

Overview of Current Long-Term Care Financing Options

By Eileen J. Tell

This series summarizes current issues in financing long-term care and outlines policy options for increasing affordable access to services.

At some point in their lives, most people will need some form of ongoing assistance, often called long term care (LTC) or long-term services and supports (LTSS). This includes assistance with activities of daily living such as bathing or dressing or supervision required by a cognitive condition such as Alzheimer's disease. LTC is provided to older people and younger adults with disabilities that typically emerge "because of a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time."¹

Specifically, 70% of those reaching age 65 will need LTC before they die, and they will receive care for an average of 3.5 years.² Also, LTC is expensive: a year in a nursing home costs over \$82,000 on average, and for a private room in an assisted living facility the amount is just under \$40,000. Home health care at 20 hours a week costs nearly \$22,000 a year.³

While a few individuals and families can cover these costs out of their income and assets without difficulty, most cannot do so without substantially lowering their standard of living, compromising on care quality, limiting care choices, and endangering their financial stability and ability to continue paying for care in the future.

Is there a solution to this problem? Several options exist today, including both government programs and private-sector financial products, but none can perfectly meet either current or growing

needs. Some options cost more than many people feel they can pay. Some provide only a portion of the funds needed. Some are available only to those who meet certain health, age, or income criteria. Others cover only limited care settings or providers. Still others require a sacrifice of assets and income before care will be paid for.

This paper surveys the various approaches to LTC financing that exist today (see Table 1). It provides a framework for the papers that follow, which explore in greater depth both current options and potential ways of addressing this important and growing need. The existing approaches can be divided into those designed to meet LTC needs and those that, although believed by many to address LTC, do not in fact adequately do so.

Family Caregiving

Care provided without compensation by family members or friends has always been and will continue to be a vital part of LTC. Today, more than 65 million people (29% of the U.S. population) have provided hands-on care, emotional support, and/or financial assistance to loved ones at some point during the year. Of these, 10 million are adults age 50 and older caring for a parent.⁴

The extent to which individuals plan to or actually do rely on family care depends on their circumstances and preferences. In some cases, family may not be available or capable of providing the type or amount of care needed. Or, for a variety of personal reasons, an individual may not wish to be cared for by relatives. On the other hand, many people have a strong expectation of family caregiving.

TABLE 1 Current Financing Products, Programs, and Approaches to Meet Long-Term Care (LTC) Needs

Intended to Address LTC Needs	Mistakenly Believed to Offer LTC Protection
Family caregiving	Medicare and Medicare supplement insurance
Medicaid	Private disability insurance
Long-term care insurance (LTCI)	Social Security disability benefits
Hybrid life/LTC and annuity/LTC products	
Health savings accounts (HSAs)	
Personal savings	
Home equity	
Department of Veterans Affairs (VA)	

One problem with planning to rely on family care is that no one can predict the future—one cannot know whether family members will be available and able to provide the kind of care needed when it is needed.

The impact of providing care on family caregivers themselves must also be considered. Family members are often quite willing to provide care out of love and a sincere desire to help. However, family caregivers can experience negative financial, physical, and emotional consequences. Financial impacts include lost wages, which can affect both one’s standard of living and the ability to save for one’s own future needs. Negative impacts on physical and emotional health are cited by 70% of caregivers.⁵ Emotional strain and mental health issues top the list, but other concerns include sleep problems, a compromised immune system, greater use of medications, heightened mortality rates, hypertension, stroke, and other problems. Negative impacts are increased for the 70% of caregivers whose loved one has Alzheimer’s disease or other cognitive impairment.⁶ And caregivers’ lives are broadly affected—research shows that they are likely to skip social obligations (74%), neglect other family responsibilities (65%),

skip exercise (52%), get to work or school late or leave early (51%), miss school or work (46%), or cancel vacations (49%).⁷

Medicaid

Medicaid is a federal-state program that provides health care coverage to low-income people. Medicaid is the largest payer of LTC services, accounting for 62% of all LTC expenditures in 2010.⁸ Each state operates its own Medicaid program within federal guidelines. States must cover institutional care (such as a nursing home), and they have the option of covering home- and community-based services (such as home care and assisted living). Eligibility varies somewhat by state, but applicants must have a certain level of impairment and limited financial resources. Those who are not already low-income must spend their income and assets on care until they have very little left to qualify for Medicaid in their state.

There are serious drawbacks to planning on Medicaid to pay for LTC. The choice of care settings may be limited, as only Medicaid-participating providers may be used, and care at home or in an assisted living facility is either

significantly limited or not available in many states. Coverage varies by state, so someone who moves may not be able to continue receiving the same care. Unlike other forms of LTC coverage, Medicaid covered services, terms, and conditions are continually subject to change, often because of state budget pressures. For those with financial means, perhaps the most significant disadvantage is the requirement to spend down income and assets to qualify. While some individuals have found loopholes with the help of attorneys, this is not the norm, and there are substantial penalties for attempting to do this, including having coverage delayed or denied.

Long-Term Care Insurance (LTCI)

With about 8.2 million insured lives, private LTCI is one of the more popular advanced planning LTC coverage options.⁹ A relatively new insurance product, LTCI has evolved significantly since it first emerged in the mid-1980s. Today's products provide comprehensive coverage for all care settings and offer prospective buyers a wide array of coverage choices and options. Consumer protection provisions guard against potential problems in areas such as qualifying for benefits, maintaining insurability, and unintended lapse. Most LTCI also offers some means of increasing benefits to keep pace with rising care costs, called "inflation protection". LTCI is available through some employers, most often on an employee-pay-all basis, and directly from agents, insurance companies, and financial advisors. All but a handful of states offer an "LTC Partnership" program that allows individuals who received benefits from a qualified private LTCI policy to obtain Medicaid LTC coverage without having to "spend down" all of their assets.¹⁰

However, LTCI is not an option for everyone. For most policies, there is medical underwriting, and someone who already needs LTC or who

has a condition that puts them at a significantly high risk of needing LTC in the future (such as Parkinson's disease) would generally not be eligible. An exception is a few employer-sponsored group plans that have guaranteed issue, making coverage available to all applicants regardless of health status.

Affordability is one of the reasons most often cited for why someone considered but did not buy LTCI. The premium is based on a person's age when they buy, so LTCI may be beyond the means of some older people. The average annual premium (across all ages) is \$2,283. (This average is based on roughly five years' coverage with a daily benefit for all settings of \$153¹¹; this daily benefit would cover about 80% of average nursing home charges, 40% of care in an assisted living facility, or home health aide visits at the rate of about 60 per month.¹²)

Few individuals and families can cover LTC costs out of their income and assets without difficulty.

Consumers also find LTCI complex and worry that they might be wasting their money if they buy it and never need LTC. Despite efforts to educate the population to think about LTCI as one does with homeowners or automobile insurance—you hope you won't need it but if you do you're glad you have it—many consumers persist in believing that they will not need it or can save enough on their own to cover LTC. Many also would rather take their chances (that is, hope they never need LTC) than to pay premiums of \$2,000 to \$4,000 a year and possibly face a future rate increase. LTCI usually appeals to those in their 50s and in relatively good health when they buy. Buyers are also people with a planning orientation who acknowledge the risks and costs of LTC and the lack of a better alternative to pay for it. The potential market for private LTCI is quite significant; one study estimates

that as many as 49% of the non-institutional population 18 and older can afford and qualify for it. Yet because of the issues discussed above, only a fraction (6.4%) of that market has been tapped.¹³

Hybrid Life/LTC and Annuity/LTC Products

Newer options, currently with a smaller share of the market than LTCI, are the so-called “combo” or “hybrid” products, which combine LTC benefits with either life insurance or an annuity. These products can pay out for both reasons—if long term care is needed, benefits are paid, but if not, there is a death benefit or annuity payout. Also, if the amount paid for LTC does not exhaust the product value, the remaining funds can go to a death benefit or annuity payout. This is one of the principal appeals of combo products—if LTC is never needed, there is still a return on the money invested. Life/LTC hybrids are underwritten for both mortality and LTC risk; annuity/LTC hybrids often have more limited underwriting.

Combo products are commonly designed with a single premium. In 2011, the average single premium for a life/LTC hybrid was \$70,000, for a face amount of roughly \$146,000 (about two years of LTC benefits). Some life products have regular premiums, and the average annual amount is almost \$5,500, for a face amount of \$278,000.¹⁴ These amounts are beyond many people’s means, but unless the initial investment is significant, the product may not be adequate for LTC needs.

The flexibility offered by these combo products is attractive, but it also makes them complicated, and some consumers find them difficult to understand. And some do not like the fact that LTC benefits, should they be used, deplete the death benefit or annuity pay-out, the main reason most people buy life insurance or an annuity.

Originally a niche market, both types of combo products seem to be increasing in popularity. As of 2011, there were approximately 266,000 life/LTC products in force,¹⁵ with single premium designs dominating sales. Regarding annuity/LTC hybrids, a survey of about half the companies offering them at the end of 2011 reported just over 10,200 in force.¹⁶ Some of this growth is fueled by favorable tax treatment granted in the Pension Protection Act of 2006. Whereas proceeds from a regular life or annuity product are considered taxable income, when the proceeds are used for LTC, they are not taxable.

Purchaser demographics for hybrid products are similar to regular LTCI. And while these products hold some appeal because the buyer is likely to get at least one type of payout, consumers have the same objections as to LTCI: denial of the need for LTC, distrust of insurance companies, and cost.

Health Savings Accounts (HSAs)

Health savings accounts (HSAs) are designed to create a tax-advantaged pool of money that a person can use to pay health care expenses not covered by insurance. Individuals who are covered by a qualified high-deductible health plan can have an HSA, with or without the involvement of an employer. Individual and employer contributions are tax-free. Funds can be rolled over in the account from year to year, and investment earnings and gains are tax-free, facilitating growth in the account balance. If withdrawals are used for qualified medical expenses, they are also tax-free.

HSAs can be used for LTC because qualified medical expenses are defined to include LTC expenses, as well as LTCI premiums up to age-based dollar limits. However, the potential of HSAs as an LTC funding source is limited because of annual caps on contributions—\$3,250 for an individual and \$6,450 for a family

(2013, adjusted annually)—with most people contributing much less (\$886 for individuals and \$1,559 for families on average in 2011).¹⁷ While in theory a person could make sizable contributions every year and let the account grow, the reality is that people with high-deductible health plans usually need funds from their HSAs to pay out-of-pocket medical costs, and rollover amounts are typically not large. As of 2011, one-third of HSAs had rollover amounts of less than \$500, and only one-fourth had \$2,000 or more.¹⁸

Personal Savings

Some individuals consider buying LTCI or other product but decide they would rather save on their own to meet their LTC needs. But how many actually do so? Many people fail to adequately save and plan ahead to ensure themselves retirement income sufficient to meet basic daily living expenses, so it is likely that even fewer set up a savings account designated for future LTC needs. People often lack a psychological framework that disposes them to long-term planning; seven in ten individuals focus on short- to medium-term goals with respect to managing finances.¹⁹ Other factors in the failure to save are the denial of the risk or need for LTC and competing needs for income and assets in the near term.

Even for those who understand the risks and costs of LTC and the value of planning ahead, personal savings as a funding approach is both difficult and inefficient. Most people lack the substantial disposable income and financial flexibility necessary to set aside large sums of money today and leave them untouched until they are needed for LTC in the distant future. And if one does not save enough, earn adequate interest, or start early enough, saving can be not only difficult but insufficient. The amount an individual will eventually need for LTC is hard to predict and costs are rising, so underfunding is common. However, for those who do have the financial resources to make large contributions to and maintain an account earmarked for LTC,

this approach has an advantage—if LTC is not needed, the savings remain available for other purposes.

LTC is provided to older people and younger adults with disabilities that typically emerge because of a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time.¹

Home Equity

The equity that many people have built up in their homes is often their largest single asset. In 2011, seniors had \$3.14 trillion in home equity, with a median home value of \$160,000.²⁰ This asset can be used in a variety of ways to pay for LTC. First, one can sell one's home and use the proceeds to pay for care in a smaller dwelling, an assisted living facility, or a relative's home. But moving can be difficult, both emotionally and physically, and if care is needed immediately, a person may be forced to sell their home when prices are low. Moreover, the funds produced may not be adequate to meet lifetime care needs.

Another option is a home equity loan. The homeowner receives a lump sum and pays it back (plus interest) in regular monthly payments (as with a home mortgage). Alternatively, a home equity loan can take the form of a line of credit, which may work better for people who are unsure of how long they will continue to live at home or how much LTC they will need. Interest rates on home equity loans are currently quite low, and interest payments may be tax-deductible to some extent. But there are also disadvantages. Some homeowners may not qualify since lenders consider income, other debt, and credit history. The funds obtained may not be sufficient for care needs. As with a mortgage, if a homeowner cannot make the payments on a home equity loan, the home could be subject to foreclosure. And if home values drop, one might end up owing more on one's property than it is worth.

An alternative available to homeowners 62 and older is a reverse mortgage (RM). The homeowner receives a loan, which may be in the form of a lump sum, monthly payments, a line of credit, or some combination, with home equity serving as collateral. The homeowner does not have to make payments as long as they continue living in the home. The loan becomes due only when the last borrower (usually a surviving spouse) dies, sells the home, or permanently moves out.

RMs offer several advantages. First, there are no requirements regarding income, credit history, or health. Money received is not taxable income. Borrowers or their heirs will never owe more than the value of the home when it is sold or the loan is repaid, even if the home's value has declined. However, RMs also have significant limitations. There are large upfront costs, so if a person anticipates moving out of their home soon for health or other reasons, an RM may not be advantageous. Because the loan must be repaid if the last borrower permanently moves out of the home, a RM may not work to finance a long stay in a nursing home or assisted living. An RM depletes home equity, so that it is not available for other uses or to pass on to heirs. Most importantly, the loan amount may not be sufficient to pay for total care costs.

Department of Veterans Affairs (VA)

The Department of Veterans Affairs (VA) pays for some LTC for veterans who meet established disability criteria and need care because of service-related disabilities. In some cases, LTC is covered for veterans who need care for non-service-related disabilities and are unable to pay for it, but middle-income veterans needing LTC for non-service-related conditions may find it difficult to qualify for benefits.

Veterans' access to LTC services is based on clinical need and setting availability. Nursing

home care must be clinically necessary, and (as with Medicaid) each state establishes eligibility and admission criteria for its nursing homes. Home care must be ordered by a VA physician, and the veteran must meet eligibility criteria involving their service-connected status, level of disability, and income. Also like Medicaid, the VA has additional programs to help veterans stay in their homes, but these programs are subject to eligibility and availability. The VA system does not pay for room and board associated with care in an adult foster care home and does not pay at all for assisted living facilities. Veterans must make copayments ranging (based on income) from zero to \$97 per day.

Programs and Products Commonly Misunderstood as LTC Coverage

Some people fail to plan ahead for future LTC needs because they mistakenly believe that Medicare or Medicare supplement insurance, disability insurance, or Social Security disability benefits will pay for LTC. The remainder of this paper examines these programs and products and explains why these do not adequately meet LTC needs.

Medicare and Medicare Supplement Insurance

Some people believe that Medicare as currently constructed in law will meet their LTC needs, but this is not the case. It is true that Medicare has benefits for skilled nursing facility care and home health care, but these are paid only for a short time (typically no more than a few weeks) while a person is recovering from an acute illness or injury, and only if certain restrictive conditions are met. For those who continue to receive benefits for facility care beyond 20 days, there is a large daily copayment (\$148 in 2013), and coverage ends after 100 days. Care needed for months and years because of a chronic functional

or cognitive impairment is not covered. Private-sector Medicare Advantage plans follow the same rules. A recent legal settlement may liberalize Medicare's requirement that an individual's condition be improving for benefits for skilled care and therapy at home to continue, but it will not likely impact LTC because most LTC delivered is not skilled care, but rather custodial care (help with activities of daily living) and supervision.

There is no simple solution to this problem—no one product that addresses all of these concerns and is suitable and affordable for everyone.

While awareness is improving, roughly one-third of Americans still mistakenly perceive Medicare as a payment option for extended LTC.²¹ And unfortunately, publicity of the settlement mentioned above and a potential loosening of Medicare's rules for skilled care at home may increase this misperception.

Medicare supplement (Medigap) policies are private-sector insurance products purchased by Medicare beneficiaries to help pay for some items not covered in full by Medicare. Because Medigap policies follow the same benefit eligibility rules as Medicare and are largely designed to cover Medicare copayments and deductibles, they do not address the need for LTC. Again, awareness of this is growing, but there are still some, particularly younger adults, who believe that “Medigap helps pay for what Medicare does not”—including LTC.

Private Disability Insurance

Nearly one in three U.S. workers in private industry has some form of private disability income (DI) insurance through an employer,²² and several million more people have individually purchased policies. While many people understandably associate a disability with the need for LTC, DI insurance is designed

to provide partial income replacement when an illness or injury prevents a person from being able to do their job. It is *not* designed to cover LTC costs. Without a doubt, short-term disability insurance, which typically provides 60% to 80% of pre-disability income for three or six months, would be woefully inadequate to cover both living expenses and care costs for a true LTC need (defined as a loss of functional or cognitive ability expected to last at least 90 days). While long-term disability coverage typically covers about 60% of pre-disability income for years, again, these benefits are designed to replace earned income needed to pay living expenses, not cover the cost of care. Finally, disability coverage and benefits generally end when someone stops working or at a retirement age specified by the policy. DI insurance is no help to someone needing LTC who is beyond a defined retirement age or no longer working.

Social Security Disability Benefits

The Social Security Administration also provides benefits for some who are unable to work because of an illness or injury. To qualify, a person must have paid into the Social Security system (through payroll deductions) for a minimum amount of time and generally must be unable to engage in any gainful work for at least a year. Benefit amounts are set to provide a minimal standard of living, not a middle-class lifestyle. Thus compared to private DI insurance, eligibility is more restrictive and benefits less generous.

As with private DI insurance, some people associate “disability” with the need for LTC and assume that Social Security disability benefits address this need. But this is not correct. Like private DI coverage, Social Security disability benefits are designed to partially replace lost income and are not sufficient to cover both living expenses and LTC. Benefits end at retirement age (usually 65), so this is not an option for older, non-working people.

TABLE 2 Long-Term Care Financing Options

Option	Evidence of Good Health Required?	Income and Assets Must Be...	Other Eligibility Criteria?	LTC Services Covered
Medicaid	No	Low to qualify or be spent down.	Certain level of impairment	Limitations on providers and non-nursing home care
Long-term care insurance (LTCI)	Usually (group may have guaranteed issue)	Sufficient to pay premiums	No	All
Hybrid insurance products	Yes, usually	Substantial to afford products	No	All
Health savings accounts (HSAs)	No	Sufficient to make sizable contributions	Covered by high-deductible health plan	All
Personal savings	No	Substantial to set aside and maintain funds	No	All
Reverse mortgage	No	Home ownership required	62 or older, remaining in and maintaining home	Cannot leave home to live in facility
Veterans Affairs	No	Low to qualify in some cases	Veteran, clinical need, availability of services	Limitations on non-nursing home care

Conclusion

We as a society, and each of us as individuals, must address the challenge of funding future LTC needs. While there are several ways to meet this need, they all have limitations. Also, despite government initiatives to raise awareness of the risks and costs of LTC, and the efforts of business-people to educate consumers about how their products can help, most people have taken no steps to plan and provide for their future needs. Why not? The most important reason is probably denial—most people simply do not acknowledge their risk of needing LTC or the potential costs they face. Lack of knowledge is also a factor—many individuals have misconceptions about the cost of care and how they can meet these future financing needs. Others are informed about the products and have considered some of them, but have concerns about their limitations and value and so have not taken action. In some cases, the complexity of products and the array of choices may keep potential buyers from reaching a decision. Some

individuals may not qualify for products for health or other reasons. Finally, many people simply feel that, with the other financial demands they face, they simply cannot afford any of the advanced planning choices. This leaves most people without any type of LTC risk protection.

There is no simple solution to this problem—no one product that addresses all of these concerns and is suitable and affordable for everyone. Rather, as we have seen, there is an array of products, each appropriate for certain people, each with advantages and limitations, costs and benefits. Today’s challenge is to further refine these products and develop new ones, so that we can better address the reasons consumers do not buy and so expand the number of people who have adequate protection against the LTC risk. We will then bring greater financial security, enhanced care options, and peace of mind to millions of Americans. The papers that follow in this series explore the new options, alternatives, modification, and incentives that may hold the promise of meeting this goal.

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References

1. Reinhard SC, Kassner E, Houser A. How the Affordable Care Act Can Help Move States Toward a High-Performing System of Long-Term Services and Supports. *Health Affairs*. March 2011; 30(3): 447-453.
2. Kemper P, Komisar HI, Alexih L. Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect? *Inquiry*. Winter 2005/2006; 42(4): 335-350.
3. MetLife Mature Market Institute. The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. November 2012. <https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf>. Accessed January 25, 2013.
4. Holland SK., Quirk S. Reducing Caregiver Burden: Report from Two Innovative Programs. March 2012; presented at the 12th Annual Intercompany Long-Term Care Insurance Conference, Las Vegas NV.
5. Ibid.
6. Ibid.
7. Ibid.
8. National Health Policy Forum. National Spending for Long-Term Services and Support (LTSS). February 23, 2012. http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_02-23-12.pdf. Accessed January 25, 2013.
9. LIMRA. LTCI Market at a Glance (2011). 2012. [https://www.limra.com/Login/?returnurl=%2fresearch%2fabstracts%2f2012%2fltci_market_at_a_glance_2011_\(2012\).aspx%3flangtype%3d1033](https://www.limra.com/Login/?returnurl=%2fresearch%2fabstracts%2f2012%2fltci_market_at_a_glance_2011_(2012).aspx%3flangtype%3d1033). Accessed January 25, 2013.
10. Department of Health and Human Services, National Clearinghouse for Long Term Care Information. State Partnership Programs. http://www.longtermcare.gov/LTC/Main_Site/Paying/Private_Financing/LTC_Insurance/State_Partnership.aspx. Accessed February 10, 2013.
11. LifePlans Inc. (for America's Health Insurance Plans). Who Buys Long-Term Care Insurance in 2010-2011? A Twenty-Year Study of Buyers and Non-Buyers (in the Individual Market). March 2012. <http://www.ahip.org/Issues/Long-Term-Care-Insurance.aspx>. Accessed January 25, 2013.

12. MetLife Mature Market Institute. The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. November 2012. <https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf>. Accessed January 25, 2013.
13. Cutler JA, Spillman B, Tell EJ. Private Financing of Long Term Care: Market Penetration and Market Potential. June 2010; presented at Academy Health ARM Conference, Boston MA.
14. LIMRA. Individual Life Combination Products: Life with Long-Term Care & Life with Chronic Illness Riders. 2011 Annual Review.
15. Ibid.
16. LIMRA. January 2013. Personal Communication
17. America's Health Insurance Plans (AHIP). Health Savings Accounts and Account-Based Health Plans: Research. May 2012.
18. Employee Benefit Research Institute (EBRI). Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006– 2011 (Issue Brief #367). January 2012.
19. Prudential Financial, Inc. Reported in What, Us Worry? Americans Fail To Plan For Retirement. The Wall Street Journal, May 25, 2005. <http://online.wsj.com/article/SB111698153579342458.html>. Accessed January 25, 2013.
20. Ecker E. At 3.14 Trillion, Senior Home Equity Fares Better Than Most. Reverse Mortgage Daily, October 5, 2011. <http://reversemortgagedaily.com/2011/10/05/at-3-14-trillion-senior-home-equity-fares-better>. Accessed January 25, 2013.
21. Kaiser Family Foundation. Kaiser Public Opinion Spotlight. December 2007.
22. U.S. Department of Labor, Bureau of Labor Statistics. National Compensation Survey, 2011. <http://www.bls.gov/eci/> Accessed January 23, 2013.

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