

Assisted Living: What is it and how will your clients pay for it?

Assisted living is the fastest growing type of senior housing in the United States with an estimate 15-20 % annual growth rate over the last few years. (AARP, "Assisted Living in the United States".) There are approximately 25,000 to 30,000 Assisted Living Facilities in the country.

I. Assisted Living

A. Assisted Living, as a concept, has been difficult to define and therefore difficult to regulate and develop. It is part of a trend of "aging in place," providing a dignifying and possibly more cost effective alternative to institutional care.

1. There are **assisted living** facilities and **assistive living** or "**look-alike**" facilities.

a. **Assisted Living** refers to the facilities that offer a "package deal," that is, the provision of housing and personal services which are coordinated by the same agency. These facilities require licensure or certification under Article 7 of the Social Services Law or Article 36 of the Public Health Law.

b. **Assistive living** or "**look-alikes**" refer to senior housing that has a home care agency which separately offers personal services to the residents. The "look-alikes" may arrange for home care services, but they do not necessarily provide the services and therefore, the look-alikes do not undergo an assisted living licensing procedure. Still, the home care agency must be licensed to provide those services. The resident may pay for the home care component separately.

B. Assisted Living is based on a philosophy that emphasizes the autonomy of the individual resident in selecting and

arranging services. Individuals live in their own private units or apartments and receive a range of services that they have selected as needed.

1. Services generally include: Assistance with Activities of Daily Living (ADL's) such as bathing, grooming, dressing, toileting, as well as protective supervision and monitoring by assisted living staff. As opposed to other types of congregate housing, assisted living is targeted to older persons who are in need of services and assistance but need less than a resident of a skilled nursing facility. Generally assisted living residents are unable to live on their own but do not need skilled nursing care or 24-hour home care.

2. As opposed to a nursing home, the living units are private (unless the resident chooses to have a roommate) and contain a full bath and some type of food preparation area. Meals are almost always offered as part of the services provided.

3. The resident agreement or contract generally includes a service or care plan; the amount of health-related services provided with the basic rate and fee structure; a detailed explanation of all charges, expenses, fees or assessment to be paid by the resident; and the conditions which the resident agreement may be amended or terminated.

C. Because of housing needs and health services coming together in assisted living facility, accountability lines are not clear. There is no federal regulation of assisted living. There is great inconsistency among the states as to whether or not assisted living facilities are regulated. Regulation activities are being consolidated under a new Office of Continuing Care that was created in January 1998.

1. Many states already have regulatory schemes for assisted living. Defined routes of development and control of these facilities has encouraged the growth of assisted living in those states. New York has been much slower in putting forth a coordinated

plan for assisted living. Legislation has been proposed but passage of Governor Pataki's bill is not imminent.

2. As of June 1998, 22 states had assisted living licensure regulations, 11 states had drafted or revised assisted living regulations; 11 states were studying assisted living and 22 states were planning to reimburse or were already reimbursing for assisted living as a Medicaid service and 6 states reimbursed for assisted living as a service in board and care facilities.

3. In New York, the Department of Health wants to regulate these facilities. Currently, they regulate the home care services but not the housing. The concern is in regard to the potential for abuse and of the safety of the residents. (For example, since they are not regulated, they do not have fire safety code standards.) The governor's bill, "The Assisted Living Reform Act," can be found: www.assembly.state.newyork.us/bill/50592.

a. The New York Legislation would create two kinds of assisted living. The first would be a licensed model in which housing and services would be combined and would both be regulated by the Department of Health. There would be a "medication aide" component, which is opposed by VNS. The second type would a license would only be required for the homecare agency and the housing part would need only to be registered.

b. In the proposal, a resident would sign a contract which outlines the services available at the facility and the cost, as well as the basis for eviction.

D. Cost: Assisted Living fees cover both the cost of capital (ie building structure) and services (meals, housekeeping, ADL assistance). New York has very high cost assisted living facilities. While some general information on Assisted Living Facilities from such organizations as AARP state that costs range from \$1,000 to \$3,000 a month, most New York

assisted living facilities start at a low end of \$3,500 and go to \$6,000 a month.

1. Some assisted living facilities have tiered rates, depending on the needs of the individual and the services selected.

E. While Assisted Living facilities thus far have been geared towards a higher income population, there is a move towards providing it for low- and moderate- income elderly as well. Such a facility is a new assisted living facility is being built in the Clinton area of Manhattan and sponsored by a nonprofit. Included in their rents, residents receive meals, housekeeping services and up to three hours a week of personal care. The rent ranges from \$2,000 to \$3700 a month.

II. Medicaid and Long Term Care Coverage

A. Generally

1. Medicaid is jointly funded by the federal government and the individual states. Each state formulates a Medicaid plan, which is then approved by the federal government. While some coverage, including skilled nursing facilities, is mandatory, the states are allowed to elect optional additional services. Over the years Medicaid has come to be the major payor of the cost of long term care for the middle class, especially nursing home care. If a person is eligible for Medicaid, Medicaid will pay for nursing home care in all states and New York has the most comprehensive Medicaid home care program.

B. Medicaid's Long Term Care coverage

1. In 1988, the Department of Health developed a new methodology to estimate the future need for nursing home beds in New York. Therefore, since then, Medicaid reimbursement rates are determined by the resident score on the Resource Utilization Groups classification scale, ie, "RUGs." The higher the score, the greater the need for skilled nursing. Nursing home generally do not want residents with low scores as the reimbursement rate will be low.

a. The majority of states that subsidize assisted living services for low-income older persons utilize Medicaid 1915c waivers under the Social Security Act. A waiver allows for a more flexible use of Medicaid to cover services, such as in an assisted living facility.

b. A model of Medicaid covering assisted living care is being developed by the St. Francis De Sales Church in Northern Manhattan. It is for low-income who score low on the "RUGs" scale, but would otherwise be eligible for nursing home care. In addition, there are other such Medicaid-waiver programs in New York, where the resident may be able to have Medicaid pay for the cost of care if they have a certain RUG score. The Medicaid-waiver program, if successful, will provide viable alternatives to low-income elderly.

2. New York has an extensive home care program which is funded by Medicaid. Obtaining eligibility for Medicaid for home care services is a simpler process than becoming eligible for Medicaid nursing home care, as there is no penalty period for transferring funds at the current time. As a result of the Medicaid home care program, many elderly may not need to--or see the need to pay for—an assisted living facility.

III. Long Term Care Insurance

A. The trend in long term insurance carries is to cover assisted living. However, some policies may not yet cover assisted living and it is likely that older policies do not cover it. As a whole the overall role of long-term care insurance is still limited, as private long-term care insurance currently pays for less than 7 percent of all long-term care costs. (AARP, "Long Term care Insurance," See: research.aarp.org)

B. To receive benefits, the insured must meet the policy's disability criteria. Typically, the policy requires that the insured lack the ability to perform two Activities of Daily Living (ADL's) to activate coverage.

C. The typical policy lists the amount of money that the company will pay out to an assisted living facility. Simply because a person goes to an assisted living facility does not mean that they will immediately be covered. The holder must demonstrate a cognitive loss or the loss of two Activities of Daily Living. The application for coverage must be accompanied by a letter from the treating physician. The company will do their own investigation. If it is determined that the criteria has been met, then the coverage will begin.

D. If the policy is for \$100 a day and the facility charges \$160 a day, then the

holder is responsible for the difference.

E. Some policies link home care coverage with assisted living. Others link assisted living coverage with nursing home care. This difference is significant, as the home care reimbursement rate may be substantially lower than the nursing home reimbursement rate. An assisted living Alzheimer's unit may cost almost as much as a skilled nursing facility. Clearly, it is better for the insured to hold a policy which links assisted living with nursing home care. While most new policies include assisted living, one needs to look closely at a policy to see where assisted living is picked up. In addition, a policy may not look as if assisted living is covered fully; there may be a rider that can be purchased that will cover the cost at 100 percent.

F. Some policies reimburse the holder for assisted living costs. Other pay the per diem amount once the holder meets the qualifying criteria.

G. The policies may have a maximum benefit amount and a maximum benefit period (eg., \$100 a day for six years). Coverage for assisted living may eat into coverage for nursing home care.

H. Many applicants will be unable to obtain coverage due to age or health. Furthermore, all policies contain limitations and exclusions, such as preexisting condition limitations, deductibles or waiting periods, exclusions for mental illness, intentionally self-inflicted injuries, substance abuse or chemical dependency, etc.

IV. Tax Deductions

A. Medical deductions are defined in Internal Revenue Code (I.R.C.) §213. Medical expenses are deductible to the extent that they exceed seven and one-half (7 1/2) percent of the taxpayer's adjusted gross income. The Health Insurance Portability and Accountability Act of 1999 (HIPAA) favorably clarified the deductibility of long term care as a medical expense. Qualified long term care services are deductible as medical expenses under §213.

B. Payment of facilities such as assisted living, retirement homes, and continuing care communities should be partially deductible to the extent that a portion

of the cost could be allocated to the provision of qualified long term care services provided that the taxpayer meets the definition of a chronically ill individual. Residents of retirement homes probably will not meet the definition of a chronically ill individual. Residents of assisted living may meet that definition. Residents in continuing care communities may or may not meet the definition depending on which level of care they are receiving. See *Estate of Smith*, 79 T.C. 313 (1982).

1. In order to be able to deduct qualified long term care services, the client must be certified as a “chronically ill individual” by a licensed health care practitioner. A chronically ill individual is defined by I.R.C. §7702B© as an individual unable to perform at least two activities of daily living or more than two activities of daily living without substantial assistance from another person due to functional incapacity or having a similar level of disability as specified by the regulations or requiring supervision to protect the individual from threats to his or her health and safety due to the individual’s cognitive impairment.
2. The condition must last for more than ninety (90) days. Activities of daily living are: eating, toileting, transferring, dressing, bathing and continence. If the client is certified as a chronically ill individual, the following expenses become qualified long term care services: diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and personal care services, provided that they are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

V. LifeCare Communities

A. “Lifecare” communities or “continuing care” communities/facilities are names given to communities that essentially charge a one-time “up-front” fee to live in the community. Along with the “entrance fee,” a retired person living in such a community is also required to pay a monthly rental fee for the cost of various services, such as upkeep of the community, meals, utilities, emergency medical help some housekeeping social activities and other amenities.

1. The entrance fee is typically used by a community to finance part or all of the cost of constructing the community. In addition,

the entrance fee may be used to pay down the cost of the mortgage on the community or to be set aside for future service costs

- B. Once the entrance fee is paid and the resident approved to move in, they are permitted to live there for the rest of their lives, even if, through no fault of their own, they run out of money to pay for the cost of the various services.
- C. Most, but not all Lifecare communities provide various levels of care, ranging from independent living to assisted living to skilled nursing care. In most cases, depending on the level of care, additional monthly fees are charged or the cost of the services.

VI. Conclusions:

1. If a client goes to an Assisted Living Facility, they should immediately begin thinking about doing Medicaid planning, since the average stay at a ASF is 2 years.
2. Long Term care insurance is appropriate for the client who is too wealthy to qualify for Medicaid coverage easily--even with transfers--but not wealthy enough to pay for long term care privately.
3. At this point, there is almost no Medicaid coverage for assisted living. As the demographics shift, however, this may slowly change.
4. At continuing care communities, look for tax deductibility of the cost--or apportionment of the cost as related to medical expenses—of the fee.

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