A Family Guide to Paying for Elder Care Services in Indiana

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Medicare and Traditional Health Insurance

There is a common misconception that health insurance will pay for the cost of long-term care. Health insurance including Medicare, Medicare Supplements, HMOs, private insurance through employers, and disability insurance were **never** designed to pay for the cost of long-term care.

Medicare and Other Health Insurances

Medicare is a federal health insurance program for people 65 and older, certain people with disabilities, and ESRD (End Stage Renal Disease). It pays for much of your health care, but not all of it. There are some costs you will have to pay yourself. (www.medicare.gov)

There are other kinds of health insurance that may help pay the costs that Medicare does not. Medicare Supplements (Medigap Policies) and Long-Term Care Insurance will pick up some of the costs that Medicare will not pay for.

Medicare was implemented in 1965.

How many times has Medicare been over-hauled since 1965?

NEVER. It was not designed to pay for care related to diseases or conditions such as Alzheimer's disease, Parkinson's, or MS. The average life expectancy was much lower in 1965 because medical technology was not as advanced. Medicare was designed for SHORT-TERM acute care, and short-term rehabilitative stays in a rehab or long-term care facility. Although Medicare Part D was added in 2004/2005 to help with the costs of prescription drugs, Medicare still does not pay for long-term care.

What will Medicare pay?

Medicare comes in three parts.

Medicare Part A, Part B and now Part D for prescription drugs.

Medicare Part A is Hospital Insurance.

Part A pays for inpatient hospital care, some skilled nursing facility care, hospice care, and some home health care. Most people get Medicare Part A automatically when they turn 65. There is usually no premium or monthly payment for Part A.

Medicare Part B is Medical Insurance.

Part B pays for doctor's services, outpatient hospital care, and some other medical services that Part A doesn't pay for. Part B pays for these services and supplies when they are medically necessary. Part B has a premium that changes every year.

What will Medicare A and B NOT pay for?

Medicare carries some high deductibles.

- For instance during a hospital stay you will automatically have a deductible for days 1-60. On day 61 you are responsible for a certain amount per day through day 90.
- On day 91 you pay even more per day (your deductible) through day 150. ***This amounts to a substantial out-of-pocket expense for the Medicare recipient.***
- For a skilled nursing facility stay, Medicare pays for days 1-20. On day 21 you pay a certain amount per day deductible through day 100.
- Also, you will be responsible for 20% for most covered services under Part B, 50% for outpatient mental health treatment, and a co-pay for outpatient hospital services.

Tip: Medicare was never designed to pay for long-term care. In other words, if you will be living in a nursing home or if you will need around the clock care at home, ***Medicare does not pay for these services.*** Medicare is for acute, short term medical care and rehabilitative care only, otherwise called ***"skilled care".***

Defining Skilled Care vs. Custodial Care

Skilled care is defined as care that is prescribed by a physician and performed by a licensed health care professional, like a nurse, physical therapist, or occupational therapist. Some examples of skilled care include: some wound care, IV antibiotics, or physical therapy immediately after a stroke.

Custodial care is another term for ***private pay care***. This type of care can be performed by home health aides or other unlicensed caregivers, like family members. Some examples of custodial care include bathing, dressing, transferring from the bed to a chair, or toileting.

Medicare Supplements

Medicare Supplements, often referred to as Medigap plans, are purchased through private insurance companies to help fill the "gaps" that Medicare leaves behind. Medicare Supplements pick up the co-pays and deductibles associated with standard Medicare. There are ten standardized plans available labeled "A" through "J". Each plan has a different set of benefits. Medicare Supplements also do not cover the cost of long-term care; they simply pay deductibles and co-pays that Medicare does not.

Medicare HMOs (a.k.a. Medicare Advantage or Medicare+Choice)

HMOs are Health Maintenance Organizations. An HMO will require that the participant use certain doctors and hospital systems in their area. HMOs are also for short acute care stays in hospitals, and for short rehabilitative stays in skilled nursing facilities. They do not pay for the cost of long-term care.

Private Insurance

Private health insurance through an employer or previous employer is essentially the same as HMOs, as far as coverage. Standard health insurance, no matter how great the benefit, will ultimately *not cover long-term care.*

Disability Insurance

Disability insurance covers household expenses, and is designed as income replacement. It will pay for things like groceries, rent and utilities. This insurance was not designed to cover the added expense of long-term care.

Veteran's Administration Benefits

Many Veterans mistakenly believe that when they need long-term care, their VA benefits will pay the expense. VA benefits for long-term care are available, but the majority of those benefits are reserved for people with service connected disabilities. Check with your local VA office for more information.

Understanding Medicaid in Indiana

Medicaid Defined

Medicaid was established by federal law (Title XIX of the Social Security Act), and is administered by each state individually. Medicaid is a program for poor or "impoverished" people, and people with high medical costs. Congress established Medicaid to provide a "safety net" for people who had no other way to pay for their health care or long-term care.

Medicaid is the long-term care payer of last resort for the frail elderly, persons with health problems, persons with mental retardation, mental illness, and those with physical or developmental disabilities.

Most long-term care and services such as prescription drugs, eyeglasses and dental care are provided at each state's discretion. When state money is scarce these services may be the most vulnerable, not because of ill will on the part of the state decision makers, but because there may be nowhere else to cut state budgets.

Medicaid is a highly flawed program, and is under-funded and over-burdened. States continue to make, and change, decisions about Medicaid that among other things, will affect the amount of long-term care assistance available in each state, the eligibility criteria and number of persons eligible for that assistance, and the types of services that will be reimbursed.

Indiana Nursing Facility Level of Care Waivers

http://member.indianamedicaid.com

These waivers are for children and adults whose needs are primarily medical. There are two waiver programs: the Aged and Disabled Waiver and the Traumatic Brain Injury (TBI) Waiver.

ELIGIBILITY FACTORS

- Medical Conditions/ADLs
- Income
- Assets

Medical Conditions/Activities of Daily Living

A person must have an unstable complex medical condition which requires:

- direct assistance from others for the following conditions: decubitus ulcers, comatose condition, or management of severe pain; OR
- direct assistance from others for medical equipment, such as ventilator, suctioning, tube feeding, central intravenous access (I.V.); OR

- direct assistance for special routines or prescribed treatments from others such as tracheotomy, acute rehabilitation conditions, administration of continuous oxygen; OR
- direct assistance for special routines or prescribed treatments from others such as tracheotomy, acute rehabilitation conditions, administration of continuous oxygen; OR
- other substantial medical conditions, OR
- Diagnosis of a Traumatic Brain Injury for the TBI Waiver

INCOME

- The income of the individual can be up to 300% of the maximum SSI benefit amount. Effective January 1, 2013 the limit is $2,130.00 per month. This amount adjusts annually according based on any changes to SSI.
- Parental income and resources disregarded for children under 18
- If your income is above 300% SSI you may still qualify with a spend down if you have a Qualified Income Trust, also known as a "Miller trust".

ASSET TEST

Spousal impoverishment provisions apply. When a couple applies for Medicaid, an assessment of their resources is made. The couple's resources, regardless of ownership, are combined. The couple's home, household goods, an automobile, and burial funds are not included in the couple's combined resources. The result is the couple's combined countable resources. This amount is then used to determine the Spousal Share, which is one-half of the couple's combined resources.

****HOME AND COMMUNITY BASED SERVICES WAIVERS****

Waiver services allow individuals with special medical or developmental needs to live in the least restrictive setting while receiving the medical care and supports they need.

Long-Term Care Insurance

How much does long-term care insurance cost?

Of course the cost of long-term care insurance depends on many different choices and options. The more bells and whistles you choose, the more costly the plan. The most important thing to remember is that long-term care insurance premiums will NEVER cost as much as a few months in a nursing home without the insurance. The problem for most people is that long-term care insurance premiums may seem unaffordable, even though it's the most cost effective way to plan ahead.

Traditional Long-Term Care Insurance

Traditional Long-Term Care Insurance used to be viewed as "nursing home insurance" because most policies from 15 years ago only offered that one option. Today that is hardly the case. Long-term care insurance now covers adult day care, in-home care, assisted living, and nursing home care. These policies are considered comprehensive in nature. Now we refer to long-term care insurance as "lifestyle insurance".

Who CAN'T Get Long-Term Care Insurance?

Underwriting Explained

When you apply for a Long-Term Care Insurance plan, you must go through underwriting. Underwriting means that the company will check your medical records to determine what medical problems you may currently have, or have had in the past.

They want to know your overall health history. If you have been diagnosed with short-term memory loss, Alzheimer's disease, Parkinson's disease, Multiple Sclerosis, Lou Gehrig's disease, or if you have had a stroke with permanent physical impairment, you may not qualify.

People who have survived cancer and are treatment free for a certain length of time can often qualify.

Each insurance company has their own underwriting guidelines. It is best to talk to your agent or call the company directly with any specific questions about health issues. Height and weight are also a consideration when applying. Sometimes the insurance company will send a registered nurse to the home to ask a few questions, and take some more medical history, or they may just call on the phone for a brief interview.

Qualifying to USE the Benefits of a Long-Term Care Insurance Plan

Activities of Daily Living

When it's time to use your tax qualified Long-Term Care Insurance plan (taxes to be discussed in a later chapter), the insured person must need help or substantial assistance with 2 out of 6 activities of daily living for a period of 90 days or greater. This need for care must be certified by a licensed healthcare practitioner such as a nurse or physician.

These activities of daily living include:

- Bathing
- Dressing
- Eating
- Toileting
- Continence
- Transferring (moving from the bed to a chair)
- Or the insured must have a cognitive impairment like Alzheimer's disease or dementia.

A cognitive impairment means that although a person may be physically able to perform all of the activities listed above, they cannot remember or rationalize how to do those activities. One example would be bathing. Sometimes people with dementia are physically able to take a bath, but can't remember to do so, or can't remember why this is important. Or perhaps when getting dressed, they put on 5 shirts instead of one.

Comprehensive vs. Facility Only Plans

Comprehensive Plans

A comprehensive plan covers all aspects of long-term care: in-home care, adult day care, assisted living, and nursing home care. These plans are designed to help people stay at home longer and also assist them with transitions to other levels of care as needed. Most consumers want to stay at home for as long as possible. A comprehensive plan will satisfy that desire.

Facility Only Coverage

Facility only plans are still available on the market today. Facility only plans pay for just that, facility care only. Usually this includes assisted living and nursing home care. A facility only plan makes the most sense for folks who do not have a large network of family and friends around them, and for people who know that this may be their only option in the future. Facility only plans are less costly than comprehensive plans but again, offer payment only for nursing home and assisted living care. The insured person cannot live at home and use the benefits of a facility only plan.

Benefit Period

The benefit period is the length of time the policy will actually pay for care. There are many different benefit periods available including 2 years, 3 years, 4 years, 5 years, 7 years, 10 years, and unlimited lifetime coverage. When purchasing long-term care insurance keep in mind that premiums are paid for

potentially the next 20 years (or until the policy holder needs care), but the plan will only last about as long as the benefit period originally selected.

People often ask, "How do I know which benefit period to choose?" "How do I know how long I might need care?"

Obviously there is no way to really determine how long a person might need care. However the best advice is for each individual to take a look at their own personal health history and their family history. If there is a history of chronic disease such as Alzheimer's, Parkinson's, MS, or Lou Gehrig's disease, it might be worthwhile to consider a longer benefit period.

TIP: The average length of stay in a nursing home is about 2.8 years; the average care giving time at home is about 4.1 years.

Daily Benefit Amount

The daily benefit amount is the maximum amount a plan will pay on a daily or weekly basis. Some policies now pay based on a weekly or monthly maximum. In this case, it is important to know the average cost of care in the local area. In the Midwest for example, the average cost of care for a semi-private nursing home bed is about $200 per day. Therefore the plan should pay a maximum of $5000 per month. Currently in New York the cost of a semi-private nursing home bed is around $400per day or $12000 per month. Consider the cost of care in the area where you live and the cost of care in an area where you might retire, and plan accordingly.

- *A semi-private room* in a nursing home means that two people share a room.
- *A private room* in a nursing home means that the room is for one person only. A private room will cost significantly more than a semi-private room. Be sure to factor in the extra cost if a private room is expected.

For some people the insurance policy's daily benefit amount doesn't need to cover the entire cost of care. If there is some Social Security income or pension income that can pick up a portion of the long-term care costs, then perhaps some premium can be saved by having a lower daily benefit amount.

Keep in mind however, that $200/day covers the cost of room and board only in the Midwest, not the added cost of prescription drugs, supplies such as adult incontinence protection, and other necessities. The additional expense of these items can add as much as 20% per day on to the cost of a nursing home bed.

Elimination Period

The elimination period is similar to a deductible or a waiting period. This is the length of time a person must wait before their plan will begin to pay. Elimination periods vary from company to company and plan to plan. The elimination period choices include 0 days, 30 days, 60 days, 90 days, 100 days, and 180 days. Some plans will offer to waive the elimination period for home care under certain circumstances,

and some offer riders that will eliminate or decrease waiting periods. Be aware that some elimination periods are based on dates of service. Therefore if only one day of home care is needed per week and the elimination period is 30 days, it could take as much as 30 weeks to satisfy that elimination period. On the other hand, many companies today will allow one day of home care to count as 7 days toward the elimination period. This is a nice strategy and is useful in encouraging people to stay home longer.

TIP: The shorter the elimination period, the more expensive the premium.

Inflation Protection Options

The average cost of health care rises anywhere from 4%-7% per year. Therefore $200 per day today won't be enough coverage 10 years from now when the cost is actually around $300 per day. So it is important to build in some protection against the cost of inflation.

There are typically three types of inflation protection that are available. One is compound inflation protection which provides an automatic increase in benefits every year (usually at 5%) with no corresponding increase in premium. This is the most expensive inflation protection but well worth the investment. For consumers who buy long-term care insurance at younger ages, for example anyone under age 70, compound inflation protection offers the most complete coverage.

Simple inflation protection is also usually at 5% per year but is not compounded. This inflation protection will grow at a slower rate than compound inflation protection and is often recommended for folks over age 70. There is no corresponding increase in premium.

Finally, there is a future purchase option offered on some plans. This option allows the consumer to decide at a later time whether they would like to buy more daily benefit amount to catch up with the current cost of care. If no extra benefit is purchased, the daily benefit amount remains the same and the premium does not increase. If extra benefit is purchased, the premium increases to the new benefit level. No further underwriting is required for future purchase option benefit increases.

Care Coordination Benefits

Some plans will offer care coordination as a built in benefit. Care coordination is a valuable service for both the person receiving care and for the other family members involved. Long-term care insurers recognize that sometimes it is difficult for a senior or a family member to know which services in their local area might be most appropriate and give the best quality care available. Care coordinators are licensed professionals such as Registered Nurses and Licensed Social Workers who have experience in home health and coordinating care for seniors in their local areas. Some companies will require the plan member to use a care coordinator designated by the insurer. Other companies will allow a family to choose that care coordinator. They will allot a certain amount of money to be used toward a comprehensive in-home evaluation and plan of care. Either way, this service is invaluable and takes the fear and confusion out of selecting a long-term care provider. Care coordinators are not "gatekeepers". They are simply healthcare professionals who know the system and the local resources. They are there for guidance and assistance along the way.

Home Care and Community Care Benefits

Home and Community Care includes services provided by a licensed home health agency. This can include services from a Registered Nurse, Licensed Practical Nurse, Physical Therapist, Occupational Therapist, Nurse's Aide, homemaker services (non-medical services), at-home hospice care, and adult day care. Some plans with enhanced home care provisions, or riders, will also allow (with authorization) a friend or family member to provide care. That family member will be reimbursed for their time and expense. Usually a family member cannot be someone who normally lives in the same home as the person going on claim. In other words, most long-term care insurance companies do not want to pay a spouse to be the sole caregiver.

Facility Care

Facility care most often refers to care received in a Nursing Home, Hospice Facility, or Assisted Living Facility. The plan will usually cover room and board, nursing care, maintenance or personal care, and hospice care in that facility. Most plans will also offer a bed reservation benefit, meaning that if a person leaves the facility for the weekend, or is hospitalized, the insurer will pay for that amount of time to hold the bed even though the insured is not in the facility. Most bed reservation benefits last about 30 days per policy year.

Respite Care Benefits

Respite Care, simply defined, is a break for the caregiver. For example if daughter Susan is caring for her father she may need a break from time to time. If she decides to take a long weekend and go on vacation, a formal caregiver can be hired to take her place. Respite care can be received in a nursing home, adult day care, in-home, or in a hospice facility. The insurer will pay the maximum daily benefit for up to 21 days per year on average. The insured does not have to meet the elimination period in order to use Respite Care benefits.

Alternate Plan of Care

Alternate plan of care usually refers to services that are not already clearly defined in the plan. Most alternate plans of care must be approved by the insurer, but would include services designed to enhance quality of life, or designed to keep a person safe in their home for a longer period of time. Examples include a Personal Emergency Service, like LifeLine, or perhaps a wheelchair ramp that would enhance accessibility to the insured's home.

Caregiver Training

Caregiver Training is useful when an informal caregiver needs to learn how to bathe, transfer, feed, or dress someone receiving long-term care. A licensed or formally trained professional will provide the training to the informal caregiver. This ensures that the care being received is quality care, and is provided in a safe and efficient manner. This training will be paid for by the plan.

Bells and Whistles (The Riders)

Riders can be purchased in addition to the standard long-term care insurance plan and offer flexibility in plan design.

Shared Benefits

Some plans will allow spouses and families to share benefits. One example would be sharing a benefit between husband and wife. In this case, the husband and wife choose an 8-year plan. If he needs to use 6 years of the plan, she will have 2 years left to use when she needs long-term care. A shared benefit plan might be recommended to a couple who have been married for many years and who are roughly the same age.

Survivorship

Survivorship typically means that if both spouses are insured by the same company with no claim having been made in 7-10 years, and one spouse passes away, the other spouse's plan will be paid up in full. There will be no further premium due for the surviving spouse and coverage will continue.

Return of Premium

Return of premium takes away the fear: "If I don't use it, I will lose it!" This simply means that if a claim has never been made and the insured person passes away, the premium paid will be returned to the surviving heirs. There are several variations on the theme and each company handles return of premium differently. Pay close attention to contract language in the policy.

Waiver of Premium

In many cases, waiver of premium is a built in feature of a long-term care insurance plan, but in some cases it can be purchased as an extra rider. Waiver of premium means that when the insured files a claim and begins using their benefits, they no longer pay premiums to the insurance company. Usually, waiver of premium goes into effect after the elimination period has been satisfied.

Indemnity

The typical long-term care insurance plan is a reimbursement plan, meaning that the insurance company reimburses the care providers after a claim has been sent in. However some plans now offer an indemnity situation. This type of plan will pay the insured the daily or monthly benefit, and it is up to the insured to pay the care providers. This type of plan is more flexible and usually more expensive. However the insured has more options when choosing a care provider. For instance, instead of using a local home health agency, the insured person may want to pay a son or daughter to care for them. Indemnity plans require that the insured, or their legal representative, makes good choices about care and is able to use the money wisely.

<u>Important Consideration When Choosing a Long-Term Care Plan</u>

Ratings

Financial ratings of a company are important when considering purchasing a long-term care insurance plan. The recommendation is to choose a company with an AM BEST rating of A+ or better.

Assets

Assets of the insurance company should be in the BILLIONS.

Discounts

Some long-term care insurers will allow for group discounts through employers, or “affinity” group discounts through a local organization. Senior clubs and organizations all across America offer discounts from 5%-10% on long-term care insurance. Not all companies permit these types of discounts however there are some discounts that almost all long-term care insurers include in their plans. Those include spousal (or partner) discounts and good health discounts. Spousal discounts are applied when a couple applies for the insurance together.

Discounts of this kind range anywhere from 30-50%. Good health discounts are given when the applicant is in excellent health. Each company has it’s own underwriting guidelines for health discounts. These will range from 10%-15%.

Tax Considerations

Currently there are some tax advantages regarding tax qualified long-term care insurance plans. At the Federal level, premiums for long-term care insurance fall into the “medical expense” category. So if the premium (or the premium plus other medical expenses) is over 7.5% of the adjusted gross income, part of that premium is tax deductible. Below is a table that determines how much of the premium is deductible. Tax payers must be able to itemize in order to take advantage of the federal deduction. It is important to talk to a tax advisor or accountant for that information, as it changes every year.

VA Home Aid and Attendance Pension Benefit

There are financial benefits available for Veterans or their surviving spouses for non-service connected disabilities.

The Veterans Administration has established a pension program whereby your purchase of personal care and attendant home services may be paid for through your acquired pension. If you are a Veteran or the surviving spouse of a Veteran who has served at least 90 days or more on active duty with one day beginning or ending during a period of war, and you are in need of assistance at HOME due to your disabilities, you may be eligible for VA's non-service connected disability pension.

Before Applying for the VA Aid and Attendance Pension Benefit for a Veteran or Surviving Spouse – Get Organized!

Make sure you have all of your paperwork in order and copies of all important documents PRIOR to filing. More importantly GET HELP. See notes below.

See links to important documents at the bottom of this article.

Step 1:

First, the Veteran must have certified copies of his or her discharge papers. If the Veteran has a copy of his or her DD 214, take it to a local Veteran's office where they will make certified copies at no charge. If there is no copy available, contact the VA to get a copy.

Step 2:

Second, the Veteran must have a medical reason for needing home care. They must be considered homebound. The medical reason does not have to be a serious or life-threatening condition. The home care agency will have a doctor's report to be completed by the Veteran's doctor. A copy of this report must be filed along with the application.

Step 3:

Third, to qualify financially, an applicant must have on average less than $80,000 in assets, excluding their home and vehicles.

Step 4:

Fourth, the Veteran must actually be receiving home care services at the time of application. The application process takes from three to six months and is retroactive to first day of the month the application was originally filed. For this reason, make sure your Veteran has the funds to cover the entire cost of home care for at least the first six months. Once the application is processed, the Veteran will receive a lump sum check for the retroactive benefit, then a monthly benefit check from that time on.

Notes- Get Help:

Veterans Home Care LLC Helps Veterans and Surviving Spouses with the VA Aid and Attendance Application Process, and in many cases may PAY for the home care while the veteran and family wait for approval. www.VeteransHomeCare.com, 1-888-808-4290

Their unique services make the difference

Veterans Home Care begins providing care promptly after the application goes to the VA. Clients pay for their own home care through their interest-free client loan, which they repay from their "Aid & Attendance" reimbursements once the VA approves the application.

Veterans Home Care keeps working

Throughout the VA's approval process, they work on behalf of their clients – answering questions, processing additional paperwork, and setting up and managing home care. Even after the VA approves the claim, Veterans Home Care is on the job, helping clients remain in compliance to receive the full benefit available, and maintaining home care scheduling, invoicing and payments.

Veterans Home Care brings home care to disabled elderly veteran families who otherwise couldn't afford it.

- They assist clients with the VA application and with any required follow up, at no charge.
- They help clients pay for their home care, by providing a loan for that purpose with no interest charges – ever.
- They arrange and monitor each client's home care, and charge no fees.

Important Documents for the VA Aid and Attendance Pension Benefit (note please contact Veterans Home Care LLC PRIOR to filing a claim on your own 1-888-808-4290)

- Standard Form 180 – Requesting Military Records
- Use VA Form 21-526 to apply for compensation and/or pension benefits.
- VA Form 21-534 to apply for benefits as a surviving spouse.
- Nursing Home Status Statement
- Physicians Statement for Need for Regular Aid and Attendance
- AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY
- Use VA Form 21-601 to apply for accrued benefits due the beneficiary but not paid prior to death.

The veteran must have served during a period of war as defined by the VA.

- **Indian Wars**: January 1, 1817, through December 31, 1898. The veteran must have served thirty days or more, or for the duration of such Indian War. Service must have been with the U.S. forces against Indian tribes or nations.
- **Spanish-American War**: April 21, 1898, through July 4, 1902, including the Philippine Insurrection and the Boxer Rebellion. Also included are those individuals engaged in the Moro Province hostilities through July 15, 1903.
- **Mexican Border War**: May 9, 1916, through April 5, 1917. The veteran must have served for one day or more in Mexico, on the borders thereof, or in the waters adjacent thereto.
- **World War I**: April 6, 1917, through November 11, 1918, extended to April 1, 1920, for those who served in the Soviet Union. Service after November 11, 1918, through July 2, 1921, qualifies for benefits purposes if active duty was performed for any period during the basic World War I period.
- **World War II**: December 7, 1941, through December 31, 1946, extended to July 25, 1947, where continuous with active duty on or before December 31, 1946.
- **Korean Conflict:** June 27, 1950, through January 31, 1955.
- **Vietnam Era**: August 5, 1964, through May 7, 1975.90 However, February 28, 1961, through May 7,1975, for a veteran who served in the Republic of Vietnam during that period.
- **Persian Gulf War**: August 2, 1990, through a date to be prescribed by Presidential proclamation or law.
- Congress has not enacted legislation that would make the periods covering the 1983-1984 Lebanon crisis or the invasions of Grenada and Panama wartime service.

Life Settlements

Seniors and their family members should know that there is another option for a life insurance policy that is going to lapse or surrender to the insurance company.

This option is called a life settlement, also known as a life insurance settlement. A life settlement is a new financial planning tool for seniors who may have a life insurance policy that they no longer need or want. A life settlement is a lump cash payment that is greater than the policy's cash surrender value and less than the death benefit. Never before have non-terminal policyholders been able to receive capital in excess of their policy's cash or surrender value to increase their wealth. A life settlement can usually provide anywhere from 2 to 5 times the cash surrender value of the policy.

Some requirements and conditions must be met for a senior to be able to utilize a life settlement. Please remember that these are general conditions and each case is looked at individually:

- The insured must be at least 65 years of age.
- The insured has experienced a decline in health since the issue date.
- The insured's life expectancy is 17 years or less.
- The face amount of the policy is at least $100,000.
- The policy is beyond the two-year contestable period.

The types of insurance policies that qualify for a potential life settlement are:

- term
- whole life
- universal life
- joint-survivorship
- group
- corporate-owned policies (COLI)
- key-man
- life policies held in irrevocable life insurance trusts

Why would anyone want to sell their life insurance policy? Here are some situations in which the policy owner may want to consider a life settlement:

1. The policy owner can no longer pay the premiums and needs relief from them. This is a common situation during retirement when income levels have changed and the premium payment can be strain on finances.
2. The policy is lapsing or surrendering because it is no longer needed for a variety of circumstances. This is one of the primary reasons to determine if a life settlement is available. If the policy is going to lapse it is wise to explore the option of selling the policy and receiving a lump sum of money.
3. New insurance coverage or a financial product better fits your current needs. Cost of insurance has changed considerably in the last few years. It is a good time to evaluate your current insurance needs and see if a better performing and cost efficient product is available.
4. The policy owner needs cash now, such as for medical needs, to assist children or grandchildren, or to supplement retirement income.
5. The insured has outlived the beneficiaries.
6. For estate tax planning purposes, it no longer makes sense for the policy to pay out as planned. An example would be that the estate no longer needs insurance for liquidity.
7. A company's key man is retiring, thus ending the need to maintain insurance on his or her life.
8. A buy-sell agreement backed by insurance has been completed.

There are numerous situations in which a life settlement can be beneficial. The reality is that thousands of seniors across the nation are lapsing or surrendering their policies without the knowledge that a life settlement could be available. Now, policies that would have been lapsed or forfeited without determining the fair market value can be sold to investment firms and funding sources for true value.

The life settlement process is not complicated at all. The policy owner would first simply fill out a life settlement application and requested authorizations. The application includes authorizations to collect medical records and up to date information about the policy to be sold from the applicant's insurance carrier. Unlike a life insurance application there is no medical examination or physical required.

The settlement company then would retrieve the needed information including attending physician statements, and insurance policy for review. This information would then be submitted to several funding organizations to receive the highest possible settlement. Settlement offers are then relayed to the policy owner or their representative for acceptance. Upon acceptance of an offer, contracts and insurance policy change of ownership documents are forwarded to the policy owner or their representative for review and signatures. The signed documents are returned to the funding

organization. The documents are then forwarded to the insurance company to record the change of ownership.

Upon written verification that changes of ownership and beneficiary have been recorded, settlement funds are paid to the policy owner. At this point the policy owner has 15 days to change their mind and cancel the transaction. The process typically takes 3 to 6 weeks to complete, depending on how long it takes to receive documents such as physician statements.

Another important benefit of the life settlement process is that there is never a cost or obligation involved in determining if a life settlement is available to the policy owner. As previously stated, not every individual will qualify for a life settlement and each situation is looked at individually. However, since there is of no cost or obligation there should be no reason not to explore the option of a life settlement.

In summary, a life insurance settlement is a strong and beneficial financial tool for senior policy owners. With this consumer friendly approach, senior policy owners now have options to receive more money, versus the previously limited options of only a cash surrender or policy lapse.

Grant Shellhammer contributed this information and is a Life Settlement Specialist and works with senior clients on a nationwide basis. He can be reached at 1-888-973-8377 or his website at www.LifeSettlementPro.com. He would be glad to assist and answer any questions regarding your life settlement needs.

Reverse Mortgages Can Help Pay for Elder Care Needs

Reverse Mortgages (Home Equity Conversion Mortgages) have become a popular and well respected way for seniors to access the equity in their homes for many reasons. Some use the equity for long-term care needs, to pay bills, pay off existing mortgages or debt, pay for prescription drug costs, home improvements, home modifications, or to simply be able to enjoy life a little more by traveling and enhancing their retirement cash flow. Many seniors use reverse mortgages to pay high property tax bills, and have even been saved from foreclosure and bankruptcy because they applied for a reverse mortgage.

Each consumer should make it his or her own responsibility to talk with an expert, and educate themselves on the facts.

The National Reverse Mortgage Lenders Association has great consumer booklets- www.reversemortgage.org .

The National Council on Aging recently did a study that concluded that reverse mortgages are good sources of funds for long-term care planning and long-term care needs. You can download the entire study by visiting www.ncoa.org

Although there are closing costs associated with these loans, most, if not all of them are factored in to the loan, and are not out-of-pocket expenses for the senior. Whether or not a reverse mortgage is right for a senior depends on their specific situation, and cash flow or estate planning needs.

What is a (HECM) Reverse Mortgage?

A reverse mortgage enables older homeowners (62+) to convert part of the equity in their homes into tax-free income without having to sell the home, give up title, or take on a new monthly mortgage payment. The reverse mortgage is aptly named because the payment stream is “reversed.” Instead of making monthly payments to a lender, as with a regular mortgage, a lender makes payments to you.

Who Qualifies for a Reverse Mortgage?

Eligible property types include single-family homes, 2-4 unit properties, manufactured homes (built after June 1976), condominiums, and townhouses. As long as you own a home, are at least 62, and have enough equity in your home, you can get a reverse mortgage. There are no special income, credit or medical requirements.

How Are Seniors Protected? Counseling is one of the most important consumer protections built into the program. It requires an independent third-party to make sure the senior understands the program, and review alternative options, before they apply for a reverse mortgage.

How Can the Cash Flow From a Reverse Mortgage Keep Mom and Dad at Home Longer?

The cash flow from a reverse mortgage can be used for any purpose. In order to keep seniors safe and at home for longer periods of time, it is recommended that the cash flow be used for home modifications, repairs, personal emergency response systems, and in-home care services.

Does the Senior's Name Remain on The Title to the Home?

The seniors' names remain on the title to the home. The bank is not in the business of taking over title, and certainly not in the business of owning homes. Therefore, just as with a traditional mortgage, the senior's name is on the title to the house.

Can Their Home Be Taken Away from Them?

When a senior implements a reverse mortgage, it is important to remember that they are responsible for keeping the home owner's insurance in force, paying annual property taxes, and for general upkeep of the home. Unless one of these criteria is not met, their home can never be taken away from them.

Will Heirs Be Responsible for Repaying This Loan?

No, a reverse mortgage is a "non-recourse" loan. This means that the lender is only entitled to loan repayment via the sale of the home for fair market value. If there is any remaining equity over and above the final loan amount, the heirs receive that remaining equity. If the home sells for LESS than the final loan amount, the federal government steps in and pays the lender the difference. Heirs' assets are never at risk.

When Does the Loan Come Due?

The loan comes due when the last remaining homeowner leaves the home permanently. This means that the loan will come due when the last homeowner passes away, sells the home, or leaves permanently (12 months or more).

Can Mom and Dad Still Leave Their Home To Their Children?

Yes, with proper planning they certainly can. One way to make sure that heirs receive the value of the home is for the seniors to purchase life insurance using the proceeds from the reverse mortgage. Some seniors end up doubling or tripling the value of their estate for their heirs because they use the reverse mortgage proceeds to pay the life insurance premiums. This way they never have to touch a penny of their savings, investments, or current income to increase the value of their own estate. This also helps the heirs, because inheritance passed on through life insurance (beneficiary designation) bypasses probate and taxes!

About GreatCare of Indianapolis

GREATCARE
Peace of Mind When You Need it Most

GreatCare is a licensed, personal services agency, providing in-home care services to the Indianapolis, Indiana and surrounding areas. We serve the personal health and daily care needs of seniors or individuals who prefer to stay at home, but require assistance with everyday activities, such as dressing, personal hygiene, meal preparation, laundry or errands. Our team of certified nurse aids and home health aides can provide you with personalized, in-home care services to meet your needs, including:

- Daytime hourly in-home care
- Temporary or post-hospital respite care
- 24-hour, around-the-clock home care
- Morning and evening care
- Overnight / Slumber care

In addition, we offer our Care Compass service, to assist in setting the course for the next stage in your loved ones life. We guide you through the currents of aging, and help you find your true north. Our licensed nurses, with experience in hospice and geriatric care, will help guide you through the complex and often sensitive journey of selecting an in-home care service, and will provide a smooth transition to a new way of life for your loved one, without the anxiety and fear.

Our current nursing and management team has more than 75 years of combined experience in the home healthcare services industry. All of our caregivers are bonded, insured and screened thoroughly, so you know you'll be receiving the greatest care possible. That's why we stand by our mission: to deliver the same, quality care we expect for ourselves and our loved ones.

www.INeedGreatCare.com

317-595-9933