

General LONG TERM CARE Education. Long-Term Care (LONG TERM CARE) is the act of providing assistance to a person who requires help because the person cannot function on their own. The term “Long-Term Care” applies to many different and unique types of programs.

It is important to understand the various programs lumped under the term Long Term Care so that you can research, become a knowledgeable consumer, and make the right choice for your situation. Let us look at a list of common Long Term Care programs:

- In-home assisted care
- Assisted living facilities
- Adult day care
- Nursing home care
- Hospice care
- Long Term Care insurance plans
- Respite care

Respite care is considered a part of Long Term Care because it is a service to provide a substitute for a caregiver so that a caregiver can run errands or take a break when the caregiver is exhausted from caregiving duties.

LONG TERM CARE costs are not covered by health insurance plans—not Tricare, employer or individual health care plans, or Medicare. Many think LONG TERM CARE is covered by health plans because the reason the person needs LONG TERM CARE assistance may have started from a medical situation that was covered by a health care plan. But the act of assisting the person after medical treatment is completed, such as during recovery or if the disability situation is long-term, is not covered by a health plan.

Long-term care is about assisting a person who cannot perform the “Activities of Daily Living” or ADLs. Again, while there may be medical issues that contribute to the need for help in the ADLs, the actual assistance in these activities is not medical, and that is why long-term care is not covered under medical/health plans. The inability to perform ADLs may be due to lack of physical ability or to cognitive impairment from Alzheimer’s or Traumatic Brain Injuries (TBIs) for example. The ADLs include but are not limited to these activities:

- Bathing
- Toileting (helping in restroom or with personal hygiene)
- Dressing
- Eating
- Transferring (example: bed to wheelchair, in and out of chairs)
- Walking
- Helping due to a cognitive impairment
- Can include help with the Instrumental Activities of Daily Living (IADL) like fixing meals or help with medications

The bottom line on LONG TERM CARE costs is that costs are primarily covered from one or a combination of:

- your own savings and income,
- LONG TERM CARE insurance,
- one of the VA's programs or,
- Medicaid as the last resort.

As a veteran, the VA is probably your primary option. You will have no choice in using your savings and income. And unless you purchased LONG TERM CARE insurance **before** your LONG TERM CARE need, you probably will not have LONG TERM CARE insurance as an option since you cannot qualify for the insurance **after** you have suffered the illness or injury that caused the LONG TERM CARE situation.

Medicaid is only available for people in severe financial hardship (minimal assets). To qualify for Medicaid support for LONG TERM CARE, you essentially have to spend down your assets (the property or cash you own) first before you qualify for coverage. Plus Medicaid has many restrictions that may not accommodate your desires. (Such as???) Medicaid may be a last resort safety net option for some but not something to shoot for if you have a family.

Medicaid probably will not be an option for military retirees. The military retirement pay may make you ineligible for Medicaid. This is true for many others covered by some sort of pension as well.

VA programs. The VA has many LONG TERM CARE programs. Some provide help and some provide additional compensation to help pay for services.

The program requirements are individualized and complex so any detailed information and whether or not you qualify needs to come from an official in a Veteran Service Office (VSO). You are probably already working with a VSO, but if you are not, please locate one in your area to help with your situation. Working with a VSO relieves you of the stress of trying to understand all the details and deal with the application process. There is no charge to work with a VSO.

Use this list of services to know what to ask about when you speak to a VSO. Descriptions of the programs follow the list.

VA programs and financial aid services include:

- Home-based care
- Homemaker and Home Health Aide Care
- Adult Day Care
- Veteran Directed Care
- Skilled Home Health Care
- Remote Home Monitoring
- Hospice Care
- Respite Care
- Aid and Attendance compensation
- Housebound compensation
- Veteran's Pension for low-income veterans
- Veteran's homes and residence care facilities

- The VA Caregiver Support Program

Long-Term Care (LONG TERM CARE) Insurance. This is a commercial insurance policy that provides money to cover the costs involved with taking care of someone who cannot care for himself. LONG TERM CARE insurance is not health insurance so it does not cover doctor, hospital or clinic visits or medical treatment. It is for paying caretakers, LONG TERM CARE facilities, and equipment needs associated with caring for a person who cannot perform the Activities of Daily Living (ADLs); see ADLs below. [or link back to General LONG TERM CARE Education section for ADLs]

Commercial and the federal LONG TERM CARE plans require a person to “qualify” before they can be approved for coverage. To “qualify” means you do not need the coverage at the time of application because you are healthy. So like any insurances, unless you owned LONG TERM CARE insurance **before** the circumstance that caused the illness or injury that resulted in a LONG TERM CARE need, this insurance will not be an option for your situation. Unfortunately, this means a commercial LONG TERM CARE insurance policy will not be an option for most wounded warrior families. And even the federal government’s LONG TERM CARE program will be iffy if the illness/disability occurred before an application for the LONG TERM CARE insurance.

The cost for LONG TERM CARE insurance can prevent some families from purchasing a plan. Shop carefully and check out the federal LONG TERM CARE insurance site at <http://www.LongTermCarefeds.com/>. This federal site has many great pages of information that answer questions about LONG TERM CARE insurance in general. It includes pages for research, costs, and a Buyer’s Guide. Specifically check out the pages under “LONG TERM CAREI Tools” and “Information and Forms.” These are excellent tools and pages for consumer information.

With most LONG TERM CARE policies (the policies labeled as “qualified” policies have tax benefits), the benefits go into effect when you can no longer accomplish 2 of 6 Activities of Daily Living (ADL) or you have cognitive impairment. The ADLs are:

- Eating
- Bathing
- Dressing
- Toileting
- Transferring (like walking or carrying from one location to another)
- Continence (control of your bladder and bowels)

When a medical practitioner of the insurance company’s choosing certifies you can no longer accomplish two of the above list without assistance, your insurance coverage is triggered.

LONG TERM CARE needs are not covered by Tricare, Medicare, or any commercial or employee health plan. A family in financial need may qualify for LONG TERM CARE coverage under Medicaid but there are income and personal asset restrictions and strict rules to follow.

Here are some terms and conditions you need to understand about LONG TERM CARE insurance as a consumer.

Typical Covered Services. LONG TERM CARE Insurance can cover Nursing Home Care, Assisted Living, and Home Care, depending on the exact details of the policy.

Elimination Period. Just like an auto insurance policy has a deductible, LONG TERM CARE Insurance has one too. However, instead of a dollar amount, LONG TERM CARE Insurance deductibles are measured in days. Common elimination periods for LONG TERM CARE Insurance are 30, 60, 90, 180 and 365 days. This means you pay for all LONG TERM CARE costs from your own pocket for the number of elimination days before the LONG TERM CARE insurance coverage kicks in. The lower the number of elimination days, the higher the premium you pay. The higher the number of days, the more you pay out-of-pocket before coverage starts and the lower the premium.

Maximum Daily Benefit. This is the maximum amount that the insurance company will pay for one day of covered services. If you select a lower daily benefit your premiums will be lower. A higher daily benefit results in higher premiums. This is one area where you may not want to economize (save money by choosing a cheaper policy). As explained later, it is better to overestimate your Daily Benefit than to underestimate it. Check out the federal LONG TERM CARE insurance site to estimate LONG TERM CARE costs in your area; [click here](https://www.LongTermCarefeds.com/LongTermCareWeb/do/assessing_your_needs/costofcare?action=costofcare) or see: https://www.LongTermCarefeds.com/LongTermCareWeb/do/assessing_your_needs/costofcare?action=costofcare

Benefit Period. This is the amount of time that the insurance will pay benefits. Common Benefit Periods include 3 years, 5 years, or for life. The shorter coverage period, the lower the premium is. Some stats to consider when making this decision...

- The average nursing home stay lasts about 2.5 years
- Men have a 5% chance of staying in a nursing home for more than five years
- Women a 13% chance of staying in a nursing home for more than five years.

Total Benefit. While not always called a Total Benefit, most LONG TERM CARE policies state a maximum amount to be paid out under the policy (Your Daily Rate x Number of Years of Coverage x 365). Think of this like a total pot of money available for your LONG TERM CARE needs. Because of this, it is often better to select a higher daily amount and a lower number of years. This is because if you don't spend the maximum daily amount, you in effect extend the Benefit Period until such point as your Total Benefit is paid out—even beyond the Benefit Period you may select.

Inflation Protection. This "rider" (additional protection for an additional cost) increases your Maximum Daily Benefit (and as a result your Total Benefit) by some set amount over the years of the policy. 3 to 5% is common. If you do purchase LONG TERM CARE Insurance, you will probably want Inflation Protection. Given the inflation rate of health and LONG TERM CARE costs, you will want your Maximum Daily Benefit to rise to meet higher future costs.

Those are some of the big things to understand when talking about and making the LONG TERM CARE insurance decision. Here are some other things to consider:

Medicare and Tricare do not cover long-term custodial care. Medicare has a limited benefit for Skilled Nursing Care which is only effective after a hospital stay and lasts for a short time.

Medicaid is probably not an option for those who are military *retirees*. Medicaid is for people in severe financial hardship. Your military retirement pay will probably make you ineligible for Medicaid. This is true for many others covered by some sort of pension as well. If you are not covered by a pension, then to qualify for Medicaid support for LONG TERM CARE, you essentially have to spend down your assets (property, cash, and investments) first before you qualify for coverage.

Premium rates for LONG TERM CARE insurance go up significantly after age 60.

For those who are military *retirees*, you have access to the Federal Long-Term Insurance Program because of your retiree status, but many wounded warriors will be ineligible to purchase coverage.

There are other options to LONG TERM CARE insurance. Depending on your level of assets, you may be able to self-insure. There are also hybrid life insurance policies and insurance annuities that provide for LONG TERM CARE coverage. Some disability insurance policies also have LONG TERM CARE coverage as well (not everyone in a nursing home is old). These policies are even more complicated to understand and must be evaluated on a case-by-case basis.

TRICARE Content for Caregiver Guide

FAQ 2: How will the TRICARE benefit be affected if I become eligible for Medicare Part B?

Answer: Once you become eligible for Medicare Part B (which happens when you turn age 65...or if you are rated as 100% disabled by Social Security (not DoD or VA) at an earlier age), you MUST enroll in Medicare Part B in order to retain TRICARE eligibility.

The TRICARE benefit for Medicare-eligibles is called TRICARE For Life (TFL). It's completely different from TRICARE Standard and TRICARE Prime, and has a separate page on the Web (www.TRICARE4u.com) that provides details on how TFL works.

Health Care and Medical Insurance (bottom of page 3 of the table of contents)

TRICARE

TRICARE is the health insurance program for military beneficiaries. While active duty members and families are mostly exempt from TRICARE fees in most cases, that's no longer true once you enter retired status. Coverage and fees can vary, depending on what kind of TRICARE coverage you choose in retirement. Coverage and fees can vary, depending on:

- (a) whether the military sponsor is on active duty or retired,
- (b) whether the beneficiary is eligible for Medicare, or
- (c) whether the beneficiary uses military or civilian facilities for health care and medications

See the following charts for programs and fees applicable to:

Active duty members and family members

Retired servicemembers and family members (not Medicare-eligible)

Medicare-eligible retired servicemembers and family members

Special considerations for military disability retirees under TRICARE:

- Protection against annual fee increases: Under current law, military disability retirees are exempt from annual increases in TRICARE Prime enrollment fees and pharmacy copays that apply to non-disability retirees. Military disability retirees do not include all retirees who have a disability rating from the VA. They only include those who received a medical (Chapter 61) retirement from their parent service. To ensure exemption from future annual fee increases, retirees in this category should contact DEERS to ensure their records reflect the medical/disability retirement.

Medicare and TRICARE:

Active Duty Members: In some cases, severely injured, ill, or wounded servicemembers may qualify for Medicare while still on active duty and awaiting medical retirement. Normally, if you are eligible to enroll in Medicare Part B (which has monthly premiums of about \$100 per month per person), you must enroll in Part B to maintain coverage under TRICARE. Active-duty Medicare-eligibles are allowed a “special enrollment period” for their remaining time on active duty. People in this situation must request an “active duty certificate of creditable coverage” from the Defense Manpower Data Center Support Office to use the special enrollment period. But they **MUST** enroll in Medicare Part B **BEFORE THEY RETIRE** from active duty in order to avoid a break in medical coverage.

Retired Members: If Medicare eligibility is established after retirement, you **MUST** enroll in Part B in order to retain health coverage under TRICARE. (For details on how the coverage works, see the Section on TRICARE For Life, under which TRICARE acts as second payer to Medicare.)

See the Defense Department’s [TRICARE and Medicare Under-65 Fact Sheet](#) for additional details on the effects of failing to enroll on time.

TRICARE For Life

TRICARE For Life (TFL) is the TRICARE program for people who are eligible for Medicare.

That includes:

- (a) all military beneficiaries who are age 65 or older, and
- (b) military beneficiaries rated as 100% disabled by Social Security (not DoD or VA) at an earlier age

Once you become eligible for Medicare, you **MUST** enroll in Medicare Part B to keep any TRICARE coverage.

2013 Medicare Part B premiums are about \$100 per month per person for most people, but can be higher for people in higher income brackets (\$85,000 a year for singles and \$170,000 a year for married couples). Part B premiums are adjusted every January based on how much Medicare costs have risen. In recent years, that’s been 3% to 4% a year.

Once you enroll in Part B, Medicare is first payer, and normally pays 80% of the cost. TFL pays whatever Medicare doesn’t (including the Medicare deductible and copays), as long as you use a doctor who takes Medicare. The doctor simply files a claim with Medicare, and the Medicare claim is sent to TRICARE automatically to pay what Medicare doesn’t. There is no need for the doctor (or you) to file a separate claim with TRICARE.

When you go to the doctor, just present your Medicare card and your military ID card.

As long as you use doctors and other facilities that accept Medicare, you shouldn’t have any out-of-pocket costs for doctor or hospital visits, except copays for any medications you get from non-military pharmacies.

US Family Health Plan (USFHP)

The USFHP is a TRICARE Prime option available to active duty and retired members and families who live in certain areas of the country, mainly the northeast (including all or parts of states from northern Virginia to New York and Maine), the Puget Sound area of Washington State, and Southeast Texas/Southwest Louisiana.

The USFHP is administered through six major facilities that have a separate, unique TRICARE Prime contract, maintain their own networks of doctors (separate from the regular TRICARE networks) and provide certain enhanced services.

Enrollees with access to USFHP coverage generally express very high satisfaction with the program.

One unique aspect of the program is that some enrollees can continue TRICARE Prime coverage under USFHP even after they have attained Medicare eligibility. This continued coverage into Medicare eligibility applies only to people who already were enrolled in the USFHP as of October 1, 2012. People who enrolled after that date must switch to Medicare and TRICARE For Life upon attaining Medicare eligibility.

Visit <http://www.tricare.mil/usfhp> for additional details on the USFHP.

TRICARE Pharmacy Benefits

TRICARE patients have multiple options to meet their medication needs, including:

- Pharmacies at military hospitals and clinics, where medications are provided at no cost to beneficiaries.
- Retail pharmacies, which provide 30-day prescription fills and require beneficiary copays, and
- The TRICARE Home Delivery Program, which provide 90-day prescription fills by mail at substantially lower copays than retail drug stores (no cost for generic drugs).

Initial medication prescriptions should be filled in military or retail pharmacies. The Home Delivery program is for refills of longer-term maintenance medications.

Beneficiaries who don't have regular access to military pharmacies should check out the Home Delivery system, which offers 67% or greater savings on refills compared to retail drug stores.

This chart compares retail vs. Home Delivery copays for different kinds of drugs.

Pharmacy Copayments for 2013*

	Military Pharmacy	Retail Pharmacy (30-day supply)	Home Delivery (90-day supply)
Generic Drugs	0	\$5	0
Brand-Name Drugs	0	\$17	\$13
Non-Formulary Drugs**	0	\$44	\$43

Notes:

*Copays for retail and home delivery are subject to possible annual increases tied to the inflation rate. At current inflation rates, there would be no increase in the generic or brand-name drug copays for 2014, and the non-formulary rate will probably rise by \$1 next year.

**TRICARE declares certain drugs as “non-formulary” if they are no more effective than other available drugs for the same purpose but cost more for the military to buy. If your doctor prescribes a non-formulary drug, talk to him or her about substituting a generic or brand-name drug that’s equally effective for you but has a lower copay. If your doctor believes a non-formulary drug is medically necessary for you, the doctor can request that TRICARE grant a waiver to give you the drug at the regular, lower copay.

Continuing Health Care Benefits Program (CHCBP)

This program allows servicemembers and family members who are losing TRICARE eligibility to buy a continuation of TRICARE-like coverage.

People who can benefit from using CHCBP include servicemembers who are separating (not retiring) from military service and their qualifying family members.

Under the CHCBP, you can purchase coverage equivalent to TRICARE Standard for periods of 90 days at a time. Like Standard, CHCBP has a deductible of \$150 (individual) or \$300 (family) and a 25% copay for inpatient and outpatient services. It also includes TRICARE pharmacy coverage.

But it’s not cheap. Premiums are:

- \$1,138 per quarter for an individual
- \$2,555 per quarter for a family

CHCBP is not a permanent health insurance option. It's meant to provide temporary coverage for 18 months (servicemember) to 36 months (family member) until more permanent coverage is found.

You must purchase the Continued Health Care Benefit Program (CHCBP) within 60 days of losing TRICARE eligibility or within 30 days of loss of TRICARE Reserve Select coverage. CHCBP coverage begins on the first day after the loss of TRICARE eligibility.

For additional details, visit <http://www.humana-military.com/south/bene/TRICAREPrograms/chcbp.asp>.

TRICARE Retiree Dental Program

Military retirees and their family members and survivors are eligible to buy coverage under the TRICARE Retiree Dental Program.

The program is administered under a TRICARE contract with Delta Dental.

See the fact sheet at

http://www.tricare.mil/~media/Files/TRICARE/Publications/FactSheets/TRDP_Delta_FS.ashx for details on coverage, deductibles, etc.

Premiums vary based on your location and the number of family members you want to cover. Visit <http://www.trdp.org/pro/premiumSrch.html> to enter your ZIP code and see what your premium would be.

TRICARE PROGRAMS FOR ACTIVE DUTY MEMBERS AND FAMILY MEMBERS

	TRICARE PRIME	TRICARE STANDARD
	<p>TRICARE Prime is an HMO-style plan that uses a specific network of doctors. Under normal circumstances, it guarantees appointments with participating providers within specific time standards. In most cases, TRICARE Prime care is delivered through military hospitals or clinics.</p> <p>TRICARE Prime is the only option available to active duty members.</p> <p>Active duty family members are enrolled in Prime automatically unless they specifically request TRICARE Standard.</p> <p>Appointments to see specialists or doctors other than your primary care manager must be pre-approved in most cases.</p> <p>There is a special program (called TRICARE Prime Remote) to provide Prime coverage for active duty family members who have been sent on military orders to locations without reasonable access to military facilities.</p>	<p>Family members may choose coverage under TRICARE Standard, a fee for service plan under which beneficiaries are free to find their own civilian doctors.</p> <p>Visits with other doctors, including specialists, do not require pre-approval in most cases.</p> <p>TRICARE Standard has an annual deductible and higher copays than TRICARE Prime.</p> <p>It may be difficult to find doctors who will accept new TRICARE patients in some areas, especially those not near military installations.</p>
Enrollment Fee	None	None
Annual Outpatient Deductible	None	E-1 to E-4: \$50 individual/\$100 family E-5+: \$150 individual/\$300 (family)
Outpatient Visit Copay	None	20% of TRICARE-allowed charges
Inpatient Copay	None	\$17.35 per day (\$25 minimum)
Catastrophic Cap (Maximum out-of-pocket payment for TRICARE-allowed charges)	\$1,000 per family per year	\$1,000 per family per year

TRICARE PROGRAMS FOR RETIRED SERVICEMEMBERS AND FAMILY MEMBERS

	TRICARE PRIME	TRICARE STANDARD	TRICARE For Life
	<p>TRICARE Prime is an HMO-style plan that uses a specific network of doctors. Under normal circumstances, it guarantees appointments with participating providers within specific time standards. Care is delivered through military hospitals or clinics or through a network of civilian providers.</p> <p>Appointments to see specialists or doctors other than your primary care manager must be pre-approved in most cases.</p> <p>As of October 1, 2013, Prime is only available to retired members and families who live within 40 miles of a military hospital or clinic (some who were already on Prime before that date may apply to retain Prime if they live within 100 miles).</p>	<p>TRICARE Standard is a fee for service plan under which beneficiaries are free to find their own civilian doctors.</p> <p>Visits with other doctors, including specialists, do not require pre-approval in most cases.</p> <p>It may be difficult to find doctors who will accept new TRICARE patients in some localities.</p>	<p>TRICARE For Life (TFL) provides supplemental coverage for military retirees and family members who are eligible for Medicare.</p> <p>For Medicare-covered services, TFL pays all expenses not paid by Medicare.</p> <p>TFL applies to all military beneficiaries <u>age 65 or older</u>, and to retired members <u>under age 65</u> who:</p> <ul style="list-style-type: none"> a. Qualify for military retired pay, AND b. Have been deemed 100% disabled by Social Security. <p>If the retiree is eligible for Medicare, but the spouse is not, the retiree is on TFL and the spouse is on Prime or Standard. <u>Medicare-eligibles can't decline Medicare/TFL and keep Standard or Prime.</u></p>
Enrollment Fee/Premium	\$269/year (single) \$539/year (family) (fee rises each year EXCEPT for medical (Chapter 61) retirees; ensure DEERS is aware of Chapter 61 status to avoid annual fee increases)	None	TFL has no enrollment fee, but <u>requires enrollment in Medicare Part B</u> , which has premiums of \$100/mo or more per person, depending on income. Part B premiums rise each year.
Annual Outpatient Deductible	None	\$150 individual \$300 family	None
Outpatient Visit Copay	\$12	25% of TRICARE-allowed charges	None
Inpatient Copay	\$11	\$698/day or 25% of charges, whichever is less	None
Catastrophic Cap (Maximum out-of-pocket payment for TRICARE-allowed charges)	\$3,000 per family per year	\$3,000 per family per year	\$3,000 per family per year

CHAMPVA COVERAGE FOR FAMILY MEMBERS OF QUALIFYING VETERANS

	CHAMPVA
	<p>CHAMPVA is a fee for service plan under which the Department of Veterans Affairs provides coverage through civilian doctors for certain veterans' family members.</p> <p>CHAMPVA patients are free to find their own doctors.</p> <p>Visits with other doctors, including specialists, do not require pre-approval in most cases.</p> <p>It may be difficult to find doctors who will accept new CHAMPVA patients in some localities.</p>
Eligibility	<p>To be eligible for CHAMPVA, you <u>cannot be eligible for TRICARE</u> (the health care program for currently serving and retired military members and families) and you must be in one of these categories:</p> <ol style="list-style-type: none"> 1. the spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office, or 2. a person officially designated under the VA caregiver program as the caregiver of a qualifying veteran, or 3. the surviving spouse or child of a veteran who died from a VA-rated service connected disability, or 4. the surviving spouse or child of a veteran who was at the time death rated permanently and totally disabled from a service connected disability.
Enrollment Fee/Premium	<p>None</p> <p>(Note: If the beneficiary is eligible for Medicare, CHAMPVA eligibility is contingent on enrollment in Medicare Part B, which has a premium of \$100/month or more, depending on income; See "Impact of Medicare Eligibility" below)</p>
Annual Outpatient Deductible*	<p>\$50 individual \$100 family</p>
Outpatient Visit Copay*	<p>25% of CHAMPVA-allowed charges</p>
Inpatient Copay*	<p>25% of CHAMPVA-allowed charges</p>
Impact of Medicare Eligibility*	<p>For a CHAMPVA-eligible person who is also eligible for Medicare and enrolled in Medicare Part A and Part B, CHAMPVA covers all costs that Medicare doesn't for Medicare-covered services. Beneficiaries in this category have no deductibles or copays for inpatient or outpatient Medicare-covered services.</p>
Catastrophic Cap (Maximum out-of-pocket payment for CHAMPVA-allowed charges)	<p>\$3,000 per family per year</p>

