Long-Term Care Insurance

What is Long-Term Care Insurance?

Long-term care insurance is a type of insurance developed specifically to cover the costs of long-term care services, most of which are not covered by traditional health insurance or Medicare. These include services in your home such as assistance with Activities of Daily Living as well as care in a variety of facility and community settings.

There is a great deal of choice and flexibility in long-term care insurance policies. You can select a range of care options and benefits that allow you to get the services you need in the settings that suit you best. The cost of your long-term care insurance policy is based on the type and amount of services you choose to have covered, how old you are when you buy the policy, and any optional benefits you choose, such as Inflation Protection. If you are in poor health or already receiving long-term care services, you may not qualify for long-term care insurance, or you may only be able to buy a more limited amount of coverage, or buy coverage at a higher “non-standard” rate.

Long-term care insurance policies have a benefit period or lifetime benefit maximum, which is the total amount of time or total amount of dollars up to which benefits will be paid. Common benefit periods for long-term care policies are two, three, four, and five years, and lifetime or unlimited coverage. Other options between five years and lifetime/unlimited coverage are also available from many companies. Most policies translate these time periods into dollar amounts and do not actually limit the number of days for which they will pay for care – just the overall dollar amount that the policy will pay. There are fewer companies today willing to offer an unlimited/lifetime policy, although some have a “high coverage option” like a $1 million lifetime limit.

With long-term care insurance, you pay premiums in amounts you know in advance and can budget for, and the policy pays—up to its coverage limits—for the long-term care you need when you need it. Typically, premiums are waived during the time you are receiving benefits.

Coverage and Benefit Choices

Policy and Benefit Choices

The following is a summary of policy and benefit choices:

- You select a daily benefit amount (for example, $100 per day), which is the maximum daily amount of expenses for care the policy will pay. Most policies let you choose from $50 per day to as much as $500 per day. A growing number of policies specify benefits in terms of a monthly amount so that you have the flexibility to receive more care on some days (for example, when family care is not available) and less care on other days.

- Often you can choose whether you want the policy to pay the same daily benefit amount for care in all settings, or whether you want the policy to pay less for care in less costly settings, such as home care. Common choices include a home care benefit of 50 percent or 75 percent of the daily nursing home benefit amount.
• You choose a Maximum Lifetime Benefit or total lifetime amount you want the policy to provide. Policies typically offer a choice of lifetime dollar amounts—for example $100,000 or $300,000. The dollar amounts may correspond to a period of time. For example, a three-year policy at $100 per day of benefits would provide you with a total of $109,500 for care. Some insurers also sell “Lifetime” or “Unlimited” coverage that has no dollar limit; you receive benefits as long as you continue to need long-term care and receive covered services.

• You choose the type of coverage you prefer—“comprehensive” or “facility care only.” Comprehensive policies cover a wider range of care settings and services including both care at home and in various types of facilities.

• Most policies today are comprehensive, but some people prefer to buy facility care only policies. These pay for care in a nursing home or assisted living facility, but not for care at home or in the community. These policies may still include hospice or respite care but only when those services are provided in a facility. Facility-care-only policies cost less than comprehensive policies, and if people prefer and have family or friends to provide care at home, they may only have the policy to reimburse them for paid care in a facility if and when they need it.

• Many policies offer additional optional benefits or “riders” allowing you to customize your coverage. One important option is Inflation Protection, which helps protect you from the rising cost of care over time. It works the same way that an inflation clause on your homeowners’ insurance works: As the cost of replacing your home increases, so does the amount of insurance coverage that you maintain on the home. Most people who buy long-term care insurance opt for an inflation protection rider which builds the cost into the starting premium, so the cost of the policy doesn’t increase simply because the value of the coverage increases with inflation. But there are many different types of Inflation Protection in long-term care insurance. Be sure to find out more about Inflation Protection options in any policy you are considering.

• Most policies offer benefits in a variety of settings, such as your home, an adult day care center, an assisted living community, or a nursing home.

Additional Costs Long-Term Care Insurance Sometimes Covers

Many policies may also pay for services or devices to support people living at home:

• Equipment such as in-home electronic monitoring systems

• Home modification, such as grab bars and ramps

• Transportation to medical appointments

• Training for a friend or relative to learn to provide personal care safely and appropriately

Some policies provide some payment for family members or friends to help care for you, but may do so on a limited basis, or only in relation to the costs that the family member incurs.

Many policies provide the services of a care coordinator, usually a nurse or social worker in your community. The care coordinator can meet with you and discuss your specific personal situation, and help arrange for and monitor your care. The care coordinator’s help is usually optional—you use it if you need and want it—and you are not limited to the providers that the care coordinator may recommend.
**What Is a Typical Comprehensive Long-Term Care Insurance Benefit?**

The majority of policies sold today are comprehensive policies. They typically cover care and services in a variety of long-term care settings:

- Your home, including skilled nursing care, occupational, speech, physical and rehabilitation therapy, as well as help with personal care, such as bathing and dressing. Many policies also cover some homemaker services, such as meal preparation or housekeeping, in conjunction with the personal care services you receive.
- Adult day health care centers
- Hospice care
- Respite care
- Assisted living facilities (also called residential care facilities or alternate care facilities)
- Alzheimer’s special care facilities
- Nursing homes

**What Does Long-Term Care Insurance not Cover?**

Like all insurance, long-term care policies have exclusions. These are listed in both the Outline of Coverage you receive before you apply, as well as in the policy after you have purchased coverage. These exclusions often follow state regulations on what exclusions are allowed. Long-term care policies typically exclude the following (even if you meet all the other requirements of the policy):

- Care or services provided by family member unless the family member is a regular employee of an organization that is providing the treatment, service or care; and the organization they work for receives the payment for the treatment, service or care; and the family member receives no compensation other than the normal compensation for employees in his or her job category.
- Care or services for which no charge is made in the absence of insurance.
- Care or services provided outside the United States of America, its territories or possessions. However, a growing number of policies now have an international care benefit that can provide care outside of the United States.
- Care or services that result from war or act of war, whether declared or not.
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury.
- Care or services for alcoholism or drug addiction (except for an addiction to a prescription medication when administered in accordance with the advice of your physician).
- Treatment provided in a government facility (unless otherwise required by law).
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law.

Although most policies do not pay for care you receive from a family member, friend, or other individual who is not paid to provide your care, some policies provide a cash payment for each day that you receive care from anyone, even if it is a family member or friend. These policies cost more (about 25 to 40 percent more) but allow more flexibility in using your benefit dollars. Most policies provide training and support for family and friends who provide care.

Most policies require that the facility, agency or individual providing your care meet certain minimum standards with respect to quality, safety, and training. For example, a nursing home that is not licensed but operates in a state that requires licensure, would not be covered. In states that do not require long-term care facilities or programs to be licensed, the insurance policy would typically describe the staffing, safety and other features that
should be present to ensure that you receive appropriate and safe care.

Long-term care policies focus on paying for the types of services and providers that someone needs when they cannot perform their Activities of Daily Living on their own or when they have a Cognitive Impairment. They do not pay for care or services unrelated to these needs, such as hospital stays or prescription medications.

However, some policies may pay for prescription drugs provided while you are in a care facility (but not at home), and some policies pay for transportation costs to help you get to medical appointments when you are physically or cognitively impaired.

Some policies provide coverage for care related to everyday household needs such as housekeeping, laundry, meals, and managing medications, so-called “instrumental activities of daily living,” but only when you receive that help as part of the help you get from a paid care provider for assistance with Activities of Daily Living. So most policies do not pay for in-home help if all you need is help with services such as housekeeping, meals, laundry, and transportation.

Finally, long-term care policies do not pay for items provided solely for your comfort or convenience, for example a television in your nursing home room or a visit to the facility’s hair care salon.

Long-Term Care Insurance Costs and Receiving Benefits

What Does Long-Term Care Insurance Cost?

Policy costs vary greatly based on your age at the time of purchase, the policy, and the coverage you select. The average annual premium cost for a policy purchased in 2007 by individual buyers, across all ages of buyers and all of the types of policies was just over $2,207. Excluding 20% of individuals who elected lifetime coverage, this represents a comprehensive policy (covering both facility and at-home care) that provides an average of 4.8 years worth of benefits, with a daily benefit amount of $160. Most policies purchased in 2007 also included some form of automatic Inflation Protection. The chart below shows the average annual premium amounts paid for long-term care insurance in 2007 overall, and for specific age groups.

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<tr>
<th>Age</th>
<th>Average Annual Premium amounts paid in 2007 – averaged for all ages and for specific age groups. (2008 LIMRA International, Inc.)</th>
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<tr>
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Designing Coverage to Best Meet Your Needs

You can customize long-term care insurance coverage to match the amount you feel you can pay. Below is an example of different long-term care insurance options—all from the same program (as illustration only)—to help you see how different coverage choices can influence the monthly premium cost you would pay. To keep it simple, the illustration only changes one coverage element at a time. The price associated with some of these changes varies by age, while for some other types of changes, the savings do not vary based on your age at the time you buy.

The basic coverage design depicted in Plan A is as follows:

- Comprehensive Coverage (Facility and at-home and community care)
- Facility care daily benefit of $150 per day
- Home Health Care Benefits paid at $112 per day (75 percent of the facility care amount).
- Elimination period of 30 days
- Lifetime coverage maximum equivalent to five years (or just under $275,000 for a policy paying $150 per day)
- Automatic Compound Annual Inflation Protection

Note—The monthly premiums shown here are based on one long-term care insurance program’s rates and represents premium costs. Premiums for the exact same coverage described here from a different company will, for a variety of reasons, vary from the rates shown here. These monthly premiums are based on the Federal Long-Term Care Insurance Program (www.ltcfeds.com). You can use the premium calculator there to see how other types of coverage changes would impact the rates, or to explore sample rates for other ages.

Plans B through E show you different ways to reduce your premium costs compared to the coverage described in Plan A. You should examine how the premium changes for Plans B through Plans E based on the Plan A (base plan).

**Plan B**: Same as Plan A, except the elimination period is 90 days instead of 30 days.

**Plan C**: Same as Plan A, except the lifetime maximum is equal to 3 years, or just under $165,000

**Plan D**: Pays benefits at $100 per day for facility care and, correspondingly, $75 per day. All other elements remain the same.

**Plan E**: Same as Plan A, except it does not include Compound Annual Inflation Protection. Instead, each year you can elect to increase your coverage by a set amount (generally five percent of the prior years’ benefit amount) and you would pay for that additional amount at the time you elect it.

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How Do You Pay Long-Term Care Insurance Premiums?

Different policies offer different payment options. With most policies, you pay premiums according to a schedule you select—monthly, quarterly, semi-annually or annually. You may be able to have the premium automatically withdrawn from your bank account, pension check, or paycheck (if you obtain coverage through your employer). Typically you pay premiums until you begin to receive benefits. Then premiums are waived as long as you continue to receive benefits.

With most policies, you pay premiums as long as you are not receiving benefits. However, with some policies you pay premiums only for a specified period—most often 10, 15, or 20 years. For example, with the 20-year option, you pay a monthly premium for 20 years and then your coverage is fully paid up. If you begin to receive benefits before the 20-year pay period is over, you stop paying premiums while you are receiving benefits. If you recover and have not yet paid in for all 20 years, you resume payments. With some policies you only pay premiums until age 65.

A few companies offer a “Single Pay” option, in which you pay for the insurance in one lump sum payment. While they are more expensive than traditional long-term care insurance, the advantage is that the single lump sum payment is the only premium required. These policies typically pay for long-term care expenses and also offer you the option to include a death benefit for your heirs. Some states do not allow single-pay policies.

When Are Long-Term Care Benefits Paid?

When benefits are paid is based on the policy’s “benefit trigger,” the length of the elimination period you choose, and sometimes when you start receiving paid care.

Policies use objective measures to determine when you need long-term care. These are called ‘benefit triggers.’ Most policies use Activities of Daily Living and Cognitive Impairment as triggers for benefits. The policy pays benefits when you need help with two or more of the six Activities of Daily Living or when you have a Cognitive Impairment.

Benefits begin to be paid after an elimination period has elapsed. This is the number of days between when a benefit trigger occurs and when you begin to receive payment for services. An elimination period is like the deductible you have on your car insurance, except it is usually specified as a period of time rather than a dollar amount. As noted above, most policies allow you to choose the length of the elimination period, generally 30, 60 or 90 days. During the elimination period, you are responsible for the cost of any services you receive. Policies differ with regard to whether you are required to receive paid care or pay for services to satisfy an elimination period before benefits start.

Once you are eligible for benefits, most policies reimburse the costs you incur for covered services up to a pre-set limit. Some policies simply pay you a pre-set cash amount for each day that you meet the ‘benefit trigger’ whether you receive paid long-term care services or not. These “cash disability” policies offer greater flexibility but are also significantly more expensive.
Buying Long-Term Care Insurance

Can Everyone Buy Long-Term Care Insurance?

No, having certain conditions means you may not qualify for long-term care insurance. However, insurance companies have different standards, so while you may be denied coverage by one company, another might accept you. You will probably not be approved to purchase a policy if:

• You currently use long-term care services.
• You already need help with Activities of Daily Living.
• You have AIDS or AIDS Related Complex (ARC).
• You have Alzheimer’s disease or any form of dementia or cognitive dysfunction.
• You have a progressive neurological condition such as Multiple Sclerosis or Parkinson’s Disease.
• You have had a stroke within the past 12 to 24 months or a history of strokes or multiple Transient Ischemic Attacks (TIAs).
• You have metastatic cancer (cancer that has spread beyond its original site).

Other health conditions are evaluated in deciding whether or not you can obtain the insurance, but these are the primary conditions that can disqualify you from obtaining insurance.

Once you are accepted for coverage, your coverage cannot be cancelled for any reason other than non-payment of premium as due, or if you have received the policy’s maximum benefits. If you develop one of the health conditions listed above after obtaining coverage, you would be covered for the care you need for that condition.

Consumer Protections

The following rules apply to all long-term care insurance policies:

• Coverage cannot be cancelled or not renewed as long as you continue to pay premiums as they are due and you have not used up the maximum policy benefits.
• You have 30 days after receiving the policy to return it for a full refund.
• You have the right to designate another person to receive notice of premiums due and payments missed so you won’t accidentally miss a payment.
• You have up to 65 days after the date a premium payment is due to make payment. Coverage cannot be cancelled for non-payment until after the grace period and until the “third party designee” has also been notified.
• If coverage lapses for non-payment because you were “disabled” at the time, you can restore your coverage within five months of the missed premium due date.
• If you have a group policy through your employer or other association, you can continue that coverage, unchanged, if you leave the group but want to maintain the policy.
• A spouse insured through an employer group plan may maintain coverage even after a divorce.
• Your premiums are designed to remain level over the lifetime of your coverage, and are based on your age when you first buy the policy. The insurer can change rates on a group (or class) basis, but has only a limited right to do so, and the change must apply to an entire group or class. You cannot be singled out for a rate increase.
In most states, rate increases must be filed with and approved by the State Department of Insurance. Many states have adopted regulations that make it very difficult for an insurer to obtain approval for a rate increase.

You typically have the right to decrease your coverage, without underwriting, if you find in the future that the current premium costs are beyond your financial means.

**Things to Consider Before Buying Long-Term Care Insurance**

- Don’t buy out of fear or emotion.
- Don’t buy more insurance than you think you may need. You may have enough income to pay a portion of your care costs and may need only a small policy for the remainder. You may have family willing and able to supplement your care needs.
- Don’t buy too little insurance. That will only delay the use of your own assets or income to pay for care. Think about how you feel about having care costs that won’t be covered. While you can usually decrease how much coverage you have, it is more difficult to increase coverage, especially if your health has declined.
- Look carefully at the policy you are considering. There is no “one-size-fits-all” policy.
- Does the policy pay only for room and board in a facility? If so, plan for other expenses, such as supplies, medications, linens, and other things that may not be covered.
- It costs less to buy coverage when you are younger. The average age of someone buying long-term care insurance today is about 60. For those who purchase policies offered at work, the average age at which they buy is about 50.
- Make sure that buying the long-term care insurance policy is a sound financial decision and affordable for you.

- Look at different options and talk with a professional before making a decision.

**Where to Buy Long-Term Care Insurance**

Most people buy long-term care insurance directly from an insurance agent, financial planner or broker. States regulate which companies can sell long-term care insurance and the products that they can sell. There are over 100 companies offering long-term care insurance nationally, however about 15 to 20 insurers sell most of the policies on the market today. The best way to find out which insurance companies offer this type of coverage in your state is to contact your state’s Department of Insurance at www.consumeraction.gov/insurance.shtml.

Another option for some people is to buy long-term care insurance offered through their employer. Many private and public employers, including the Federal government and a growing number of state governments, offer group long-term care programs as a voluntary benefit. Employers do not typically contribute to the premium cost (as they do with health insurance), but they often negotiate a favorable group rate.

If you are currently employed, it may be easier to qualify for long-term care insurance through your employer than purchasing a policy on your own. Check with your benefit or pensions office to see if your employer offers long-term care insurance.

The U.S. Office of Personnel Management has additional information about the Federal Long Term Care Insurance Program at www.opm.gov/insure/ltc. Check the list below to see if your state has a program to offer long-term care insurance to public employees, public retirees, and their families.
State Partnership Long-Term Care Insurance Programs

A Partnership Program is a collaboration or “partnership” among a state government, the private insurance companies selling long-term care insurance in that state, and state residents who buy long-term care Partnership policies. The purpose of the Partnership program is to make the purchase of shorter term more comprehensive long-term care insurance meaningful by linking these special policies (called Partnership qualified or PQ policies) with Medicaid for those who continue to require care.

Partnership qualified policies must meet special requirements that can differ somewhat from state to state. Most states require Partnership policies to offer comprehensive benefits (cover institutional and home services), be Tax Qualified, provide certain specific consumer protections, and include state specific provisions for inflation protection. Often the only difference between a partnership qualified policy and other long-term care insurance policies sold in a state is the amount and type of inflation protection required by the state.

Partnership policies must be certified by the State as meeting the specific requirements for the Partnership Program. State insurance departments are responsible for ensuring that individuals who sell Partnership policies are trained and understand how these policies relate to public and private coverage options.

How Do Partnership Policies Work?

A Partnership qualified policy provides you, as the purchaser, with the right to apply for Medicaid under modified eligibility rules that include a special feature called an “asset disregard.” This allows you to keep assets that would otherwise not be allowed if you need to apply, and qualify, for Medicaid in order to receive additional long-term care services. The amount of assets Medicaid will disregard is equal to the amount of the benefits you actually receive under your long term care Partnership qualified policy. Since these policies must include inflation protection, the amount of the benefits you receive can be higher than the amount of insurance protection you originally purchased. If you have a Partnership-qualified long term care insurance policy and receive $100,000 in benefits, you can apply for Medicaid and, if eligible, retain $100,000 worth of assets over and above the State's Medicaid asset threshold. In most states the asset threshold is $2,000 for a single person. Asset thresholds for married couples are typically more generous.

The following is an example of how a Partnership Qualified policy works. Let’s say John, a single man, purchases a Partnership policy with a value of $100,000. Some years later he receives benefits under that policy up to the policy’s lifetime maximum coverage (adjusted for inflation) equaling $150,000. John eventually requires more long-term care services, and applies for Medicaid. If John’s policy was not a Partnership-qualified policy, in order to qualify for Medicaid, he would be entitled to keep only $2,000 in assets. He would have to spend down any assets over and above this amount. However, because John bought a Partnership-qualified policy, if he needs to apply for Medicaid and is deemed eligible, he can keep $152,000 in assets and the State will not recover those funds after his death. However, any assets John has over and above the $152,000 would have to be spent in order for him to be eligible for Medicaid. He would also have to satisfy the income, general eligibility and functional eligibility requirements for Medicaid before he can qualify.

Partnership programs help both individuals and the state. For individuals, it allows them to get and pay for services they need without having to spend all of their assets. For the state, it can decrease the amount of Medicaid dollars used for long-term care services.
Some Important Considerations for Consumers

- It is important to know if the long-term care insurance policy you buy is a Partnership qualified policy or not, since they can be the same as non-Partnership policies. A Partnership qualified policy is one that is certified by the State, and it must include the level of inflation protection coverage set by the State. Only if you have a Partnership policy will you be eligible for an asset disregard if and when you apply for Medicaid.

- Policies issued prior to a state Partnership Program’s effective date will not be considered Partnership-qualified; however there are circumstances under which you may be able to exchange a policy you previously purchased for one that is Partnership qualified.

- It is important to buy your Partnership qualified policy from an agent who is specially trained to sell that type of coverage. States with Partnership Programs have additional educational requirements for agents who wish to sell Partnership policies.

- It is important to note that eligibility for Medicaid is not automatic. You must still apply and meet the income, functional and general eligibility requirements of the Medicaid program in your state. The long-term care services provided by Medicaid vary by state and may not be the same as the services you are eligible to receive under your private Partnership long-term care insurance policy (for example, many state Medicaid programs do not pay for room and board costs in an Assisted Living Facility even if you are also receiving personal care).

- States that have Partnership programs are automatically considered to have “reciprocity” with each other and to honor the asset disregard you earned under a Partnership policy you purchased in a different state. However, States can “opt out” of this requirement at any time.

Which States Have Partnership Programs?

The chart on the next page shows which states have implemented Partnership programs and are offering long-term care Partnership policies as of June 1, 2009. There are numerous other states in the process of implementing these programs. If you want more information on your State’s program including which insurance agents are selling Partnership policies, or if you want to find out if your State is planning to offer a Partnership program, contact your State’s Department of Insurance at www.consumeraction.gov/insurance.shtml.
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Source: U.S. Department of Health and Human Services, National Clearinghouse on Long-Term Care Information.