Long-term care insurance policies do not cover hospital stays. They are designed to pay for custodial, long-term care at home or in a facility.

Long-term care insurance policies have exclusions and will not cover: certain disorders such as alcohol or drug addiction, or care necessitated by an act of war or self-inflicted injury. Some policies have limited international coverage.

Once you are approved, there are no pre-existing conditions. The Outline of Coverage that is yours to keep will explain, in detail, the coverage included in your policy.

What are some important things to consider when looking into long-term care insurance?

Consult with a trusted insurance professional who has knowledge about long-term care planning and understands the health care community. You want one who will assist you in designing a plan that will offer protection today and peace of mind in the years to come.

Make sure to ask how long the insurance carrier has been offering their long-term plans and if they have good claims experience.

If there is a Partnership Plan offered in your state, ask how it works to protect your assets should you need to use Medicaid benefits. Many states offer these plans to help encourage consumers to buy long-term

care insurance before spending down assets.

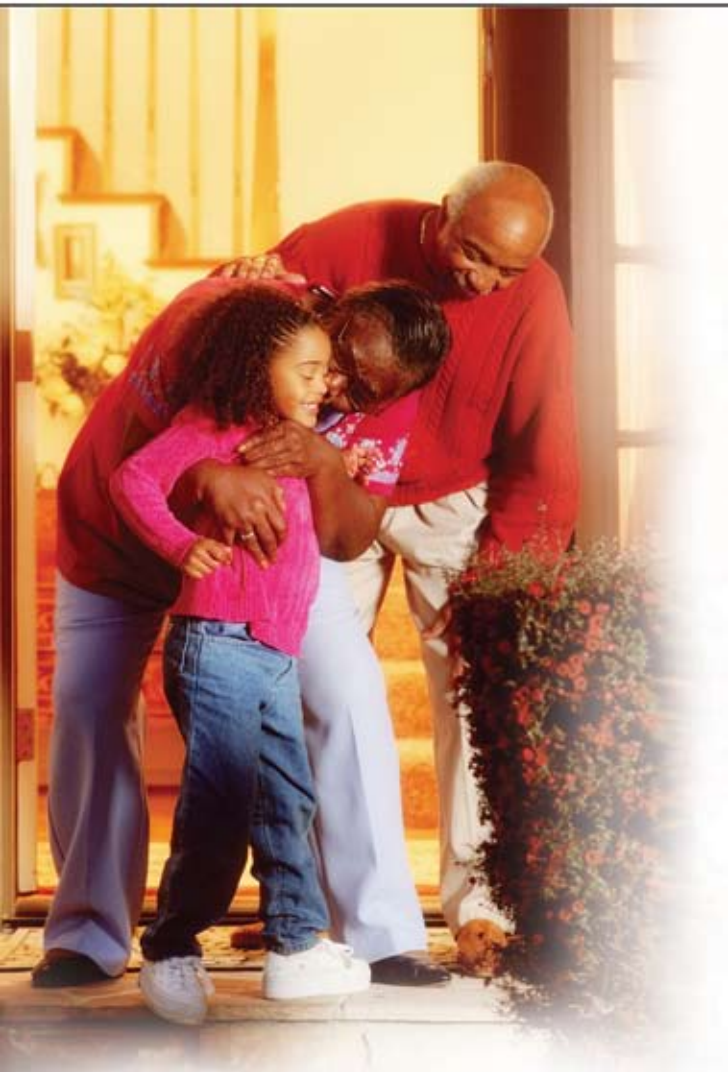
Long-term care insurance should not be confusing. Planning for care, and having money to pay the cost, is important and the best way for you to control your care and provide protection for your family should you need care yourself.

Resources:

www.pueblo.gsa.gov/cic_text/health/ltc/t_guide.htm

Working with Seniors textbook, Society of Certified Senior Advisors, 2009.

In-Home Care



The term "aging in place" refers to living where you have lived for many years (or to living in a non-health-care environment) and using products, services and conveniences that support you in staying “in place” as circumstances change. Many seniors want to remain at home as long as possible, and planning ahead is a good idea for them and their families.

Oftentimes decisions must be made quickly and sooner than expected because of an accident or an unexpected

illness. Short or long-term in-home care by a family member or friend may be required and means a change in how individuals and families function in their daily lives. The good news is that if this happens, you aren't alone. There are individuals and organizations qualified to provide advice or in-home care to assist your family. Your local Area Agency/Council on Aging can provide you with a list of services that are available in your area.

The National Association of Area Agencies on Aging (N4A) is the umbrella organization for the 655 Area Agencies on Aging (AAAs) in the United States. The fundamental mission of the N4A is to provide services that make it possible for older individuals to remain in their homes. Their website is www.n4a.org .

What is in-home care?

The majority of in-home care (commonly referred to as simply 'home care') is provided by informal caregivers, usually family and friends. Home care can also be provided through non-medical staff contracted from home care agencies. Most of the care is non-skilled, custodial long-term care, providing assistance with things such as meals, transportation, medication management, paying bills, shopping, housework, laundry, bathing, dressing, transferring and help with toileting. Other non-medical services such as companion care and personal care may be available from local home care agencies.

How does home health care differ from home care?

Home health care refers to the provision of skilled nursing care and other skilled care such as speech, physical or occupational therapy. There is scientific evidence that when medical care is provided in the home, some patients may heal faster and many risks, such as infection, can be minimized. Patients

who stay at home can continue their customary daily routines, and their own physician continues to oversee their care. Home care is generally custodial, non-skilled care covering those services listed in the previous section.

Does Medicare pay for home care or home health care?

Medicare covers **some** home health care if **all** of the following conditions are met:

- A doctor must decide that the patient needs medical care in the home.
- The patient must require at least one skilled service on a part-time or intermittent basis (skilled nursing care, physical therapy or speech language pathology services, or continuing occupational therapy).
- The patient must be homebound; this means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care does not keep you from getting home health care.
- Medicare must approve the home health agency caring for the patient.

What doesn't Medicare cover for home care?

- 24-hour-a-day care at home;
- Prescription drugs;
- Meals delivered to your home;
- Home support services like shopping, cleaning, and laundry; and
- Personal or companion care, such as bathing, dressing and using the bathroom, when this is the only care needed (custodial care).

It is important to consider the needs of the caregiver and the level of care needed. Caregivers may not be

able to care for you 24 hours a day, every day. They may need help so they can provide you with the best possible care on an ongoing basis.

How much does home care (custodial care or respite care) cost?

It depends primarily on location. Home care services are usually provided on a one-on-one basis with tasks and schedules customized to meet the needs of the patient. Hourly rates across the U.S. may range from a low of $10 to a high of $25 or even more in major metropolitan areas. Most home care agencies have a minimum per-visit rate which usually covers a few hours per visit.

Resources:

www.medicare.gov/longtermcare/static/home.asp

Working with Seniors textbook, Society of Certified Senior Advisors, 2009.

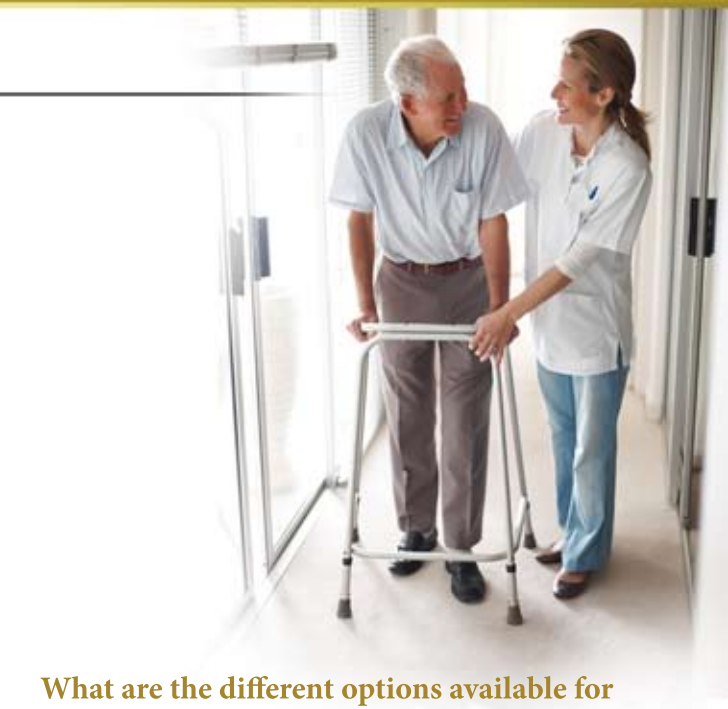
Senior Housing

There may be a time when you will need to consider alternative housing and having the right information about the options can make all the difference in whether you or someone you care about ages successfully. It's important to find the right senior housing option as this allows a senior to have the appropriate level of support and care. Factors such as the senior's health and financial situation are critical to this decision since there are many different levels of care, each with different service and payment options. Finding the right place begins with assessing the senior's current health condition, determining the level of care the senior needs both currently and in the future and matching that with the services offered at the facility.

A major factor in determining the level of care needed is the senior's ability to perform their own basic Activities of Daily Living (ADLs) which include but are not limited to bathing, dressing, eating, toilet use, transferring from a bed or a chair and walking. The ability to perform Instrumental Activities of Daily Living (IADLs) are another indicator to consider. These include the ability to use a telephone (look up numbers, dial, answer), travel by car or public transportation without issue, shop for food or clothes, prepare meals, prepare and take the correct dose of medication, and manage money such as write checks and pay bills.

For a thorough assessment, a General Practitioner, Geriatrician, Social Worker for care planning, Geriatric Care Manager or other specialist can make a professional assessment of your options.

Another major component is a senior's financial situation relative to the costs associated with each senior housing option. Understanding what is covered by private funds, Medicare and Medicaid, and long-term care insurance is often a major factor in making a final decision.



What are the different options available for Senior Housing?

Independent Living
Also referred to as Active Lifestyle Communities, Retirement Communities and Senior Living Communities, this type of housing is for independent and active adults interested in recreational and social opportunities, who have few or no health care needs and can perform their own ADLs. Built to accommodate an active senior lifestyle, these properties offer many amenities and are constructed for a physically safer environment such as handrails in the bathrooms and 24-hour emergency response systems. Services for home care may be available on site. These facilities are most commonly paid for by private funds, but subsidized programs may be available. They are not licensed or regulated by federal or state agencies.

Continuing Care Retirement Communities (CCRCs)
CCRCs are campus-style communities which offer all levels of senior housing on one property – independent living, assisted living and skilled nursing facilities. As an individual's healthcare needs change, he or she can

remain on the same property but transfer to the next level of care needed, allowing a person to 'age in place'. These are also referred to as Life Care Communities and Life Services Communities. The most common form of payment is private funds. Some communities require a non-refundable entrance fee or equity payment. For the assisted living section of the community, Medicaid may be accepted. With the exception of independent living, each level of care at a CCRC is regulated.

Assisted Living

Assisted living facilities are for people who don't need care 24 hours a day, but who require some assistance with activities such as bathing and dressing. They do not provide complex medical care. Typically, the home environment includes bedrooms, kitchenettes and living area. Paid for most often by private funds, long-term care insurance may cover this living situation. In a few states, Medicaid funds could be available. Assisted living is regulated at the state level, but those standards vary from state to state.

Skilled Nursing/Nursing Home

Skilled nursing is for individuals requiring long-term, 24-hour care from a licensed nurse and possible short-term rehabilitation services. It also provides the services offered at the assisted living level. Private funds, Medicaid and long-term care insurance are most common in covering the costs. Medicare may cover some costs for a short-term rehabilitation stay. These facilities are regulated at the state and federal levels and licensed at the state level. They are certified by both Medicare and Medicaid. The staff and administrators must conform to licensing standards.

Alzheimer's and Dementia Care

A few options exist for patients dealing with Alzheimer's or dementia. Assisted living and skilled nursing facilities often have programs devoted to the needs of memory

care individuals. Additionally, facilities developed especially for patients dealing with memory issues are also an option. When assessing a facility for quality Alzheimer's and dementia care, safety, supervision and structured activity offerings should be considered first because of the nature of the disease. Payment options vary depending on which level of care is chosen. Private funds and long-term care insurance most commonly cover the costs. It is possible that Medicaid may be available to assist with payment as well. Visit the Alzheimer's Association website for more information at **www.alz.org.**

What does 'Medicare certified facility' mean?

Facilities which are 'Medicare certified' are required to be in compliance under the Medicare or Medicaid programs. The state is responsible for certifying that a facility is in compliance and recommends appropriate enforcement. The Centers for Medicare and Medicaid Services (CMS) regional offices determine a facility's eligibility to participate in the Medicare program based on the State's certification of compliance and a facility's compliance with civil rights requirements.

How do I locate a senior housing facility?

Medicare.gov has a 'Resource Locator' that finds facilities within a defined mile radius and compares the facilities with a thorough and easy-to-read chart. The CSA website, **www.csa.us**, also has a locator tool to assist you in finding facilities by inputting a city and state or zip code.

Resources:
www.assistedlivinginfo.com;
www.medicare.gov; www.stronghealth.com;
www.alz.org; www.healthcare.uci.edu
Working with Seniors textbook, Society of Certified Senior Advisors, 2009.

About Society of Certified Senior Advisors® (SCSA)

SCSA is the world's largest membership organization educating and designating professionals who serve seniors. SCSA was founded in 1997 with the input of doctors, attorneys, gerontologists, accountants, financial planners and other experts who believe that there was a need for standardized education and a credential for professionals who work with seniors.

What is a Certified Senior Advisor (CSA)?

A CSA is a professional who has knowledge about aging and the important health, financial and social issues that affect the majority of seniors. Typically, CSAs already have expertise in a professional discipline – home care, senior housing, law, real estate, health care, clergy, insurance services and financial planning – and have chosen to supplement that existing professional knowledge with the CSA education. While many are licensed in their professional discipline, it is only after they meet all eligibility requirements that they may use the designation *Certified Senior Advisor.*

All candidates for the CSA designation must meet eligibility requirements established by the SCSA Certification Council, an independent body that oversees the development and administration of the CSA exam and designation program. These requirements include:

- education about senior issues and/or experience working with seniors
- pass a criminal background check
- pass the CSA designation exam
- pass the CSA Code of Professional Responsibility exam

To remain members of SCSA, CSAs are required to fulfill requirements for continuing education, disclose

any new legal or regulatory issues and re-affirm their pledge to uphold the *CSA Code of Professional Responsibility.*

Certified Senior Advisor Education

Among the hundreds of education programs and credentials available today, the Certified Senior Advisor course is in a category by itself because it educates professionals about seniors – how aging works, how it changes seniors' lives, how it affects their decisions and how we can apply what we know about growing older to help people age successfully.

The CSA course was developed with experts in aging from across many industries and covers 23 different topics that explore the health, social and financial issues that most impact the lives of seniors today. These 23 topics are divided into 5 key areas:

- Social aspects of aging
- Health aspects of aging – physical & mental
- Financial and legal aspects of aging
- Government assistance for seniors
- Ethical communication with seniors

SCSA also provides its members with ongoing education on leading-edge developments in the field of aging to continually enhance and expand the CSA's knowledge about working with seniors.

Where do I find a CSA?

On the Internet. Go to **www.csa.us** and click on "Find a CSA."

Notes

CSA
Certified
Senior Advisor (CSA)™

When you work with a professional who has added the Certified Senior Advisor (CSA)® designation to his or her credentials, you know you're working with someone who has invested time and effort into learning about the things that are impor tant to you. Work with a Certified Senior Advisor, work with someone who's committed to you.

www.csa.us/FindaCSA

Important: Certified Senior Advisors (CSA) have supplemented their individual professional licenses, credentials and education with knowledge about aging and working with seniors. The CSA designation alone does not imply expertise in financial, health or social matters. Find out more at www.csa.us

NCCA
NCCA ACCREDITED PROGRAM

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