Partnership Long-Term Care Policies

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United Insurance Educators, Inc.
8213 – 352nd Street East
Eatonville, Washington 98328-8638
mail@uiece.com
www.UIEce.com

Partnership Long-Term Care Policies

Welcome

There was a time when any appropriately licensed insurance producer could present and sell long-term care policies. Today's policies are complicated and today producers who work in this market must be specialists in the long-term care marketplace. This course is designed for those agents.

Each state mandates specific education requirements. Some states require Partnership long-term care education as part of (not in addition to) other state requirements while other states simply have a Partnership continuing education requirement, but the course need not actually be part of the state's formal approval process. That is not the case for insurance companies. Since the Partnership long-term care requirement is a federal requirement, insurers must be able to validate the education that has been taken. As a result, our LTC courses are registered on the Clear-Cert website and they meet the federal guidelines for Partnership education.

Please Complete Your Own Work

The states require each insurance producer and adjuster to complete their own education without help from another person or entity. If we learn that another individual allowed you to use their completed test as a marker we will deny you a certificate of completion, as required by the states. *No refund will be due as a result of this action.*

There is a reason the federal government has mandated education for agents selling or marketing Partnership long-term care policies: they are complicated. It is important that all in the industry know what they are doing.

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Your cooperation is appreciated.

Welcome to

8-Hour Partnership Long-Term Care Policies

United Insurance Educators, Inc.

8213 352nd Street East
Eatonville, Washington 98328-8638

253-846-1155
800-735-1155

FAX only: 253-846-7536

www.**uiece**.com

Partnership Long-Term Care Policies

Chapter 1

Partnership Program Creation

Our grandparents did not anticipate ever needing care in a nursing home. If they lived to be very old or became ill it was likely that a family member, often a daughter, would take care of them for the last years of their life.

Times have changed. Today our daughters work outside of the home and may live in another state. Families also tend to have fewer children to share the responsibilities associated with caring for an elderly or sick family member. As families found themselves needing to care for an elderly member, they began to turn to paid care in private homes and eventually this evolved into facilities offering such care.

Care for an elderly or sick member is expensive. Nursing home care is the most expensive, but care in assisted living or in other facilities is not far behind. Today families need to consider long-term health care needs along with their planning for a financially secure retirement. If an individual fails to consider the costs of health care in their final years, they may find all the financial planning they did is quickly eroded by long-term nursing care costs. Financial planning is only complete when health care issues are fully considered.

With the baby boom generation aging and the cost of services going up, paying for long-term care is an issue of pressing importance for policymakers who fear Medicaid applications will outpace the program's financial ability. While some individuals can count on friends and family to assist with the activities of daily living, many others must determine how to pay for extended home-health services or a potential stay in a nursing facility.

The likelihood of needing nursing home care is significant. A 65-year-old man has a 27 percent chance of entering a nursing home at some point in his life; a 65-year-old woman faces a 44 percent probability of doing so. The likelihood of receiving some form of care at home is higher. While costs vary from state to state, and even from region to region within states, the average nursing home stay costs more than $77,380 per year ($6,500 per month). The financial stakes are high for both state and federal governments. On average, states spend 18 percent of their general fund budgets on Medicaid. Individuals

must spend nearly all their non-housing assets before they qualify for Medicaid assistance (which is financed through our taxes), so financially it is devastating for everyone.

Defining Long-Term Care

It is important to define long-term care since it relates to insurance contracts and federal and state guidelines. Long-term care is not hospital care although some hospitals may have long-term care sections. Long-term care specifically applies to care in a nursing home, home health care setting, or other institution providing non-hospitalization benefits. When hospitals provide such care the wing of the building is called a "nursing unit" rather than a "hospitalization unit."

Various laws will define long-term care based on their interpretation or intent. Partnership states will define long-term care based upon Partnership requirements. Federal law considers "long-term" to mean care provided for 90 days or more. Additionally, most long-term care definitions relate to the inability to perform the general activities of living, called "activities of daily living" or ADLs. These activities include eating, toileting, transferring to and from beds and chairs, bathing, dressing, and continence. Non-tax qualified state plans may include ambulating as an ADL, the ability to move around independently. When ambulating was omitted from federal requirements, many long-term care professionals felt the omission reduced their client's ability to collect insurance policy benefits.

A cognitive impairment is also used as a measure for defining and collecting services based on the legal definition of long-term care. A cognitive impairment would be the inability to take care of oneself due to Alzheimer's disease, dementia or some other mental incapability.

While it does make a difference as to who is defining long-term care, the government considers it to be a range of services and support that is needed to meet every-day needs. Often the help needed is not medical in nature, but rather assistance with the basic personal tasks we take for granted, such as housework, cooking and taking medication. It can also include tasks that we might not think about, such as caring for pets.

Service Providers

Nursing Homes

Long-term care providers are as varied as the services they provide. As previously mentioned, most long-term care is performed outside of hospitals, but there are some

hospitals that have a wing specifically for care on a long-term basis. However, this is not hospitalized care; it is a nursing unit similar to a nursing home.

Most people immediately think of nursing homes when they think of long-term care services and nursing homes do provide a large portion of the care. However, nursing homes are also the most expensive place to receive such care so, as increasing numbers of Americans need long-term services we have turned to other sources for care. Where ever care is received however, the services must be appropriate for the type of care needed.

Nursing homes have three levels of care: skilled, intermediate, and custodial (often referred to as maintenance or personal care). Medicare covers a limited amount of skilled care and most people do not need that level for any extended period of time. Skilled care is the highest level of medical care provided outside of a hospital. Individuals might initially receive skilled care when moved from the hospital to a nursing home but the care level quickly reduces to either intermediate or custodial (neither of which Medicare will pay for).

Assisted Living Facilities

In recent years we have seen facilities called "assisted living" receiving acceptance from both the medical community and Americans. Assisted living allows those with long-term requirements to receive them in a location that resembles living at home. They are similar to apartment complexes in that the residents typically furnish the small apartments with their own furniture and accessories but nursing personnel is available on a 24/7 basis. In most cases the residents must be partially self-sufficient, able to go to a common dining room on their own and perform other functions involving mobility that reduce the amount of care required. Many assisted living facilities also have an adjoining nursing home so that an individual whose care needs increase can simply be moved to a different location within the same facility.

Care at Home and in the Community

Most people prefer to remain at home and if that is possible, it can be the lowest cost of all types of long-term care services, but not always. If the family is not in a position to provide at least part of the services required by the patient it can be very expensive to hire around-the-clock care. However, if family and friends can provide at least half of the time needed for care, then it is often the least expensive form of extended care services.

Care at home might include housekeeping services, meals provided by outside sources, transportation to and from appointments, and general personal services such as bathing or transferring from bed to chair or chair to wheelchair. Home care is really anything that needs to be done from changing linens to overseeing medication.

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There are many community services that help an individual to remain at home. They include adult day care, hospice services, respite care, and really any type of help that makes remaining at home possible. Usually successful home care means that family or friends are also involved. It might mean that family members stay the night with the patient, cook their meals, clean their homes, and pay their bills. Outside help is used to fill in the gaps that cannot be handled by family or friends. For example, a daughter might take her mother to adult day care Mondays through Fridays while she goes to her paying job.

As our elderly population continues to increase it is likely that the government (state or federal) will sponsor increasingly more types of services to enable people to remain in their homes. There may be no other choice since nursing home care is so expensive and there are limited spaces available in assisted living facilities, although they are likely to continue expanding. From the government's perspective it is a cost-saving measure to encourage families to participate in the care of their elderly family members and that can only happen if there are back-up services available.

Many of the baby-boom generation have long-term care insurance policies that will assist with the costs of care at home, but not enough have purchased insurance to defray the costs that will hit Medicaid as this generation ages. Therefore, as states struggle with difficult budgets, it may be the various community service organizations assisting those who are attempting to remain at home that rescue the states from increasingly heavy Medicaid expenditures.

History of the Long-Term Care Partnership Program

In the late 1980s the Robert Wood Johnson Foundation (RWJF) supported the development of a new LTC insurance model, with a goal of encouraging more people to purchase LTC coverage. The program, called the **Partnership for Long-Term Care**, brought states and private insurers together to create a new insurance product that would encourage the uninsured to purchase long-term care coverage. It was hoped that moderate-income individuals, who faced the greatest risk of future reliance on Medicaid, would cover long-term-care needs through insurance policies.

The Partnership program was designed to attract consumers who might not otherwise purchase this type of insurance. States offered the guarantee that if benefits under a Partnership policy did not sufficiently cover the cost of care, the consumer could apply and qualify for Medicaid under special eligibility rules while retaining a pre-specified amount of assets (though income and functional eligibility rules would still apply).

Partnership Long-Term Care Policies

Consumers would be protected from having to become impoverished to qualify for Medicaid, and states would avoid the entire burden of long-term-care costs.[1]

In 1987 the Program to Promote Long-Term Care Insurance for the Elderly was authorized. The Robert Wood Johnson Foundation (RWJF) was charged with providing states with resources to plan and implement private/public partnerships for funding long-term care needs. A primary goal of the Partnership Program was estate preservation, but also to promote an awareness of long-term health care needs faced by individuals as they age. The partnership programs joined the private insurance sector already offering long-term care insurance with the goal of developing high-quality insurance options that would prevent asset depletion and dependence on Medicaid.

Partnership programs protect assets (not income) from the high costs of home care, community care, and nursing home care. Income would still need to be used for the individual's care, but assets would be protected. No policy protects income once benefits are used up and the insured goes on Medicaid.

Between 1987 and 2000, a total of 104,000 applications had been taken and more than 95,000 policies had been sold in the four trial program states: California, Connecticut, Indiana, and New York.

Analysts in the health care industry first recognized the need to develop and promote long-term care policies in the early 1980s. This was about the same time that government realized the need to seek funding solutions for the care of those who were ending up on Medicaid. By the mid-1980s insurance companies were marketing private long-term care policies, although these early policies had several flaws in coverage.

Many were surprised to learn that it was not just the poor who were ending up dependent upon state and federal aid for their long-term health care needs; the middle class were finding themselves quickly impoverished once they entered a nursing home. It took less than one year for many individuals to become poor enough to qualify for Medicaid.

The situation is not expected to improve unless the general population accepts their responsibility by purchasing insurance or providing some financial avenue to pay for long-term care needs. Concern about the financing of long-term care is based on set predictions: the population of chronically ill elderly will inevitably increase with the population of those older than age 80 and with medical advances that enable those with chronic diseases to survive longer. According to a study published by the New England Journal of Medicine, 43 percent of all Americans will enter a nursing home at some time

[1] Issue Brief Long-Term Care Partnership Expansion: A New Opportunity for States

before they die.[2] Of these, 55 percent will stay at least one year and 21 percent will stay at least 5 years. The average stay will last two and a half years. Medicare will pay less than 9.4 percent of the long-term care costs since that program was never designed to cover care in a nursing home beyond a very short period of time.

Medicaid, the program that ends up paying the costs once a person becomes impoverished, is one of the largest items in state budgets. The elderly and disabled population represents less than one-third of the total Medicaid caseload, but consumes over two-thirds of the total program funding for care in nursing homes. Obviously, this is a situation that has the potential of totally draining state budgets as the baby-boomer set becomes elderly.

A number of studies and commissions at the federal and state levels have reported the need for long-term health care insurance development is urgent. Additionally, some broad agreements have been reached, including:

- Delaying the moment at which patients qualify for Medicaid could avoid financial disaster for the patient and their families.
- Preventing financial spend-down, and subsequent qualification for Medicaid benefits, would save public funds.
- Elderly consumers would benefit if risk pooling could be implemented by state legislatures specifically designed to provide a safety net for medically uninsurable people.

Even though these agreements are generally accepted little action has been taken by the public sector. Private long-term care insurance represents more than a $200-million industry, but the coverage is often limited and premium costs are high. As a result, sales of private long-term care coverage have not been as good as analysts hoped for. Only a small segment of the population have actually purchased such coverage; of the total costs of long-term care services, less than 1 percent are covered by private insurance. Our tax dollars still cover the largest part of long-term care costs.

Why haven't more people bought long-term care policies? Most people do not want to go to a nursing home and this may be part of the problem. Some may believe owning such coverage will encourage their family members to use it, versus caring for them at home or in a family member's home. This equates into a lack of education regarding health care at this stage of life. Even when family members are willing to provide care for a long period of time it is not always prudent for them to do so; often it is better for

[2] Program to Promote Long-Term Care Insurance for the Elderly, July 2007, Robert Wood Johnson Foundation

the patient to receive professional care at locations prepared to supply appropriate services.

As the financial crisis became more evident, the idea of financing long-term care through some type of public-private cooperation gained favor. As a result of state government and insurance company meetings and discussions during the 1980s, a partnership for long-term care needs developed. The Robert Wood Johnson Foundation was attracted by its win-win-win potential. Who wins? Consumers, Medicaid, and private insurers all had the potential to win. RWJF authorized the national program in 1987.

The Robert Wood Johnson Foundation (RWJF) had specific goals:

1. Avoiding impoverishment for elderly individuals by guaranteeing some measure of asset protection;
2. Providing access to quality long-term care that is appropriate for the individual's medical situation;
3. Providing coverage for a full range of home and community-based services;
4. Development of a case management infrastructure in which the gatekeeper bears some financial risk in order to prevent excessive or inappropriate utilization (they did not want family members to be able to use this program inappropriately for their ill or frail member); and
5. Assurance of equity and affordability in the long-term-care-insurance program for lower-income individuals.

Partnership Policy Creation

The national program office is located at the University of Maryland Center on Aging. Their primary responsibilities were to provide leadership and technical assistance for grantee institutions during the planning and implementation stages. They would also offer information to other states that were interested in replicating the public-private partnership programs, or even pursue alternative programs that might appropriately address the situation. Additionally, they wanted to develop and implement some type of media relations strategy that would increase policy sales. Obviously, if consumers did not buy the partnership policies, they would not solve the problem.

The planning phase of Partnership long-term care policies was authorized in 1987 with funding of $3.2 million. The national program office contacted states that had demonstrated a commitment to reforming long-term care financing. Grants were awarded to California, Connecticut, Indiana, Massachusetts, New Jersey, New York,

Oregon, and Wisconsin. These eight states collected and analyzed data from nursing homes, the elderly population, state Medicaid files, and insurers to help them design and price their products and to assess products' impact on costs.

Based on the Brookings/ICF long-term care financing model, which simulates utilization and financing of long-term care services through the year 2020, it was estimated that a national Partnership program involving all 50 states could result in a 7 percent drop in Medicaid's share of the total long-term care bill between 2016 and 2020.[3] Most states do now have Partnership programs. Since the Partnership program will protect assets (not income), it is expected to be well received in those states that begin to utilize Partnership long-term care programs.

Some interesting early Partnership facts:

- The average age of early Partnership respondents was 58 or 59 years old (depending upon the state).
- Respondents listed their health as primarily excellent.
- The average age of Partnership policyholders ranged from 58 to 63, depending upon the state. California, for example, reported an average age of 60.
- Women purchased more Partnership policies than men.
- The majority of Partnership policy owners were married.
- For most, this was the first time they had bought a long-term care policy of any type.
- In California, Connecticut, and Indiana the majority of policy holders had income greater than $5,000 per month and total non-housing assets of more than $350,000.

The purchase of Partnership policies have increased significantly since the program began, although there were some down periods in sales. Two states reported that they did not feel the decline in sales had anything to do with Partnership plans since all long-term care policy sales were down.

Most of the Partnership policies written were comprehensive, covering both nursing home care and home and community-based care.

[3] Robert Wood Johnson Foundation's Program to Promote Long-Term Care Insurance for the Elderly

Partnership Long-Term Care Policies

State Amendments and Waivers

Medicaid is the largest payor of nursing home bills for the elderly. Medicaid is a joint federal-state program that is financed (on average) 57 percent by the federal government and 43 percent by the states. The individual states administer the program in their state according to their Medicaid state plans, which are set up within broad federal guidelines. States can make changes or innovations that go beyond current state parameters, which is the case with Long-Term Care Insurance for the Elderly initiatives in Partnership participating states. States must have the federal governments' permission to have the federal parameters or requirements changed, even when it benefits consumers.

One approach has been to use waivers of federal requirements. A waiver of Medicaid requirements can be obtained in different ways:

1. **Federal legislation:** a federal legislative waiver is essentially a congressional mandate that gets written into public law.
2. **Administrative approval:** Health Care Financing Administration (HCFA) of the U.S. Department of Health & Human Services administers Medicaid and can grant an administrative waiver of Medicaid requirements. Administrative waivers come in three types:
    a. Freedom-of-choice waivers;
    b. Home- and community-based-services waivers; and
    c. Research waivers, which are typically used to test innovative ideas on a portion of those eligible for Medicaid.

Administrative waivers typically have a time limit on their duration and have special reporting requirements.

Another approach, the one used for the Partnership program, is through a state amendment to its Medicaid state plan. A state plan amendment may be used in lieu of waivers. States submit their plan amendments to the HCFA requesting permission to alter their Medicaid programs. In this case, the federal role is to approve the modifications (rather than waive compliance with the law) within the existing federal statutory authority. When such amendments are approved the changes become part of the state plan until either the state makes another amendment or until the statutory requirements are changed. Where administrative waivers have a set durational time limit, state plan amendments have no time restrictions and there may be no special reporting requirements.

Partnership Long-Term Care Policies

The first Partnership models required waivers, but later models did not. Models were amended to minimize the need for federal waivers. The plans initiated in early 1988 required a Federal waiver.

Early legislative activity for the waivers included introducing bills specifically aimed at Partnership plans, along with attempts to include waiver language in various budget reconciliation bills. Those efforts never reached the floor of Congress for a vote because a congressional conference eliminated from consideration all budget-neutral items, which included the Partnerships. This decision reflected the need to undo a logjam in the 1989 budget reconciliation process.

Subsequent efforts to revive waiver legislation met with strong opposition led by Democratic Congressmen Henry Waxman of California, Chair of the House Subcommittee on Health and the Environment, which controlled legislation involving the Medicaid program, and John Dingell of Michigan, chair of the House Energy and Environment Committee. They had specific concerns, including the belief that:

1. The standards implicit in the waiver request were too lenient;
2. Private insurers needed to improve consumer protections substantially before playing a major role in public-private partnerships;
3. Medicaid dollars should go to help only the poor and nearly-poor rather than those with enough assets to purchase long-term care policies; and
4. The direct link between the public and private sectors should be made only with great caution, since direct links might imply extensive public responsibility to ensure the fairness, viability, and quality of the private insurance product.

After the political opposition blocked the initial attempts in the late 1980s, the state Partnership program teams shifted to a Medicaid state plan amendment strategy to obtain the required approvals. This was not a fast process. Delays occurred for various reasons, including:

1. Insurance regulations governing partnerships in several of the states had to be modified to reflect the Medicaid state plan amendments;
2. State legislatures usually had to approve the regulation changes and then HCFA had to approve the state plan amendments.

In the end, the four states that implemented their partnerships (California, Connecticut, Indiana, and New York) received HCFA approval of their Medicaid state plan amendments.

Due to the delays caused by the Medicaid state plan amendment process and HCFA's separate process needed to approve them, the Robert Wood Johnson Foundation (RWJF)

awarded implementation grants to the states one at a time, from August 1987 through December 1988. Normally the national program procedure is to authorize all project sites at once.

The states that had planned to have a Partnership program, but did not implement it, cited political opposition, fiscal constraints, and regulatory barriers as the primary obstacles to doing so.

California, Connecticut, and Indiana based their Partnership plans on a dollar-for-dollar model, although Indiana changed its model in 1998. Under the dollar-for-dollar model, for each dollar of long-term care coverage purchased by the insured from a private insurance carrier participating in the partnership, a dollar of assets was protected from the spend-down requirements for Medicaid eligibility. Therefore, if Joe buys a policy that provides $50,000 in benefits, he is protecting the same amount ($50,000) of his personal assets from the spend-down requirement. Partnerships do not protect Joe's income, just the assets he has acquired.

For asset protection, the consumer purchases an insurance policy that stipulates the amount of coverage that he or she wishes to have. That figure purchased is the amount the insurer will pay out in benefits under long-term care coverage in a nursing home, assisted living, or other qualified service. Once the purchased benefit amount has been fully paid out by the insurer, Medicaid can assume coverage, following application and approval for Medicaid eligibility. The policyholder, as previously stated, would contribute income towards his or her care since only assets are protected by Partnership policies.

Traditional long-term care policies still offer valid benefits, but since they do not protect assets, Medicaid coverage could only begin after the insured had depleted their assets down to approximately $2,000. In other words, after the non-partnership insurance policy had paid out all available benefits, the individual would still have to use all their assets *before* Medicaid would step in and pay anything towards their medical care. With Partnership policies, special Medicaid eligibility regulations allow the policyholder to keep assets (not income) up to the level of long-term care benefits they purchased. Since assets are protected only to the level of insurance benefits purchased, the amount of coverage needs to be given great thought. If the Partnership policy benefits expire with the policyholder having assets greater than those protected by the Partnership policy, the insured will be required to spend-down the excess assets prior to qualifying for Medicaid. This does not necessarily mean that he or she should have purchased greater benefits, but it is certainly something to be considered.

Whatever non-housing assets the insured has, he or she will be allowed to keep an amount of assets equal to the amount of long-term care coverage that was purchased

through the Partnership program (plus the $2,000 in assets that everyone is allowed to keep). Any income, including Social Security income, pension income, or any non-housing income that is received must be contributed to the policyholder's medical care expenses.

In any dollar-for-dollar Partnership program, the spending of assets would look like the following:

Partnership Policy Benefits Purchased:	Policyholder Assets Upon Medicaid Application:	Required Asset Spend Down for Medicaid Eligibility:
$100,000	$100,000	None
$100,000	$150,000	$50,000
Traditional non-partnership policy purchased	$100,000	$100,000
No Policy Purchased of any type.	$100,000	$100,000

Even though a traditional, non-partnership policy does not protect assets, such policies still have value. The benefits provided by non-partnership policies still allow the insured to keep assets that might otherwise have been spent for medical care – *if enough traditional insurance benefits were purchased they might fully cover the care preventing Medicaid application entirely.* Even so, it would seem prudent (if the choice is available) to purchase Partnership policies since extra protection for assets come with them.

When the first states introduced Partnership plans, New York chose a different approach. Rather than offer dollar-for-dollar benefits, they chose a program called the **total-assets protection model**. Under this program, certified policies had to cover three years in a nursing home or six years of home health care. Once the benefits were exhausted, the Medicaid eligibility process did not consider any assets of the insured at all. Protections were granted for all assets, even those far above the amount of protection purchased. Income still had to be contributed to the individual's health care, just as in the dollar-for-dollar plans. Total Asset Partnership plans are more expensive than dollar-for-dollar plans. The Deficit Reduction Act specifies that new long-term care Partnership programs offer dollar-for-dollar models only, not total asset models.

States participating in Partnership plans all conducted extensive promotional and educational campaigns designed to inform the public about the availability of these insurance policies with the goal of increasing sales (which would ultimately relieve the state of some portion of their Medicaid expenditures). RWJF contributed to some of the promotional campaigns by providing contracts with public relation firms. Participating

states collected and analyzed sales and marketing data and used the information to evaluate the Partnership programs, making any changes they felt necessary.

Informal versus Formal Care

We usually think of long-term care in terms of formal care (care in an institution) but long-term care can happen anywhere the individual resides, including their home. When care is received at home by family members or friends it is considered informal care.

Most long-term care begins as informal care. Grandma begins forgetting to pay her bills so her daughter takes over that duty. Then Grandma begins to mix up her medications, so her daughter begins laying them out for her each day and maybe supervising as she takes them as well (to make sure she actually does take them). Grandma begins displaying other issues, such as lack of hygiene or getting lost easily. This might be a gradual slip into cognitive impairment or physical limitations.

Most families initially care for their elderly members. In some cases, they are able to provide care without outside help but in many cases family members eventually need some type of formal care for their ailing members.

Formal caregivers are often paid providers although they may also be volunteers from nonprofit or government organizations, such as meals on wheels. When the beneficiary is able to remain at home there is often a mix of formal and informal care; formal care on a part-time basis (such as visiting nurses) and informal care filling in where necessary by family members. Since family members are often employed it is often necessary to pay formal care providers since there is simply no way for family to care for the patient on a full time basis.

There are various types of both medical and non-medical care and often it is a mix that is required. For example, Grandma might need help with her medications, help bathing, and weekly checkups for her medical conditions to monitor how she is doing. In addition family members might need days off from caring for her.

If it is possible to maintain care at home the cost will be significantly less than moving Grandma to a nursing home or even an assisted care facility. The ability to maintain Grandma in her own home is a significant financial savings. However, as the patient's needs increase (both medical and non-medical) informal caregivers often do not realize the physical and emotional stress that is developing as they try to do everything, while still maintaining their own personal life. Bringing in formal caregivers can allow family members to continue helping, but their help is then more effective. In many cases, keeping informal care available is the key to avoiding institutionalization.

Partnership Long-Term Care Policies

New Federal Legislation: The Deficit Reduction Act of 2005

In the spring of 2006 President George W. Bush signed the Deficit Reduction Act of 2005 (DRA 2005) allowing long-term care insurance Partnership models to be used in all 50 states. This Act makes it harder for individuals to give away money and property (lengthening the time period available for asset repositioning from three to five years) before asking Medicaid to pay for their nursing home care, but it also increased the incentives to purchase long-term care insurance. Policies in the new programs must meet specific criteria, such as federal tax qualification, specified consumer protections and inflation protection provisions.

The Deficit Reduction Act of 2005 included a number of reforms related to long-term care services. Of interest to many states is the lifting of the moratorium on Partnership programs. Under the DRA all states can implement LTC Partnership programs through an approved State Plan Amendment, if specific requirements are met. The DRA requires programs to include certain consumer protections, most notably provisions of the National Association of Insurance Commissioners' Model LTC regulations. The DRA also requires that polices include inflation protection when purchased by a person under age 76.[4]

Questions that Remained Unanswered

Some of the concerns that prompted Congress in 1993 to halt further implementation of additional Partnership programs in other states remain relevant. Do Partnership programs really save state Medicaid funds or do only the wealthy buy them? What consumer protections are needed to ensure that policies will provide meaningful benefits when they are needed 20 years from now? Will existing Partnership and non-partnership policies still be affordable in ten to twenty years? We are finding that some currently issued non-partnership policies have become so expensive that policyholders are allowing them to lapse even though premiums have already been paid for many years.

Health Insurance Portability and Accountability Act (HIPAA)

The federal government has recognized the urgency for long-term care insurance. Although funding the cost of institutionalization can be achieved through other means besides long-term care insurance, it is the most logical avenue for most people. As a

[4] Robert Wood Johnson Foundation • May 2007 • Long-Term Care Partnership Expansion

result of this recognition, in 1996, the U.S. Congress enacted the **Health Insurance Portability and Accountability Act,** generally referred to as **HIPAA.** It may also be known as the **Kennedy-Kassebaum Bill.** President Bill Clinton signed this act into law in August of 1996. It may also be referred to as **Public Law 104-191**. The entire law is very complex, but for our purposes only the long-term care portion will be relevant.

Congress attempted to fulfill a number of different public policy objectives:

1. Classification of long-term care costs as a medical expense thus providing taxpayers some economic relief, but only if they met specific criteria, including the type of policy they purchased.
2. Categorized long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premium and benefits.
3. Provided the general public with an incentive to purchase this type of product.

Specifically, the IRS defines "qualified long-term care services" as:

> Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.

Obviously, this definition is very broad. It could include any type of health service. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a "chronically ill individual."

*A **chronically Ill Individual** must be certified by a licensed health care practitioner within the previous 12 months as one of the following:*

1. *The insured is unable, for at least 90 days, to perform at least two activities of daily living, called ADLs, without substantial assistance from another individual, due to the loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.*
2. *The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.*

It is important to note that this standardized definition of a chronically ill person cannot be altered in any way by state law, and it is the only definition allowed to receive the favorable tax treatment for the cost of long-term care services.

Perhaps the most misunderstood aspect of HIPAA is the 90-day certification for activities of daily living. Its relevance to the deductibility of long-term care expenses is

clear. Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short-term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it would have had the unintended consequence of allowing taxpayers to deduct all their expenses associated with short-term disabilities, due to the vague nature of the definition of qualified *long-term care service*.

A taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. It is important to note the requirement concerns the *likelihood* of needing care, not necessarily the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be re-certified at least annually.

The IRS Publication 502 stipulates that the 90-day certification period is *not* a deductible period for people who have long-term care insurance. Long-term care insurance may still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is *likely to need* qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

Grandfathered Policies

While questions of tax deductibility follow non-tax qualified LTC policies, tax-qualified long-term care contracts are clearly deductible if specified qualifications are met. Under HIPAA any long-term care insurance contract that meets the Act's requirements will receive specific tax advantages. All other policies are considered to be non-tax qualified. There is an exception, which was made for all long-term care policies issued before HIPAA had been state approved. These policies were "grandfathered" in. Therefore, they are considered tax-qualified even though they did not meet the requirements that were spelled out in the legislation. However if these policies are altered the grandfathered tax-qualified status is lost.

OBRA 1993 Provisions and the Partnership for Long-Term Care

The Omnibus Reconciliation Act of 1993 contained language with direct impact on the expansion of Partnerships for long-term care. The Act recognized the initial four states operating Partnership programs as well as the future program in Iowa and the modified program in Massachusetts. These six states were allowed to operate their Partnership

programs as planned since their state plan amendments were approved by HHS prior to May 14, 1993.

States seeking a state plan amendment after May 14th had to follow the conditions outlined in OBRA '93. There are three sections with specific language pertaining to Partnership programs. Requirements in each section are as follows:

Sec 1917(b) paragraph 1 subparagraph C

Section 1917(b) paragraph 1, subparagraph C requires any state operating a Partnership program to recover funds from the estates of all persons receiving services under Medicaid. The result of this language is lost asset protection occurring as soon as the insured dies; only while he or she is living are their assets protected from Medicaid recovery. This means assets do not pass on to the insured's heirs. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets under Partnership policies.

Sec 1917(b) paragraph 3

This section prevents any state from waiving the estate recovery requirement for Partnership participants even if they want to in order to promote Partnership plan sales.

Sec 1917(b) paragraph 4 subparagraph B

A specific definition of "estate" was necessary for Partnership participants. **Estates**:

A. shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

B. . . . any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other assignment.

The above definition may vary from the current definition used by a state for estate recovery. States implementing their Partnership program sometimes found themselves in the position of having to use a more encompassing definition for Partnership participants alone. These post OBRA Partnership states may even have to seek legislative approval to implement the required recovery process for Partnership participants.

Partnership Long-Term Care Policies

Promoting Partnership Long-Term Care Plans

Several organizations promote Partnership plans, including the Center for Health Care Strategies, the National Association of State Medicaid Directors and George Mason University.

There is no doubt that as the numbers of elderly Americans increase, long-term-care (LTC) needs and costs are growing. Many professionals believe that private long-term-care insurance can and should play a more significant role in the financing of home care, community care, assisted living facilities and nursing home services. The hope is that greater use of individually purchased insurance policies will reduce the burden on Medicaid to some degree. State Medicaid programs are the largest payer of nursing home costs since they often serve as the default financier of long-term care services.

One vehicle designed to encourage consumers to invest in LTC insurance is the expansion of the **Partnership for Long-Term Care**, developed in the 1980s with support from the Robert Wood Johnson Foundation (RWJF). Through the Partnership program states are promoting the purchase of private LTC insurance by offering consumers access to Medicaid under special eligibility rules should additional LTC coverage (beyond what the policies provide) be needed. Partnership policies encourage individuals to take responsibility for financing their own initial phase of long-term care through use of private insurance and asset preservation.

About 80 percent of those surveyed in the Partnership program said they would have purchased long-term care whether the Partnership program was available or not, since they consider such policies a valuable financial planning tool. The other 20 percent indicated they would have self-financed long-term care if the Partnership plans had not been available (so they would *not* have bought non-partnership policies) since the need of such care may or may not occur. They purchased the Partnership policies primarily on the basis of asset conservation.

Program Growth

Four states initially implemented Partnership programs in the early 1990s (California, Connecticut, Indiana and New York) and the assumption was that other states would follow. That did not immediately happen however. Citing concerns about the appropriateness of using Medicaid funds for this purpose, Congress enacted restrictions on further development of Partnership programs in the Omnibus Budget Reconciliation Act (OBRA) of 1993. The four states with existing Partnership programs were allowed to continue, but the OBRA provisions ended the replication of the Partnership model in new states.

Partnership Long-Term Care Policies

There were two different models used for asset protection: dollar-for dollar and asset protection. California, Indiana and Connecticut chose the *dollar-for-dollar* model. Under dollar-for-dollar, the amount of insurance coverage purchased equals the amount of assets protected from consideration if and when the consumer needs to apply for Medicaid benefits. For example, a consumer who bought a policy with $100,000 in benefits would receive up to $100,000 worth of qualified long-term care insurance benefits. Once the insurance benefits were exhausted, if further care was necessary, the individual would be able to apply for Medicaid coverage, while still retaining $100,000 worth of assets.

New York elected to use the more generous *total asset protection* model, where consumers were required to buy a more comprehensive benefit package, as defined by the state. The state initially mandated that Partnership policies cover three years of nursing home or six years of home-health care. Consumers purchasing such a policy could protect *all* of their assets when applying for Medicaid.

In 1998 Indiana switched to a hybrid model, whereby consumers could choose between dollar-for-dollar or total asset protection.

Partnership Participation

The successful implementation of Partnership programs involves several parties, which includes state policymakers, private insurers and, of course, individuals to purchase the policies.

The process always begins with the state that is the convener of any Partnership effort. This typically involves many aspects of state government. The Medicaid agency, Governor's office, state budget office, state unit on aging, state legislature, and the state's Department of Insurance all provide input on the design of the program. If a state passed enabling legislation prior to the DRA, then modifications to that legislation may be needed to conform to the requirements of the federal statute.

The private insurance industry also needs to be involved in the development of a Partnership program from the very beginning. Consumer input is valuable since a policy that no one buys accomplishes nothing. Although the DRA mandates a number of consumer protections for Partnership programs, consumer input can be invaluable in helping states determine the best way to implement those protections and whether to offer additional provisions, such as premium protection and non-forfeiture clauses. Consumer groups may be helpful in designing public awareness or educational campaigns.

Partnership Long-Term Care Policies

The insurance industry plays a key role in underwriting Partnership policies. Insurers and the independent agents with whom they work may have extensive experience in the long-term care insurance market. Experienced field agents may have insight that policymakers lack. As such, they may be able to provide states with programmatic and fiscal projections, as well as advice on effective marketing strategies for LTC insurance products.

Public Education

The success of Partnership programs in reducing state long-term care expenditures depend on the program's ability to encourage people to buy them. The consumers they most wish to target are those with moderate incomes and assets. These are the consumers most likely to need Medicaid benefits since they will quickly deplete their assets and their incomes are not high enough to fund the cost of private care. If the Partnership program merely provides "substitute" insurance for wealthier individuals, who could otherwise afford to pay out-of-pocket or purchase other private LTC insurance, then state savings will not be realized.

As states considered the best way to attract individuals who would not otherwise purchase LTC insurance, the experience of the demonstration states played a major role. The two models, *dollar-for-dollar* and *total asset protection*, seemed to attract consumers with different levels of assets. To qualify for total asset protection, New York mandated a relatively comprehensive benefit package. This increased the premiums and attracted consumers who were financially better off. A Congressional Research Service report noted that some Partnership state directors in the original states felt that the dollar-for-dollar model promoted more affordable policies than the asset protection models. It is no surprise that affordable policies attract persons with less wealth.

The DRA specifies that all **new** LTC Partnership programs use the dollar-for-dollar methodology since they seem to attract those with less income and assets. To keep premiums affordable, states should create benefit options that appeal to people with varying levels of assets: less coverage (and associated asset protection) for those with limited income and assets; more generous coverage for those with more to protect. In finding a successful balance between coverage and costs, it will be necessary for the states to develop and implement programs that alert their residents to the possibilities offered through Partnership long-term care programs. This would include educating consumers about the benefits they are purchasing, the level of benefits that will be provided, and what protection might be best for them.

Partnership Long-Term Care Policies

DRA Requirements

Given the complexity of the long-term care insurance industry, and the additional benefits of Partnership programs, many people felt it was necessary to include not only consumer education, but also agent education in the new state Partnership programs. Long-term care policies have so many options, gatekeepers, and limitations that even experienced agents may not be fully educated on these contracts.

The DRA addresses some issues related to education for both consumers and agents:

1. The secretary of Health and Human Services (HHS) is required to establish a **National Clearinghouse for Long-Term Care Information** that will educate consumers about the need for long-term care and the costs associated with these services. HHS will provide objective information to help consumers plan for the future. The website www.longtermcare.gov was established to aid in consumer education.
2. Partnership programs must include specific consumer protection requirements of the 2000 National Association of Insurance Commissioners (NAIC) LTC Insurance Model Act and Regulation. If the NAIC changes the specified requirements, the HHS secretary has 12 months to determine whether state Partnership programs must incorporate the changes as well.
3. State insurance departments are responsible for ensuring that individuals who sell Partnership policies (insurance agents) are adequately trained and can demonstrate understanding of how such policies relate to other public and private options for long-term-care coverage.

Education for both consumers and insurance agents are closely aligned. Insurance agents play a vital role in ensuring that consumers understand their policy options, policy terms, and benefit conditions of any given policy. Of primary importance is guaranteeing that consumers understand the criteria that will allow them to become eligible for both private LTC coverage and, if necessary, Medicaid. Simply having a Partnership policy does not guarantee that Medicaid benefits will be available after exhausting Partnership policy benefits. Each individual must still qualify for Medicaid based on their state's income and functional eligibility criteria. Consumers should also be aware that, although a Partnership policy may cover home-based care, Medicaid coverage may (depending on the state) only entitle them to care in a nursing facility.

The DRA specifies that *"any individual who sells a long-term-care insurance policy under the Partnership receives training and demonstrates evidence of understanding of such policies and how they relate to other public and private coverage of long-term care."*

Partnership Long-Term Care Policies

To ensure that insurance agents are well schooled in the intricacies of long-term care and the Medicaid program, states may require a specific number of hours of training on each. The four current Partnership states require LTC insurance agents to undergo a number of hours of initial training specifically devoted to the Partnership program, in addition to other general training and continuing education requirements.

Unfair Claim Practices Defined Under the NAIC

Model Unfair Claims Settlement Practices Act

The NAIC also listed unfair acts:

1. Knowingly misrepresenting to claimants or insureds relevant facts or policy provisions that relate to the coverages at issue;
2. Failing to acknowledge with reasonable promptness the receipt of communications that are pertinent to claims;
3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims;
4. Not attempting in good faith to settle claims promptly, fairly, and equitably when it is reasonably clear the insurer is liable to pay such claims;
5. Compelling claimants to institute lawsuits to recover amounts due under policies by offering substantially less than the amounts that claimants ultimately recovered in lawsuits;
6. Refusing to pay claims without conducting a reasonable investigation of those claims;
7. Failing to affirm or deny coverage of claims within a reasonable time after completion of the claim investigation;
8. Settling or attempting to settle claims for less than the amount that a reasonable person would believe the claimant was entitled to receive according to the terms of advertising material that accompanied or was part of an application;
9. Settling or attempting to settle claims based on an application that was materially altered without notice to, or the knowledge or consent of, the policyowner;
10. Making claim payments without indicating the coverage under which each payment is being made;
11. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in

duplication of information and verification appearing in the formal proof of loss form;

12. In the case of claim denials or offers of compromise settlement, failing to promptly provide a reasonable, accurate explanation of the reason for such actions; and
13. Failing to provide forms necessary to present claims within 15 calendar days of a request for such forms.

Unfair Claim Distributions

Policyholders have the right to expect their insurers to handle valid claims in a fair manner. Of course, the claims must comply under the benefits purchased in the policy, but when it is a valid claim insurers have the responsibility of responding in a timely and responsible manner. Most states have rules that prohibit unfair claim practices. Here are some examples of unfair claim practices:

- Attempting to settle a claim based on an application which the company has changed without the insured's knowledge or permission;
- Delaying a claim investigation by requiring unnecessary reports or documents;
- Failing to act promptly after receiving information concerning an insurance claim;
- Failing to comply with prompt claims investigation standards;
- When applicable, failing to pay a claim quickly, fairly and equitably;
- Failing to promptly settle claims where liability is reasonably clear under one portion of the policy to influence settlement under any other portion of the insurance policy coverage;
- Failing to promptly and clearly explain the basis in the policy or the law for either denying a claim or offering a compromise settlement;
- Discouraging a policyholder from using arbitration;
- Misrepresenting significant facts or insurance policy provisions;
- Refusing to keep an insured informed of claim developments within a reasonable time after receiving a completed proof of loss statement;
- Denying claims without a reasonable loss investigation;
- Offering very low settlements to encourage insureds to sue; and
- Settling claims for amounts that are lower than a reasonable person would expect.

Partnership Long-Term Care Policies

Policy Benefits are Chosen at the time of Application

The type of benefits available in a long-term care policy will depend in part on what the individual chooses at the time of application. He or she determines the types and extent of the policy's coverage; the more benefits chosen, the more expensive the policy will be.

Mandatory Protection in Partnership LTC Policies

In Partnership policies some types of coverage are mandatory, such as inflation protection. Inflation protection has recently gained recognition for its value as costs have sharply risen. An inflation provision stipulates that benefits will increase by some designated amount over time. Inflation protection ensures that long-term care insurance products retain meaningful benefits into the future. Because policies may be purchased well before they are needed, and long-term care costs are likely to continue to increase, inflation protection can be a key selling point for consumers interested in purchasing private LTC coverage.

The DRA requires that Partnership policies sold to those under age 61 provide compound annual inflation protection. The amount of the benefit (e.g., 3 percent or 5 percent per year) is left to the discretion of individual states. Policies purchased by individuals who are over 61 but not yet 76 must include some level of inflation protection, and policies purchased by those over 76 may, but are not required, to provide some level of inflation protection.

FPO and ABI

There are two main types of inflation protection used in long-term care insurance plans: **future-purchase options (FPO)** and **automatic benefit increase options (ABI)**. Under FPO protection the consumer agrees to a premium for a set amount of coverage. At specified intervals (such as every two years, for example), the insurance issuer offers to increase existing coverage for additional premium. If the consumer declines the increased benefits (or cannot afford to buy them) policy benefit levels remain the same, even though costs for long-term care services may be increasing. A policy purchased to pay a $100 daily benefit may not be adequate ten years later. On the other hand, it may be better to have a $100 per day benefit than none at all.

With ABI, the amount of coverage automatically increases annually by a contractually specified amount. The cost of those benefit increases are automatically built into the premium when the policy is first purchased, so the premium amount remains fixed. Policies that have ABI protection are generally more expensive up front, but are more effective at ensuring that policy benefits will be adequate to cover costs down the road.

Consumer advocacy organizations and some members of Congress maintain that the intent of the language in the DRA was to require **automatic** compound inflation protection for those under age 61, but some insurers believe that future-purchase option protections can also satisfy the requirement. As of this writing, the Centers for Medicare and Medicaid Services (CMS) have not issued guidance on this matter.

Suitability Forms and the NAIC Model Regulations

"Model Regulations" mean the NAIC Long-Term Care Insurance Model Regulation, Model #641, as adopted by the NAIC on September 1, 2000, including all amendments.

Suitability Form Requirements:

(1) Long-Term Care Insurance Personal Worksheet;

a) The standards for the Personal Worksheet must be at least those prescribed in Appendix A of these standards, and the text used may not be less than 12-point type (this text is in 12-point type).

b) The insurance company may request the applicant to provide additional information to comply with its suitability standards.

c) The Rate Increase History section of the Personal Worksheet must accurately list each premium increase the company has instituted on the worksheet and similar policy forms in any state during the last 10 years. The list must provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The company must provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The company may provide, in a fair manner, additional explanatory information as appropriate. Supporting documentation for each state validating the Rate Increase History section of the Personal Worksheet must also be included with the filing.

Unfortunately applicants are not always willing to provide requested financial information; when this occurs, agents and insurers are not responsible for unsuitable decisions made by the buyers, but agents and insurers must still follow all suitability guidelines as much as possible.

Reciprocity between States

In 2001 Indiana and Connecticut implemented a reciprocity agreement between them allowing Partnership beneficiaries who have purchased a policy in one state (but move to

the other) to receive asset protection if they qualify for Medicaid in their new locale. Prior to this agreement asset protection did not transfer outside of the state where the policy was purchased, although the Partnership insurance benefits were portable. The asset protection specified in the agreement are limited to dollar-for-dollar, so Indiana residents who purchase total asset protection policies would only receive protection for the amount of LTC services their policy covered if they moved to Connecticut.

An individual who has not yet retired may not know where he or she will reside in future years so reciprocity is an attractive feature. The DRA requires the HHS secretary (in consultation with National Association of Insurance Commissioners, policy issuers, states, and consumers) to develop standards of reciprocal recognition under which benefits paid would be treated the same by all such states. States will be held to such standards unless the state notifies the secretary in writing that it wishes to be exempt.

State Funding

States already face huge financial stress as the baby boom generation ages. The **Center for Health Care Strategies** (CHCS) launched an initiative designed to help states take advantage of new opportunities through the DRA. The Long-Term Care Partnership Expansion project was underwritten by the Robert Wood Johnson Foundation.

George Mason University has served as the national program office for the original Partnership for Long-Term Care program and continues to provide the latest in research knowledge on Long-Term Care Partnerships to health care policymakers.

The National Association of State Medicaid Directors (NASMD) is available to assist states with concerns or questions regarding the Partnership program implementation process. NASMD will continue to periodically survey states to gather implementation status updates and lessons learned to inform other states.

Partnership Long-Term Care Policies

Chapter 2

Program Benefits

Partnership plans, while preserving assets also have many other components. Just like a non-partnership policy, the applicant must make decisions regarding the type and quantity of benefits they wish to purchase. Just like traditional LTC policies the applicant must medically qualify for the Partnership plans. Since insurers underwrite the policies, even asset protection models must be an acceptable risk.

Not every person will feel they need the same policy benefits in their long-term care insurance policy. While most states mandate some types of coverage, such as equality among the levels of care, there are other options that may be purchased or declined. An educated and caring agent can help the consumer understand those options and make wise choices.

Making Benefit Choices

Some choices are made for consumers by the insurers, such as the *minimum daily benefit* available. Other choices fall on the applicant, such as whether to purchase a $100 per day benefit or a $150 per day nursing home benefit. Regardless of the choices consumers make, all policies must follow federal and state guidelines. In fact, insurers will not offer a policy that does not meet minimum state and federal standards. For example, in some states insurers must offer no less than a $100 per day nursing home benefit and all three levels of care must be covered equally (skilled, intermediate and custodial, also called personal care). Policies following federal guidelines will be tax-qualified. Non-partnership polices following state guidelines might be non-tax qualified plans. Many states mandate specific agent education prior to being able to market or sell non-partnership LTC policies. Agents selling Partnership policies must certainly acquire additional education in order to market partnership plans. In both cases, the goal is to have educated field staff relaying correct information to consumers.

All policies offer some options, which may be purchased for additional premium. Of course, consumers may also refuse the optional coverage. When refusing some types of options, a rejection form must be signed and dated by the applicant. In some states, an existing policy may be modified; in others an entirely new policy would be required when changes are desired.

Partnership Long-Term Care Policies

When a consumer decides to purchase an LTC policy, several buying decisions must be made. These could include:

1. **Daily benefit amounts:** this is the daily benefit that will be paid by the insurer if confinement in a nursing home occurs.
2. **The length of time the policy will pay benefits:** this could range from one year to the insured's lifetime. Of course, the longer the length of policy benefits, the more expensive the policy will be.
3. **Inclusion of an inflation guard:** Non-partnership plans will not require this, while Partnership plans have inflation protection guidelines that must be followed. An inflation protection guards against the rising costs of long-term care by providing an increasing benefit according to contract terms. Partnership plans have two types: an increase based on a predetermined percentage and an offer at specific intervals allowing the insured to increase benefits without proof of insurability.
4. **The waiting period, also called an elimination period**, must be selected. This is the period of time that must pass while receiving care before the policy will pay for anything. It is a deductible expressed as days not covered. The most common options range from zero days to 100 days. Insurers may offer longer time periods as well, up to six months.
5. **Dollar-for-Dollar Partnership asset protection or Total Asset protection**, if both are available. A Hybrid model may also be available. Not all states offer all options since DRA specified all new LTC Partnership plans to offer only dollar-for-dollar models, in the hope of keeping premiums affordable for lower and medium income individuals.

Clients often prefer to have their agent make selections for them, but this is not wise. Although the agent will be valued for the advice he or she gives, the actual benefit decisions need to be made by the consumer. This means the agent must fully explain each option so that the consumer can make informed choices. In a way, it is similar to the cafeteria insurance plans where employees have an array of choices in benefits. The difference is that the long-term care policies have no limits on the choices that the consumer can make. If he or she is willing to pay the price, absolutely everything available can be selected. Typically an agent will go from available benefit to available benefit, explaining each option, and getting a decision from the applicant before moving on to the next decision.

Benefit choices are primarily the same as for non-Partnership policies in that there is a daily or monthly benefit, elimination or waiting period, a home health care and adult day care benefit level, an inflation feature, and a benefit period with a lifetime maximum generally offered. Those who choose the lifetime Partnership benefit have apparently decided that they never want to use Medicaid funding. This is not surprising since people

often believe Medicaid funding leads to inferior care, although statistically that has not been validated.

There is something else about Partnership policies that mirror non-partnership contracts: underwriting. Just as insurers underwrite traditional long-term care policies, they also underwrite Partnership contracts. Therefore, the applicant must medically qualify in order to purchase such a plan. Perhaps that explains the younger ages that seem to be applying for and buying Partnership long-term care plans.

Daily Benefit Options

While there are many policy options, the *daily* benefit amount is usually the first policy decision, with the second one being the *length of time* benefits will continue. Both of these strongly affect the cost of the policy, but they also affect something else that is very important: the amount of assets that will be protected from Medicaid spend-down requirements. The total benefit amount (daily benefit multiplied by the length of benefit payouts) determines the amount of assets protected in dollar-for-dollar Partnership plans.

The type of policy being purchased affects how the daily benefit works; for example a non-partnership policy may be purchased that covers home health care only (not institutionalized care). The daily benefit is based upon the type of policy selected. Policies that cover institutional care in a nursing home will have options that may vary from policies that cover only home care benefits. Integrated policies will vary from those that pay a daily indemnity amount. Many states have mandatory minimum limitations ($100 per day benefits for example). Insurance companies will determine the upper possibilities. Obviously, the consumer cannot select a figure higher than that offered by the issuing company. Nor can an insurer offer a daily indemnity amount that is lower than those set by the state where issued. At one time insurers offered as low as a $40 per day benefit in the nursing home. With today's long-term care costs, that would be extremely inadequate for nursing home care.

This daily benefit can have variations. Some policies will specify an amount (not to exceed actual cost) for each nursing home confinement day. Other policies (called integrated plans) offer a more relaxed benefit formula. These policies have a "pool" of money, which may be used however the policyholder sees fit, within the terms of the contract. As a result this pool of money could be spent for home care rather than a nursing home confinement, as long as the care met the contract requirements. Benefits will be paid as long as this maximum amount lasts regardless of the time period. The danger in having a pool of money, however, is that the funds may be used up by the time a nursing home confinement actually occurs. If the funds have been previously used up, there will be no more benefits payable. Since people prefer to stay at home, this may work out well, if benefits are appropriately used.

The benefit amounts paid vary depending upon whether they are going towards a nursing home confinement, home health care, adult day care, and so forth. The "pool of money" policy type is gaining popularity since consumers see it as a way to make health care choices freely, based not on policy benefits but rather their needs at the time. Integrated policies are generally more expensive than indemnity contracts. As in all policy contacts, integrated plans have benefit qualification requirements, exclusions, and limitations; they do not simply hand the insured money to be used in any manner desired.

Expense-Incurred and Indemnity Methods of Payment

When benefits are paid from a specific dollar schedule for a specific time period, they are generally paid in one of two ways:

1. The **expense-incurred method** in which the insured submits claims that the insurance company then pays to either the insured or to the institution up to the limit set down in the policy.
2. The **indemnity method** in which the insurance company pays benefits directly to the insured in the amount specified in the policy without regard to the specific service that was received.

Of course, both methods require that eligibility for benefits first be met.

Determining Benefit Length

While the daily benefit is typically the first choice made, the second choice is just as important to the policyholder: the length of time for which benefits will be paid. This may apply to a single confinement or it can apply to the total amount of time spent in an institution. An indemnity contract offers benefits payable for a specified number of days, months or years, depending on policy language. An integrated plan pays whatever the daily cost happens to be unless the contract specifies a *maximum* daily payout amount. When funds are depleted, the policy ends.

While statistics vary depending upon the source, most professionals feel a policy should provide benefits for no less than three years of continuous confinement. Some people will only be in a nursing home for three months while others may remain there for five years. While it does not make sense to over-insure, it is also important to have adequate coverage. Since the majority of consumers will not be willing to pay the price for a life-time benefit, three or four year policies are likely to do a good job for them and still be affordable.

Partnership Long-Term Care Policies

Asset Protection in Partnership Policies

A primary reason for purchasing a Partnership long-term care policy is the asset protection it provides. There were initially two asset protection models, although a third variety developed:

1. **Dollar-for-Dollar:** Assets are protected up to the amount of the private insurance benefit purchased. If policy benefits equal $100,000, then $100,000 of private assets are protected from the required Medicaid spend-down once policy benefits are exhausted and Medicaid assistance is requested.
2. **Total Asset Protection:** All assets are protected when a state-defined minimum benefit package is purchased by the consumer. In this case, as long as the individual buys the minimum required benefits under the state plan, all his or her assets are protected from Medicaid spend-down requirements even if the assets exceed the total policy benefits purchased. Only New York and Indiana had this option. Total asset protection plans are not offered in any of the new Partnership plans.
3. **Hybrid:** This Partnership program offered both dollar-for-dollar and total asset protection. The type of asset protection depended on the initial amount of coverage purchased.

Indiana introduced a hybrid model in 1998. Consumers purchased more long-term care insurance coverage to get total asset protection than they did the less expensive coverage for the dollar-to-dollar program. This indicated that consumers were willing to pay a higher premium for the better asset protection offered by the total asset model.

Under state Partnership programs the policyholder's personal assets equaling benefit amounts paid out under a qualifying dollar-for-dollar model insurance policy were disregarded for purposes of Medicaid qualification; under the total asset model, all assets were disregarded for purposes of Medicaid qualification.

Policy Structure

We have seen much legislation by the states directed at long-term care policies. Even the federal government has been involved in this with the tax-qualified plans. Since only the federal government can allow a federal tax deduction, tax-qualified plans always come under federal legislation whereas non-tax qualified plans come under state legislation. Each state will have specific policy requirements. Partnership plans come under federal requirements and will be tax-qualified. The states will assign descriptive names in an effort to identify policies in a way that consumers can comprehend. Such terms as Nursing Facility Only policy, Comprehensive policy or Home Care Only policy will be used. Each state will have their specific way of labeling policies. Long-term care

policies often do not pay benefits for years after purchase. An error on the part of the agent can have devastating consequences.

Home Care Options

While it is very important to cover the catastrophic costs of institutionalization in a nursing home, most Americans would prefer to remain at home. It is often possible to obtain both nursing home benefits and home care benefits in the same policy. In such a case, home care is typically covered at 50 percent of the nursing home rate. Therefore, if the nursing home benefit is $100, the home care rate will be $50. This may not be adequate funding for home care. If home care is a primary concern, it may be best to purchase a separate policy for this if financially possible. Some home care policies carry additional benefits such as coverage for adult day care.

Inflation Protection

Industry professionals generally recommend inflation protection, but the cost can be high. Those who purchase at younger ages are especially encouraged to add this feature since the cost of long-term care is certain to increase over time. The cost of providing long-term care has been increasing faster than inflation. At older ages, the consumer will need to weigh the cost of the additional premium option with the amount of increase in benefits that will result.

The rising costs of institutional care and medical care in general, surpass the increase in the Consumer Price Index. Few retired people can afford to pay such high costs, so they turn to nursing home policies. Since such policies can be expensive, consumers may not purchase features that are designed to keep the coverage adequate. While traditional policies still give the applicant the choice of having or not having inflation protection, Partnership policies are structured differently.

Partnership policies have specific inflation protection requirements under the Deficit Reduction Act of 2005:

- Applicants under 61 years old must be given compound annual inflation protection;
- Applicants 61 to 76 years old must be given some level of inflation protection; and
- Applicants 76 years old or more must be offered inflation protection, but they do not have to accept it.

Partnership Long-Term Care Policies

Traditional long-term care plans continue to make inflation protection an option, which may be rejected by the applicant. Many in the health care field state that the amount of increase offered is not adequate, but it will help to offset the rising costs of long-term care. The inflation protection, usually a five percent compound yearly increase, may eventually become part of all policies, but currently it is most likely to be just an option that the consumer must accept or reject. Some states require the consumer to sign a rejection form as proof that the agent offered the option.

Simple and Compound Protection

Inflation protection based on percentages is offered in one of two ways: simple increases in benefits or compound increases in benefits. Like interest earnings, the benefits increase based on only the original daily indemnity amount or on the total indemnity amount (base plus previous increases). Some states mandate that all inflation protection options offered must be compound protection; others allow the insurers to offer both types. Under a simple inflation benefit, a $100 daily benefit would increase by $5 each year. Under a compound inflation benefit the protection increases by 5 percent of the *total daily benefit payment*. This is called a **compound** inflation benefit because it uses the previous year's amount rather than the original daily benefit amount. This is the same basis used with interest earnings on investments. Compound interest earnings are always better than simple interest earnings. The following graph more clearly illustrates how compounding works with the inflation protection riders:

	Year 1	Year 5	Year 10	Year 15	Year 20
Base Policy	$100	$100	$100	$100	$100
Simple	$100	$120	$145	$170	$195
Compound	$100	$121	$155	$197	$252

Required Rejection Forms

The individual state insurance departments generally recommend inflation protection riders to their citizens. Inflation protection benefit increases must continue even if the insured is confined to a nursing home or similar institution. Many states are now requiring a signed rejection form if the insured does not accept the inflation protection option. Although this is intended to be consumer protection, it is also *agent* protection. It assures that the family of the insured will not later try to sue the agent for failing to sell the inflation protection.

Periodic Coverage Increase Options

Some policies include the ability to increase coverage without using an inflation rider. These options vary, but usually they are periodic options that allow the insured to increase coverage by paying additional premium. If the insured refuses the increased

coverage options two or more times, such offers may discontinue since they often require acceptance to continue future offering.

Elimination Periods in LTC Policies

In auto insurance and homeowner's insurance, higher deductibles are recommended as a way of reducing premium cost. The point is catastrophic coverage – not coverage of the small day-to-day losses. The same is true when it comes to health insurance. In long-term care contracts, there are a variety of waiting or elimination periods available in policies. Basically, a waiting or elimination period is simply *a deductible expressed as days not covered.* The choice is made at the time of application. Policies that have no waiting period (called zero elimination days) will be more expensive than those that have a 100-day wait. Fifteen to thirty elimination days are most commonly seen, although the zero day elimination option has gained popularity.

As one might expect, the *longer* the elimination period, the less expensive the policy; the *shorter* the elimination period, the more expensive it is. Therefore:

Zero day elimination = higher cost.

100 day elimination = lower cost.

All the variables between the two examples here will have varying amounts of premium; 30 day elimination periods will cost less than 15 day elimination time periods, and so on.

When considering which elimination period is appropriate, one should consider the consumer's ability to pay the initial confinement. For example, if thirty-day elimination is being considered at $150 per day benefit, by multiplying $150 by 30 days, it is possible to see what the consumer would first pay: $4,500 before his or her policy began paying benefits. If this is something the consumer is comfortable with, then it may be appropriate to choose a 30-day elimination period. Again, a larger elimination (deductible) period will mean lower yearly premium costs.

Policy Type: Comprehensive and Non-Comprehensive

The specific type of policy to be purchased can be a harder decision. Many of the nursing home policies are basically the same, with differences being hard to distinguish. It is very important that the agent fully understand what those differences are before presenting a policy. Some policies will offer coverage only in the nursing home while others offer a combination of possibilities. The insurer will mark their policy types in some specific way. The agent is responsible for understanding the differences. Some states use titles such as "Comprehensive," "Nursing-Home Only," and so forth.

Partnership Long-Term Care Policies

Many policies offer extra benefits, which agents often refer to as "bells and whistles" since they give additional features, but those features are not vital to the effectiveness of the policy. Even so, consumers may find value in them.

Restoration of Policy Benefits

Some policies have a restoration benefit in their policy. This means that part or all of used benefits renew after a specific length of time and under specific circumstances. During this period of time, the policyholder must be claim free.

Preexisting Periods in Policies

Obviously as we age it is more likely that our health will not be perfect. High blood pressure, arthritis, or other ailments are likely to develop. It is possible that conditions existing at the time of application could present claims soon after the policy is issued. Because of this, companies may have clauses that are called **preexisting condition periods**.

A preexisting condition is one for which the policyholder received treatment or medical advice within a specified time period prior to policy issue. Under federal law, that period of time prior to application is six months. Failure to disclose conditions that were known to the applicant can result in claims being denied when benefits are applied for. Medication, it should be noted, constitutes treatment. In some cases, the insurance company will even rescind the policy due to failure to disclose all requested medical history. Some policies will cover all conditions that were disclosed but apply the preexisting period to any that were not listed as a means of encouraging full disclosure.

When the preexisting period has passed, all medical conditions are then covered. Not all policies will impose a preexisting period; as long as the condition was disclosed at the time of application, all claims will be honored in such policies. Other policies do impose preexisting periods, but usually no more than six months from the time of policy issue (which may be mandated by state statute). Policies tend to specifically list preexisting conditions in a separate paragraph in the policy.

Prior Hospitalization Requirements for Skilled Care

Under Medicare, hospitalization must have occurred for the same or related condition in order to receive Medicare's skilled care benefits (additional criteria for skilled care also exists). With traditional LTC policies, sometimes prior hospitalization is required to collect nursing home benefits and sometimes it is not. Some states do not allow insurers

to require prior hospitalization, while others allow it. In states that allow prior hospitalization, policies may still offer a non-hospitalization option for extra premium.

When prior hospitalization is required in a policy, typically the patient must have been there for three or more days. They must also have been admitted to the nursing home for the same or related condition for which they were hospitalized. The nursing home admittance may have to be anywhere from 15 to 30 days following discharge from the hospital.

Deciding Between Federal Tax-Qualified or State Non-Tax (Non-Partnership) Qualified Policies

For individuals who desire asset protection, there would be no consideration of non-tax qualified policies since all Partnership plans have tax-qualified status. The only reason an individual would be seeking a non-tax qualified plan would be for the additional ease of collecting benefits, based on use of additional ADLs in the policy.

One might easily assume that everyone would want a tax-qualified plan, but that is not necessarily the best choice for every individual. Of course, if asset protection is the goal, there is no choice available – it must be tax qualified. The major difference between tax qualified and non-tax qualified has to do with benefit triggers. **Benefit triggers** are the conditions that "trigger" benefit payment from the insurance company. If a person needs to enter a nursing home, but his or her policy will not pay because the policyholder has not met the criterion for collecting benefits, he or she will not be able to access their policy's benefits. The difference directly relates to the activities of daily living (ADL). In the non-tax qualifies policy forms, ambulation tends to be the primary difference. Ambulation is the ability to move around without help from another individual. This daily activity is often the first to deteriorate as we age.

Tax-qualified plans come under federal legislation. Federally qualified long-term care policies providing coverage for long-term care services must base payment of benefits on certain criteria requirements:

1. All services must be prescribed under a plan of care by a licensed health care practitioner independent of the insurance company.
2. The insured must be chronically ill by virtue of either one of the two following conditions:
    a. **Being unable to perform two of the following activities of daily living (ADL)**: eating, toileting, transferring in and out of beds or chairs, bathing, dressing, and continence, or
    b. **Having a severe impairment in cognitive ability**.

Partnership Long-Term Care Policies

There are differences in the tax-qualified and non-tax-qualified long-term care plan ADLs. These differences are important because they relate to the benefit triggers. Tax-qualified plans have eliminated the ADL of ambulation (the ability to move around independently of others).

Nonforfeiture Values

The purpose of nonforfeiture provisions is to provide the insured with a mechanism for preserving part or all of the premiums paid out for a policy if benefits are never used, whether due to lack of need, inability to maintain the policy, or death.

While provisions vary, often when a policy lapses, the insured is offered either a return of premiums paid or a shortened benefit period. If the shortened benefit is chosen the benefit period is adjusted so that it is equal to the type of policy that would have been bought based on the total premiums already paid in. That might be reducing from a five year policy period to a three year policy period, for example.

If there is a nonforfeiture value related to death, there may be a return of premiums paid, less any claims that were already paid by the insurance company.

There are several standard nonforfeiture options and which ones are available may depend upon state regulations. It is unfortunate that so few agents consider nonforfeiture values when presenting policies to their clients because they can have a great impact in later years. Other types of policies, such as life insurance, also have nonforfeiture values, but the following are the ones that apply to long-term care policies:

- Cash Surrender Value: this is a guaranteed sum paid to the policyholder upon policy surrender or lapse of the contract. This sum is usually equal to some portion or percentage of the insurer's policy reserve at the time premium payments stop.
- Reduced Paid Up: this is the lesser or reduced amount of daily benefit payable for the maximum length of the policy's benefit period with no further premium payments required.
- Extended Term: extended term provides an extension of insurance coverage for the full amount of the policy benefits without any further premium payments, but for a limited period of time.
- Return of Premium: this provides a lump-sum cash payment equal to some percentage of the total premiums paid. The percentage returned can vary, but it is often around 70 percent. It is paid to the policyowner when he or she surrenders the policy or it lapses. Usually any claims that were previously paid under the contract would be deducted from the amount returned.

Of the four, the reduced paid up and extended term options are paid from the policy's cash values. These are fairly standard and are similar to the nonforfeiture options found in permanent life insurance policies.

A variation of this payout option is the form of banked LTC claims, where instead of the return of premium being paid in a lump sum, the value is banked and paid out as future LTC claims until the banked money is exhausted.

When a contract has no nonforfeiture clause all premiums paid in are forfeited (thus the name "nonforfeiture value"). Many people paid into long-term care contracts for years; then when premiums began to escalate dramatically in the last few years policyholders were left with nothing: they could no longer afford the premiums and were not able to get any portion of them returned.

Although some in the industry feel the time of wilding escalating premium rates are behind us there is no way to be sure of that. As a result of the rise in premium that caused so many to lapse their policies due to financial reasons, state regulators began giving nonforfeiture values a hard look. When a consumer has held a long-term care policy for many years, never claiming any benefits, a lapse of the policy means wasted premium dollars even though many years' worth have already been paid. It obviously means that insurers have benefited while consumers have merely wasted premium dollars. In too many cases insurers benefited unfairly. Federal law requires that companies at least offer a nonforfeiture provision to prospective policyholders in Partnership tax-qualified plans. Non-tax qualified plans do not need to offer this additional benefit unless state law requires it. The importance of nonforfeiture values are often overlooked by consumers in favor of lower policy premiums. Even agents often fail to realize the importance of nonforfeiture values.

Waiver of Premium

Waiver of premium is offered in most policies. Some make this benefit part of the policy for no added premium while others view it as an option that must be purchased. Waiver of premiums occurs when the policyholder is in the nursing facility or other contractually covered facility, as a patient. At a given point, he or she no longer needs to pay premiums but policy benefits continue. The point of time when the waiver kicks in will depend upon policy language. Some policies specify that the waiver starts counting only from the time the company *is actually paying benefits*; other policies let it begin from the first day of confinement. This is an important point unless the policyholder has selected a zero elimination period. If a zero elimination period were selected there would be no difference between the two types.

If the policy waiver of premium begins from the day the insurer *actually pays benefits* and the policy contains a 30-day elimination period, it would look like this:

30 days + benefit days = waiver of premium satisfaction.

While the period of time can vary, it is common to begin after 90 benefit days. Therefore, it would be 30 days plus an additional 90 benefit days before the waiver actually became effective. If the confinement stops, the premiums are reinstated, but the policyholder would not have to pay premiums for the previously waived time period.

If the policyholder is paid ahead, most companies will not refund premium, even though the waiver of premium has kicked in. The policyholder would have to wait until premiums were actually due to utilize this feature. Some of the newer policies will, however, make refunds on a quarterly basis for paid-ahead premiums during qualified waiver of premium periods.

Unintentional Lapse of Policy

As people age, forgetfulness is common. Many states now have provisions for unintentional lapses of policies. Both regulators and insurers have realized that this may especially be a problem in the older ages and especially when illness has developed. A long-time policyholder, without meaning to, can allow a policy to lapse for nonpayment of premiums. It can happen when coverage is most needed because illness or cognitive impairment has developed. Therefore, many states have provisions that allow the policyholder to reinstate without having to go through new underwriting. Of course, past premiums will need to be paid.

The length of time that may pass while still allowing reinstatement varies. Typically, insurance companies allow a 30-day grace period anyway, but some reinstatement periods can be as long as 180 days (again, past due premiums must be paid). It is the waiver of new underwriting that is most important since illness or cognitive impairment may be a factor in the lapse. Obviously, having to underwrite a new policy could mean rejection for the insured. The existing policy is simply reinstated as it was before the lapse.

Policy Renewal Features

It is now common for nursing home policies to be either guaranteed renewable or non-cancelable.

Guaranteed renewable means the insured has the right to continue coverage as long as they pay their premiums in a timely manner. The insurer may not unilaterally change the terms of the coverage or decline to renew. The premium rates *can* change and are likely to at some point in time.

Non-cancelable means the insured has the right to continue the coverage as long as they pay their premiums in a timely manner. Again, the insurer may not unilaterally change the terms of coverage, decline to renew, *or change the premium rates*. Please note non-cancelable policies may not change premium rates. Such LTC policies would be rare, if available at all.

Policy Exclusions: Items Not Covered by the LTC Policy

All policies have exclusions (items that are not covered by policy benefits). While states will vary to some extent on what may be excluded, some items are fairly standard in the industry. These include, but may not be limited to:

1. Preexisting conditions, under certain circumstances;
2. Mental or nervous disorders, except for Alzheimer's and other progressive, degenerative and dementing illnesses;
3. Alcoholism and drug addition;
4. Treatment resulting from war or acts of war, participation in a felony, riot, or insurrection, service in the armed forces or auxiliary units, suicide whether sane or insane, attempted suicide, or intentional injury, aviation in the capacity of a non-fare-paying passenger, and treatment provided in government or other facilities for which no payment is normally charged.

Extension of Benefits

If an insured is receiving benefits and for some reason the policy cancels, most states have provisions that require benefits to continue. This is called **Extension of Benefits**. It does not cover an individual whose benefits under the policy simply run out or are exhausted.

Affordability of Long-Term Care Insurance Contracts

No matter how important asset protection might be, if the policies are not affordable they will not accomplish what was intended. The individuals who developed the Partnership programs recognized that the consumers most likely to buy long-term care Partnership coverage were also going to be sensitive to rate and premium increases. The goal was to give Partnership policies economic value to those insured, both when issued and at the time a claim occurs. Of course, they also wanted to encourage a competitive marketplace since that tends to keep prices down and values high. Low lapse rates were also a priority since a policy that is purchased but not maintained does not benefit anyone. It is necessary to have a long-term commitment to LTC policies since they are

typically purchased many years prior to need. Since Partnership plans were an experiment in the four states that initially offered them, Federal law actually discouraged other states from enacting them through restrictive language. That changed in 2005 (signed into law in 2006) with the Deficit Reduction Act of 2005.

Standardized Definitions

As is so often the case, definitions must be standardized to avoid misunderstandings. No policy may be advertised, solicited or issued for delivery as a long-term care Partnership contract that uses definitions more restrictive or less favorable for the policyholder than that allowed by the state where issued.

Minimum Partnership Requirements

Long-term care Partnership policies do, of course, have minimum standards, which must be met. Standards are based on the state where issued. Since each state may have different state requirements, plans may vary from state to state. In all states, an agent would be acting illegally if he or she told a prospective client that the policy he or she was demonstrating for sale was a Partnership policy when, in fact, it did not meet partnership criteria.

The minimum standards set down by each state are just that: *minimums*. They do not prevent the inclusion of other provisions or benefits that are consumer favorable, as long as they are not inconsistent with the required standards of the state where issued.

Benefit Duplication

It is the responsibility of every insurance company and every agent to make reasonable efforts to determine whether the issuance of a long-term care Partnership policy might duplicate benefits being received under another long-term care policy, another policy paying similar benefits, or duplicate other sources of coverage such as a Medicare supplemental policy. The insurance company or agent must take reasonable steps to determine that the purchase of the coverage being applied for is suitable for the consumer's needs based on the financial circumstances of the applicant or insured.

Partnership Publication

Every applicant must be provided with a copy of the long-term care Partnership publication (which was developed jointly by the commissioner and the department of

social and health services) no later than when the long-term care Partnership application is signed by the applicant.

On the first page of every Partnership contract, it must state that the plan is designed to qualify the owner for Medicaid asset protection. A similar statement must be included on every Partnership LTC application and on any outline or summary of coverage provided to applicants or insured.

Partnership versus Traditional Policies

Statistical records of those who first bought Partnership long-term care policies determined that they were first-time buyers of this type of coverage. Partnership policies are most likely to be purchased for their asset protection qualities, which traditional policies do not provide and never will provide. It is not the insurers that provide the asset protection; insurers provide the benefits within the policies, but the states provide the asset protection within them, which is why insurers may not charge additional premium for Partnership plans.

In May of 2007 a report to Congressional Requesters by the United States Government Accountability Office (GAO) came to several conclusions regarding the effectiveness of the Partnership plans and if and how they might save the states money by preventing use of Medicaid funds. Their report said Partnership policies included benefits that protect policyholders but are not likely to provide substantial Medicaid savings. Many in the long-term care market strongly disagreed with their conclusion however.

Partnership programs allow individuals who purchase Partnership long-term care insurance policies to exempt at least some of their personal assets from Medicaid eligibility requirements. The hope is that Middle-America will increasingly protect themselves by purchasing partnership long-term care benefits (versus just the wealthy).

Abbreviations

As the student reads this course, he or she will see many abbreviations. To fully understand the long-term care program, it is necessary to understand the abbreviations commonly used:

ADL = Activities of daily living

ACS = American Community Survey

CBO = Congressional Budget Office

CMS = Centers for Medicare & Medicaid Services

DOI = Department of Insurance

Partnership Long-Term Care Policies

DRA = Deficit Reduction Act of 2005

GAO = The United State's Government Accountability Office

HHS = Department of Health and Human Services

HIPAA = Health Insurance Portability and Accountability Act of 1996

HRS = Health and Retirement Study

IADL = Instrumental activities of daily living

LTC = Long Term Care

NAIC = National Association of Insurance Commissioners

OBRA '93 = Omnibus Budget Reconciliation Act of 1993

RWJF = The Robert Wood Johnson Foundation

UDS = Uniform Data Set

Long-Term Illness Impacts Families

National spending on long-term care, including care provided in nursing facilities, amounted to billions of dollars and accounted for nearly half of the total spending by Medicaid, the joint federal-state program that finances medical services for certain low-income adults and children. We know that the demand for long-term care services in and out of facilities will increase as the elderly population increases. With Medicaid financing nearly half of the long-term care costs nationwide, policymakers are concerned that the growing demand for this type of care will continue to strain the resources of federal and state governments unless a way is found to divert the costs elsewhere.

Research shows that at least 70 percent of people over age 65 will need long-term care services and support at some point in their lifetime. Long-term care impacts patients and their families in many different ways including finances, careers, lifestyles and state of mind. As assets are depleted, family members may find themselves supplementing the cost of care, affecting everyone in the family.

It's a Partnership

The Partnership program is well named since it is exactly what it says it is: ***a partnership***. The states have partnered with the private insurance sector to provide consumers with an incentive to purchase insurance coverage that will cover the costs of long-term care services. The goal is to ease Medicaid's financial burden. Medicaid gets its funding from taxes, so every individual who pays taxes has a stake in the success of the Partnership program. This is especially true of the baby boomer's children and

grandchildren who will be shouldering tremendous costs as their grandparents and parents age and need long-term care services.

Medicaid does not grant asset protection for long-term care insurance policies purchased outside of the Partnership programs. In order to implement their Partnership programs, the four participating states had to obtain approval from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, and amend their state Medicaid plans to allow them to exempt the assets of Partnership program participants from Medicaid eligibility requirements. Medicaid is jointly operated by the states and the federal government so both have a financial stake in the Partnership plans.

The term **"Partnership policies"** refers to long-term care insurance policies purchased through Partnership programs.

The term **"traditional long-term care insurance"** refers to long-term care insurance policies that are not purchased through these programs.

When referring to both Partnership and traditional long-term care insurance policies, the phrase **"long-term care insurance"** is used.

A state plan describes the state's Medicaid program and establishes guidelines for how the state's Medicaid program will function.

While "assets" may be defined in various ways, this text uses the Partnership program's definition of **"assets."** Therefore, when referring to assets, we mean **savings and investments, excluding income.** For Medicaid eligibility purposes, the Medicaid program considers both income and assets.

Medicaid defines **income** as anything received during a calendar month that is used (or could be used) to meet food or shelter needs, including resources such as cash and anything owned, including but not necessarily limited to savings accounts, stocks, or property that can be converted to cash.

Another objective of OBRA '93, as expressed in the accompanying House of Representatives Budget Committee report, was to close a loophole permitting wealthy individuals to qualify for Medicaid through asset transfer and other financial moves.[1]

[1] H.R. Rep. No. 103-111, at 536.

Partnership Long-Term Care Policies

Tax Treatment

States are responsible for overseeing Partnership programs and regulating them along with the traditional long-term care insurance policies sold in their state. As states passed legislation establishing Partnership long-term care programs, there was also interest in how long-term care benefits would be treated for taxation purposes.

HIPPA included provisions for favorable tax treatment of qualified long-term care insurance contracts because the federal government wanted Americans to buy these types of insurance contracts.

Partnership policies must include certain benefits not generally required of traditional long-term care insurance policies. Insurance companies cannot charge higher premiums for asset protection in Partnership policies. Partnership and traditional long-term care insurance policies with otherwise comparable benefits must have equivalent premiums. However, Partnership policies are likely to have higher premiums because they are required to have inflation protection and other benefits that are not required for traditional long-term care insurance policies.

Since Partnership contracts tend to be more expensive it is often the tax incentives that promote their sale over that of traditional long-term care contracts. Tax-qualified premiums are considered a medical expense. For someone who itemizes tax deductions, medical expenses are deductible to the extent that they exceed current amounts required to meet the individual's adjusted gross income (AGI). The amount of the LTC premium treated as a medical expense is limited to the eligible premiums, as defined by the Internal Revenue Code 213(d), which is based on the age of the insured. That portion of the premium that exceeds the eligible premium is not included as a medical expense.

There are specific dollar figures for long-term care insurance federal tax deductions that are based on age (40 or less, 40-50, 50-60, 60-70, and more than age 70). Since the dollar amounts change from year to year, we are not going to list them here. Individuals should consult with their tax advisor each year the deduction will be taken to obtain current figures.

Some insurance companies offer long-term care policies allowing two people to share from one pool of benefits; these are often referred to as **"shared care" policies**. This may be used to maximize the eligible tax deductibility when there is a difference in ages between the two spouses.

Buyers must be aware that when they are younger they may not be able to use the long-term care tax deduction because their health is good enough that they do not meet the requirements to deduct medical expenses. However, as people age they usually have increased medical expenses so even if the LTC premiums are not initially deductible they are likely to become deductible eventually. Of course, the ideal situation is to be so

healthy that no medical expenses occur so premiums are never deductible. Few people will buy long-term care insurance for the tax deduction; they are purchased for protection against long-term care expenses. The tax deduction is merely an added attraction.

Group Long-Term Care Insurance

Many types of insurance coverage are available through group contracts, which are usually issued to employers. There may be other organizations however that also offers group coverage. Perhaps the best known is AARP for example.

Not too many organizations offer group long-term care insurance because today's employers are decreasing insurance coverages for their employees rather than increasing what is available. Insurance is expensive so employers will offer that which seems to be the most pressing, which has traditionally been major medical coverage. Major medical coverage does not generally include care in a nursing home. However, if an employer does offer group long-term care coverage it is certainly worth looking at.

One great advantage of group long-term care coverage is likely to be the fact that health underwriting may not be necessary. Most group coverage waives underwriting since risk is considered to be lower when there is a mix of applicants.

Deciding When to Buy

The typical 65-year-old has about a 70 percent chance of needing long-term care services in his or her life. Long-term care services, such as personal care, homemaker services, and respite care, are known as home care. Home care can also include services provided outside of policyholders' homes, such as services provided in adult day care centers. Long-term care services provided in community-based facilities are generally designed to help people receive long-term care and remain living in their own homes. Known as community-based services, these long-term care services can be supplied in settings such as policyholders' homes, adult day care facilities, or during visits to a physician's office.

Long-term care insurance is used to help cover the cost associated with long-term care. Long-term care insurance policies may be bought directly from insurance companies, or through employers or other groups. Women account for two thirds of the long-term care claims and their premiums are often higher than that charged for men. As time goes on industry specialists expect the cost of all types of long-term or on-going care to rise significantly, which may be the best argument of all for buying inflation protection.

Statistically, the youngest person to file a long-term care claim was 27 and the oldest was 103. Obviously we would not expect many twenty-something people to own a

policy, let alone file a claim. On the other end of the age bracket we can expect to see many older people file claims.

The longest running claim was 18.7 years, amounting to over $1,200,000 in benefits. This is obviously not typical. The largest insurance provider of long-term care insurance paid out approximately $4,300,000 in benefits every business day based on 2012 figures. That figure will only go up. The entire market, consisting of all insurers, has a *daily* payout range from $9-$15 million, depending upon the source of the data.

According to LTC-Tree *"You either have a 100% chance of needing care or a 0% chance and you don't know until the time comes."* Of course, an individual can look to his family history for clues but as we live longer that might not provide reliable hints. Still, it is a good idea to consider genetic longevity, current health and lifestyle.

Although all long-term care claims are likely to be expensive, those lasting a year or less may be managed without insurance by some, though certainly not all. Claims lasting more than a year instantly become catastrophic in cost. Those who continue needing care past the first year will statistically experience an average care time of nearly four years (3.9 years).

In the past a claim lasting more than five years was unusual and it was widely quoted that claims seldom went beyond five years. However, a 2012 statistical update revealed that claims lasting beyond five years had tripled and now accounts for about 15% of all claims (some sources quoted 20% so it depends on where the figures originate). Due to these statistics, many insurers no longer offer lifetime benefits or unlimited coverage. There are companies that offer up to ten years of benefits, but of course the premiums will reflect that.

There are so many types of insurance that are prudent that many people feel they cannot afford to add long-term care premiums to everything else they purchase. It is not until we reach older ages that long-term care is even considered in most cases, which is unfortunate since the younger it is purchased the less expensive it is. Underwriting is also easier at younger ages before serious health conditions develop.

All individually-issued long-term care policies are underwritten. Underwriting is not the same as it might be for life insurance since the risks insurers face is not death, but rather chronic conditions and cognitive impairments such as dementia. People can live a very long time with conditions that require long-term care services.

Considering the underwriting requirements, it certainly makes sense to buy long-term care coverage sooner than later. However, the most advantageous reason to buy sooner has to do with cost; the older the applicant the more costly the policy will be.

Partnership Long-Term Care Policies

Available survey data, according to the GAO, suggests that 80 percent of Partnership policyholders would have purchased traditional long-term care insurance policies if asset protecting Partnership policies had not been available. This indicates that the concern is not so much preserving assets through Partnership plans, but rather preserving assets in general by buying long-term care coverage. Having asset protection is certainly desired, but coverage in general seems to be the goal. The survey data also indicated that the remaining 20 percent of those surveyed would not have purchased any long-term care insurance had the Partnership programs not existed. It should also be noted that the majority of Partnership policy purchasers had sufficient income and assets to fund their long-term care even without such a policy, so perhaps they have the income and assets they do because they tend to plan ahead.

There is a difference in how Medicaid measures the need for benefits and how private insurance plans measure the need. Therefore, those considering the purchase of long-term care insurance benefits should not look to Medicaid when considering the purchase of LTC insurance.

Long-term care includes services provided to individuals who, because of illness or disability, are generally unable to perform activities of daily living (ADL), such as bathing, dressing, and getting around the house. As people age, they typically experience a decline in their ability to perform basic physical functions, increasing the likelihood that they will need long-term care services. Individuals qualify for Medicaid coverage for long-term care services if they meet certain functional criteria. Medicaid assesses the person's impairment by measuring the level of assistance an individual needs to perform six activities of daily living (ADL): eating, bathing, dressing, using the toilet, getting in and out of bed, and getting around the house, as well as the instrumental activities of daily living (IADL), which include preparing meals, shopping for groceries, and venturing outside of a home or facility. These ADLS are not the same ones used by the insurance industry when measuring their ADLs for benefit qualification. Medicaid allows these services to be provided in various settings, such as nursing facilities, an individual's own home, or the community.

A higher percentage of both Partnership and traditional long-term care insurance policyholders are married rather than unmarried, and female rather than male. This might reflect the fact that Americans are more educated today than they were even just a decade ago regarding the aging process. Women live longer than men and tend to care for their male partners at home; once he has died there is no one left to care for her. Partnership policyholders are younger on average than traditional long-term care insurance policyholders. This may be a reflection of generally higher premiums in Partnership plans, discouraging older ages from applying.

Partnership Long-Term Care Policies

Partnership Policy Requirements

Partnership policies must include certain benefits, such as inflation protection and minimum daily benefit amounts, while traditional long-term care insurance policies may include these benefits but are generally not required to do so. Partnership policies include these benefits in order to increase the likelihood that Partnership policyholders will have sufficient long-term care insurance coverage to pay for a significant portion of their long-term care requirements as they age. For example, Partnership policies must include inflation protection, which increases the amount a policy pays over time to account for increases in the cost of care, and minimum daily benefit amounts, which are set at levels designed to cover a significant portion of the costs of an average day in a nursing facility.

Traditional long-term care insurance policyholders are able to purchase most of the same benefits as Partnership policyholders (asset protection is *not* available in traditional LTC policies), but they are not required to include them; the decision rests on the applicant.

Long-term care insurance companies generally structure their long-term care insurance policies around certain types of benefits and related options.

- A policy with comprehensive coverage pays for long-term care in nursing facilities as well as for care in home and community settings, while a policy with coverage for home and community-based settings pays for care only in these settings.
- A daily benefit amount specifies the amount a policy will pay on a daily basis toward the cost of care, while a benefit period specifies the overall length of time a policy will pay for care.
- A policy's elimination period establishes the length of time a policyholder who has begun to receive long-term care has to wait before his or her insurance will begin making payments towards the cost of care.
- Inflation protection increases the maximum daily benefit amount covered by a policy, and attempts to ensure that over time the daily benefit remains commensurate with the costs of care.

Determining Policy Benefits

There can be a substantial gap between the time a long-term care insurance policy is purchased and the time when policyholders begin using their benefits, and the costs associated with long-term care can increase significantly during this time. A typical gap between the time of purchase and the use of benefits is 15 to 20 years: the average age of all long-term care insurance policyholders at the time of purchase is 63, and in general policyholders begin using their benefits when they are in their mid-70s to mid-80s.

Usually, automatic inflation protection increases the benefit amount by 5 percent annually on a compounded basis. A policy with automatic 5 percent compound inflation protection and a $150 per day maximum daily benefit at the time of purchase would be worth approximately $400 per day 20 years later. Another means to protect against inflation is a future purchase option. This option allows the consumer to increase the dollar amount of coverage every few years for an extra cost. Some future purchase options do not allow consumers to purchase extra coverage once they begin receiving their insurance benefits and the opportunity to purchase extra coverage may be withdrawn should the consumer decline a predetermined number of premium increases. A policy with a future purchase option may be less expensive initially than a policy with compound inflation protection. However, over time the policy with a future purchase option may become more expensive than a policy with compound inflation.

Without inflation protection, policyholders might purchase a policy that covers the current cost of long-term care but find many years later, when they are most likely to need long-term care services, that the purchasing power of their coverage has been reduced by inflation and that their coverage is less than the cost of their care. For example, if the cost of a day in a nursing facility increases by 5 percent every year for 20 years, a nursing facility that costs $150 per day at the time of purchase would cost about $400 per day 20 years later. A policy with a daily benefit of $150 without inflation protection would still pay only $150 per day (or 38 percent) of the current daily cost of $400. The remaining $250 would have to be paid by the policyholder.

Long-term care insurance policies may also include other benefits or options. For example, policies can offer coverage for home care at varying percentages of the maximum daily benefit amount. Some policies include features in which the policy returns a portion of the premium payments to a designated third party if the policyholder dies. Some policies provide coverage for long-term care provided outside of the United States or offer care-coordination services that, among other things, provide information about long-term care services to the policyholder and monitor the delivery of long-term care services.

Many factors impact the premiums individuals pay for long-term care insurance. Long-term care insurance companies charge higher premiums for policies with more extensive benefits. In general, policies with comprehensive coverage have higher premiums than policies without such coverage, and policyholders pay higher premiums the higher their maximum daily benefit amounts, the longer their benefit periods, the greater their inflation protection, and the shorter their elimination periods. The age of an applicant also impacts the premium; premiums are typically more expensive the older the policyholder is at the time of purchase. Health status affects premiums too, assuming issuance is possible at all. Insurance companies take into account the health status of an applicant to evaluate their risk. If an applicant has a medical condition it increases the likelihood he or she would use long-term care services. This fact would not automatically disqualify the

applicant if a substandard rating is allowed by state statutes, but it probably would result in a higher premium.

The process of reviewing medical and health-related information furnished by an applicant to determine if the applicant presents an acceptable level of risk that is insurable is known as **underwriting**. Examples of medical conditions that may not disqualify an individual from obtaining insurance but that can result in a substandard rating during the underwriting process include osteoporosis, emphysema, and diabetes. However, the severity and the ability to control and treat the medical condition are all factors that can also impact how a non-disqualifying medical condition impacts an underwriting rating.

Industry Regulation

Regulation of the insurance industry, including companies selling long-term care insurance, is a state function. Those who sell long-term care insurance must be licensed by each state in which they sell policies, and the policies sold must be in compliance with state insurance laws and regulations. These laws and regulations can vary but their fundamental purpose is to establish consumer protections that are designed to ensure that the policies' provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected.

Individuals who purchase policies that comply with HIPAA requirements, which are therefore "tax-qualified," can itemize their long-term care insurance premiums as deductions from their taxable income along with other medical expenses, and can exclude from gross income insurance company proceeds used to pay for long-term care expenses. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specified conditions under which long-term care insurance benefits and premiums would receive favorable federal income tax treatment. Under HIPAA, tax-qualified plans must begin coverage when a person is certified as:

- Needing substantial assistance with at least two of the six ADLs for at least 90 days due to a loss of functional capacity, having a similar level of disability, or
- Requiring substantial supervision because of a severe cognitive impairment.

HIPAA also requires that a policy comply with certain provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Act and Regulation adopted in January 1993. This model act and regulation established certain consumer protections that are designed to prevent insurance companies from:

1. Not renewing a long-term care insurance policy because of a policyholder's age or deteriorating health, and

2. Increasing the premium of an existing policy because of a policyholder's age or claims history. In addition, in order for a long-term care insurance policy to be tax-qualified, HIPAA requires that a policy offer inflation protection.

Medicaid

Medicaid supplies health care financing for poor individuals of all ages, not just the elderly. Some health care services, such as nursing facility care, must be covered in any state that participates in Medicaid. States may choose to offer other optional services in their Medicaid plans, such as personal care. Personal care includes long-term care services that help people meet personal needs such as assistance with personal hygiene, nutritional or support functions, and health-related tasks.

Medicaid coverage for long-term care services is most often provided for individuals who are aged or disabled. To qualify for Medicaid coverage for long-term care, these individuals must meet both functional and financial eligibility criteria. Functional eligibility criteria are established by each state and are generally based on an individual's degree of impairment, which is measured in terms of the level of difficulty in performing the ADLs and IADLs. To meet the financial eligibility criteria, an individual cannot have assets or income that exceed thresholds established by the states and that are within standards set by the federal government.

Generally, the value of an individual's primary residence and car, as well as a few other personal items, are not considered assets for the purpose of determining Medicaid eligibility. Those with assets that exceed state thresholds can "spend down" their assets on their long-term care. If their incomes are also high (though perhaps not high enough to fund the entire cost of long-term care) spending down their assets may bring their income qualification requirements below the state-determined income eligibility limit. Under Partnership programs, for the purpose of obtaining Medicaid eligibility, individuals are allowed to deduct medical expenses, including those for long-term care, in order to bring their incomes below the state-determined thresholds.

Under DRA, individuals with an equity interest in their home that is greater than a specified dollar amount are not eligible for Medicaid coverage for nursing facility services or other long-term care services. States have the option of increasing the home equity interest level to an amount that does not exceed the specified limitation. The home equity limitation would not apply to individuals with a spouse, child under age 21, or a child who is blind or disabled living in the home.

In order to meet Medicaid's eligibility requirements, some individuals may choose to divest themselves of their assets. For example, by transferring assets to their spouses or other family members they may be able to qualify for Medicaid. For asset transfer purposes, Medicaid defines the term "assets" to include income and resources, such as

bank accounts. However, those who transfer assets for less than fair market value during a specified **"look-back" period** (the period of time before an individual applies for Medicaid during which the program reviews asset transfers) may incur a **transfer penalty**. In this circumstance, that penalty is the period of time during which the individual is not eligible for Medicaid coverage for long-term care services. The DRA lengthened the "look-back" period from three to five years. The state will look at the value of the asset and refuse Medicaid coverage for the length of time the asset would have covered the cost of their care. However, GAO's March 2007 report on asset transfers suggested that the incidence of asset transfers is low among nursing home residents covered by Medicaid.[2] Nationwide, about 12 percent of Medicaid-covered elderly nursing home residents reported transferring cash during the four years prior to nursing home entry, and the median amount transferred was very small ($1,239). The percentage of nursing home residents not covered by Medicaid who transferred cash was about twice that of Medicaid-covered nursing home residents.

The median amount of cash transferred as reported by non-Medicaid covered residents and Medicaid-covered residents did not vary greatly. The median amount of cash transferred by non-Medicaid-covered residents during the four years prior to nursing home entry was $1,859. During the two years prior to nursing home entry, the median amount transferred for both non-Medicaid-covered residents and Medicaid-covered residents was $2,194.

In addition to the nationwide analysis, the GAO report summarized an analysis of samples of approved Medicaid nursing home applicants in three states who generally applied to Medicaid in 2005 or before. They found that about 10 percent of applicants had transferred assets for less than the fair market value during the three-year look-back period before Medicaid eligibility began. The median amount transferred was about $15,000. DRA tightened the requirements on Medicaid applicants transferring assets by extending the look-back period for all asset transfers from three to five years. In addition, DRA changed the beginning date of the penalty period. Prior to enactment of DRA, the penalty period started on the first day of the month during or after which assets were transferred. DRA changed this so that the penalty period now begins on the first day of the month when the asset transfer occurred, or the date on which the individual is eligible for medical assistance under the state plan, and is receiving institutional care services that would be covered by Medicaid were it not for the imposition of the penalty period, whichever is later. The extension of the look-back period and the redefinition of the penalty period may reduce transfers of assets.

The Partnership programs are public-private partnerships between states and private long-term care insurance companies. The programs are designed to encourage individuals, especially moderate income individuals, to purchase private long-term care

[2] GAO-07-280

insurance in an effort to reduce future reliance on Medicaid for the financing of long-term care.

Partnership programs attempt to encourage individuals to purchase private long-term care insurance by offering them the option to exempt some or all of their assets from Medicaid spend-down requirements. However, Partnership policyholders are still required to meet Medicaid income eligibility thresholds before they may receive Medicaid benefits. Those who purchase long-term care insurance Partnership policies must first use their insurance benefits to cover the costs of their long-term care before they begin accessing Medicaid. For the purposes of their report, the GAO used the term **"accessing Medicaid"** to describe the point at which long-term care policyholders first begin receiving Medicaid payments for their long-term care.

Partnership program offices reported that about 235,000 Partnership policies had been sold since the four Partnership programs began, but that number included people who subsequently dropped their policies within 30 days of purchasing the product. The four original states with Partnership programs gave Partnership policy purchasers a 30-day "free look" period during which they could decide to keep their policy or drop it and receive a full refund.

Protecting Partnership Policyholder Assets

The initial four states with Partnership programs varied in how they protected policyholders' assets. The Partnership programs in California, Connecticut, Indiana, and New York used dollar-for-dollar models in which the dollar amount of protected assets was equivalent to the dollar value of the benefits paid by the long-term care insurance policy. For example, a person purchasing a long-term care dollar-for-dollar insurance policy with $300,000 in coverage had $300,000 of assets protected if he or she were to exhaust the long-term care insurance benefits and apply for Medicaid. However, New York's program also offered total protection. That is, those who purchased a comprehensive long-term care insurance policy, covering a minimum of three years of nursing facility care or six years of home care, or some combination of the two, could protect all their assets at the time of Medicaid eligibility determination. Indiana, in addition to the dollar-for-dollar model, offered a hybrid model that allowed purchasers to obtain dollar-for-dollar protection up to a certain benefit level as defined by the state; all policies with benefits above the threshold provided total asset protection for the purchaser.

Under DRA, any state that implemented a Partnership program had to ensure that the policies sold through the program contained certain benefits, such as inflation protection. DRA requires Partnership policies to provide compound inflation protection for individuals younger than 61. For individuals younger than 76, Partnership policies must provide policyholders with some level of inflation protection, although not necessarily

compound inflation protection; inflation protection is an optional feature for Partnership policy applicants aged 76 or older.[3]

DRA requires Partnership policies to provide dollar-for-dollar asset protection. Insurers are not allowed to offer Partnership policies that provide the total asset protection feature found in Partnership policies in New York and Indiana. According to CMS officials, policies in New York and Indiana may continue to provide this type of coverage.

DRA also requires Partnership policies to include consumer protections contained in the NAIC Long-Term Care Insurance Model Act and Regulation, as updated in October 2000. DRA established specific requirements for Partnership policies that do not apply to traditional long-term care insurance policies sold in the Partnership states, such as inflation protection and dollar-for-dollar asset protection. DRA prohibits states from creating other requirements for Partnership policies that do not also apply to traditional long-term care insurance policies in the four states with Partnership policies. The Partnership programs in California, Connecticut, Indiana, and New York, which were implemented before DRA, are not subject to these specific requirements, but in order for those programs to continue, they must maintain consumer protection standards that are no less stringent than those that applied as of December 31, 2005.

States with Partnership programs require them to include certain benefits, such as inflation protection and minimum daily benefit amounts, while traditional long-term care insurance policies *may* include these benefits but *are not generally required* to do so. When compared with policyholders of traditional long-term care insurance policies, a higher percentage of Partnership policyholders bought policies with more extensive coverage. Insurance companies are not allowed to charge policyholders higher premiums for policies with asset protection; partnership and traditional long-term care insurance policies with comparable benefits are required to have equivalent premiums since asset protection does not cost insurers more.

In general, Partnership programs require Partnership policies to include certain benefits that are not required in traditional long-term care insurance policies. A state DOI official told the GAO that they have these benefit requirements for Partnership policies in order to protect policyholders by helping to ensure that benefits are sufficient to cover a significant portion of their anticipated long-term care costs and to protect the Medicaid program by reducing the likelihood that policyholders will exhaust their benefits and become eligible for Medicaid.

In addition to asset protection, which by definition Partnership policies include, states typically require Partnership policies to include or at least offer (depending on the applicant's age) inflation protection. Partnership policies include inflation protection

[3] Pub. L. No. 109-171, § 6021(a)(1), 120 Stat. 68 (codified at 42 U.S.C. § 1396 p(b)(1)(c)(iii)(IV)).

because the goal is to keep the policyholders financially protected over time as the cost of care goes up.

Traditional long-term care insurance policies may offer inflation protection as an optional benefit, but they are not required to include it. While policies with inflation protection may include coverage that is more commensurate with expected future costs of care, these policies can be two or three times more expensive than policies without inflation protection. In 2005 an insurance company official told the GAO that the additional cost of inflation protection is the primary reason individuals do not buy Partnership policies.

Partnership policies have a minimum daily benefit requirement but most states have specific requirements in general regarding this. Therefore, a non-partnership traditional long-term care insurance policy may have a similar requirement.

According to Partnership and DOI officials, minimum daily benefit amounts are required for Partnership policies in order to prevent consumers from purchasing coverage that would be insufficient to cover a substantial portion of the cost of their care. The required daily minimum benefit will depend upon the state since costs of care vary widely.

Partnership and traditional long-term care insurance policies both typically include elimination periods, which establish the length of time the policyholder who has begun to receive long-term care has to wait before receiving long-term care insurance benefits. Partnership programs usually limit the length of the elimination period that can be included. A commonly selected elimination period is thirty days whether the policy is a traditional one or a partnership plan. Traditional plans offer a wide variety of options from zero days to as long as six months. In many cases, partnership plans have the same options available.

The point of increasing the elimination period (like all deductibles) is to increase the out-of-pocket costs for policyholders which then lower the premium cost of the contract. One official from an insurance company that sells long-term care insurance policies told the GAO that having long elimination periods could quickly deplete an individual's assets, which might make the asset protection under the Partnership program less valuable. Not all agree of course.

Unlike traditional long-term care insurance policies, Partnership policies must cover or at least offer **case management services**. In two of the original partnership states (Connecticut and Indiana), the case management provision for Partnership policies is specific to home and community-based services, but it is important for agents to know what their specific state requirements are.

Case management services can include providing individual assessments of policyholders' long-term care needs, approving the beginning of an episode of long-term

care, developing plans of care, and monitoring policyholders' medical needs. A Partnership program official said that, by helping policyholders assess their medical needs and develop a plan of care, case management services can help policyholders use their benefit dollars efficiently. Some Partnership program management services are provided through state-approved intermediaries that are independent of insurance company control. Partnership program officials in New York reported that Partnership policyholders have the option to seek case management services from independent case management service providers, but they can also elect to receive case management services from their own insurance company. Traditional long-term care insurance policies are not required to cover case management services, though some may offer this service as an optional benefit. In addition, some insurance companies selling traditional long-term care insurance policies may directly provide case management services to make benefits more cost effective both for the insurer and the insured.

Insurance companies are subject to restrictions on the types of coverage they can offer in Partnership policies, but insurers are allowed to offer traditional long-term care insurance policies with more options in coverage, as long as the additional options comply with state statutes. For example, a partnership policy may only be available as comprehensive care in one state, but may offer choices between comprehensive and home and community care in another.

Partnership and traditional long-term care insurance policies must have equivalent premiums if the benefits offered (except for asset protection) are otherwise comparable. Unlike other policy benefits, insurance companies do not provide asset protection to Partnership policyholders. Asset protection is provided through federal legislation, not insurer benefits. However, because Partnership policies are required to have inflation protection and other benefits that traditional long-term care insurance policies are not required to have, Partnership policies may have higher premiums.

State officials reported that, while both Partnership and traditional long-term care insurance policies undergo reviews by the DOI in each state with Partnership programs, Partnership policies in some states also undergo another review by state Partnership program officials.

Partnership Education Requirements

Before insurance producers may sell Partnership policies, they must complete additional federally-mandated training requirements in Partnership long-term care policies. Although states with Partnership programs may have different educational requirements, in general the states require Partnership agents to undergo about an eight-hour day of training specific to the Partnership program in addition to any training that the states require for those who sell traditional long-term care insurance. In order to continue selling long-term care insurance, insurance producers must receive several hours of

continuing education every 2 years. After the initial training, the "refresher" requirement comes up each license renewal period in many cases. If state credit is available, the LTC training may apply towards the state license renewal requirements.

Partnership program training typically includes information on topics such as long-term care planning, Medicaid, Medicare, the specific benefits required by the Partnership program, and how Partnership policies differ from traditional long-term care insurance policies. While there may be variances among the state requirements, most states will accept the training received in another state to meet its education requirements. If a state has a specific requirement, however, agents working in multiple states may need to complete more than one Partnership educational program.

Partnership Policy Buyers

Policyholders of both Partnership and traditional long-term care insurance are likely to have higher incomes and more assets than people without long-term care insurance. On average, Partnership policyholders are younger than traditional long-term care insurance policyholders. As previously reported they are also more likely to be female and married.

Although survey data and scenarios indicated that about 80 percent of Partnership policyholders who became eligible for Medicaid were likely to do so sooner than they otherwise would have without a Partnership program (since it was not necessary to spend down their assets), it is expected that few Partnership policyholders will actually become eligible for Medicaid and turn to the program to finance their long-term care. There are two reasons for this expectation: first, most Partnership policyholders purchased policies that are likely to cover all or most of their long-term care expenses during their lifetimes, thereby reducing the likelihood that they will require financing from Medicaid for their long-term care. It was found that 86 percent of Partnership policyholders had benefits covering three or more years, while the average nursing facility stay lasts approximately three years (depending on whose study is used). One study of traditional long-term care insurance policyholders with lifetime benefits found that only about 14 percent of policyholders used their benefits for more than three years. At one time it was thought that very few individuals required care for more than five years, but that has changed. Where once fewer than 5 percent of all policyholders used their benefits for more than five years, today between 15 percent and 20 percent (depending on which study figures are used) of policyholders do so and that figure appears to be rising. It is now necessary to consider only recent figures on long-term care, since older figures are no longer reliable for guidance.

Secondly, it is estimated that few Partnership policyholders are likely to turn to Medicaid for their long-term care financing since they have incomes that exceed Medicaid's income eligibility thresholds. Remember that income is not protected for Medicaid qualification purposes, only assets.

Partnership Long-Term Care Policies

Although Partnership policyholders can purchase varying amounts of asset protection, they must still meet state Medicaid income thresholds in order to become eligible for Medicaid.

Insurance can be expensive and long-term care policies most certainly are, although the value when needed far surpasses the cost. The income levels we see for those who buy Partnership policies may reflect the fact that many elderly households cannot afford to buy Partnership plans; as a result it is the higher income segments of our society that do so. According to guidelines published by the NAIC, a person should spend *no more than 7 percent* of his or her income on long-term care insurance.

Receiving Policy Benefits

Every policy has specific criteria for receiving benefits under the contract. Obviously insurers could not stay in business if there were not gatekeepers. A "gatekeeper" is a condition or requirement that "closes the gate" on receiving benefits. For example, requiring that the insured be unable to perform two of five listed activities of daily living is a gatekeeper because an individual who can perform all but one activity may not receive benefits; the two-out-of-five requirement is a policy requirement for receiving benefits from the policy.

While policies may vary, generally speaking, in order to receive benefits from the long-term care policy two criteria must be met: the benefit trigger and the policy elimination period must be satisfied.

Benefit triggers are the conditions or criteria an insurance company uses to determine if the insured is eligible for benefits. As it relates to long-term care policies, benefit triggers typically rely on the activities of daily living to determine if the conditions exist that "trigger" benefits under the policy.

If the insured meets the requirements to receive benefits then he or she must then satisfy the policy's elimination period. This is a deductible expressed as days not covered. Elimination periods are determined by the policyowner at the time of purchase. When the application was made, the applicant paid a premium based on the conditions he or she agreed to, one of which was an elimination period. If the applicant chose a 30 day elimination period then that is the amount of time that must pass before policy benefits will be due and payable.

Elimination periods work in different ways so it is important to understand what is being purchased; some elimination periods start from the first day of otherwise being qualified under the policy, while others require the insured to actually be receiving long-term care

services. During the elimination period, the insured must cover any costs associated with his or her care; the insurer is not liable for these costs.

Once policy benefits begin most contracts will pay up to a pre-set daily limit until the maximum amount has been reached. Some contracts pay from a "pool" of money but even then there may be maximum daily amounts stated in the policy. Except for guaranteed lifetime coverage contracts, all policies will have maximum payout amounts stated in the policy. Once that amount is reached, the insurance company will cease paying benefits, which is why it is important to purchase adequate coverage.

Adequate Coverage

Like all types of coverage it is necessary to purchase adequate coverage in the policy. Just as it is possible to underinsure a home, it is possible to underinsure long-term care services. Under-insuring happens in several ways: buying too few daily benefits, buying too short of a coverage period or buying too few types of benefits.

Daily benefits refer to the amount of coverage available per day in a nursing home or for care at home or in the community. For example, a policy applicant might choose a $150 per day benefit in a nursing home but when he or she actually uses the policy they discover that the cost is $250 per day, $100 per day more than was purchased.

Another short-coming may be the type of policy purchased. A comprehensive policy pays benefits for services received in nursing homes, assisted living facilities, adult day care centers and services received at home. A non-comprehensive policy restricts benefits to services that are provided in nursing homes.

It is true that the most expensive type of care is the care received in a nursing home so the applicant may have wanted to simply cover the most devastatingly expensive type of care. However, he or she may find that they do not need care in a nursing home so they are then liable for care received elsewhere, such as assisted living or care at home.

Joint and Linked Long-Term Care Policies

There was a time when insurance producers discouraged couples from utilizing a joint policy due to one simple reason: divorce. A divorce often caused a policy to lapse as neither person was willing to pay the cost to insure an ex-partner. However, in this case it often makes sense to use a joint or linked long-term care policy.

There are differences between joint and linked long-term care insurance contracts. One type allows the couple to share the policy while the other allows either the husband or wife to tap into the benefits of the other.

Partnership Long-Term Care Policies

Linked

There are advantages to each type, as long as it meets their personal needs and their needs in the future. Linked policies allow the first spouse needing care to tap into the benefit pool of the second once all the first spouse's benefit dollars have been spent on his or her care. In other words, two policies are bought (one for each spouse) and they are joined by a ride allowing couples to share each other's benefit pools. Of course, once benefits are exhausted that is the end of it. There may be nothing left for the second spouse once the first spouse has used all benefits up.

Many people feel this is a good way to buy long-term care insurance even though one person may use up the benefits bought by both of them. Linked benefit policies are often referred to as "shared care." Insurance companies offering this option may charge extra for the privilege of sharing benefits since it is a higher risk for the insurer.

Like so many things in life, there are both advantages and disadvantages to linked policies. The advantage is simple: there are two separate policies that can be shared in succession, doubling the amount of money available to one of the two people insured. However, both policies cannot be used at the same time *by the same spouse*; benefits may be used at the same time if each insured spouse is using his or her own policy. If only one person is receiving benefits, the patient would first draw on his or her own policy and only when all benefits are expired would claims then be moved on to the spouse's policy.

Linked policies cost more so that must be a consideration. However, it does offer a doubling of benefits since there is a shared care rider that was purchased. It is the shared care rider (for an extra cost) that allows the linking of policy benefits. Even though there is the availability of additional benefits beyond the separate policy, the amount bought must still be adequate. It is always important to buy adequate coverage.

Joint

When long-term care insurance is bought jointly it is equally owned by both the wife and husband or any qualifying couple. They offer the same types of coverage as an individually owned policy, including inflation protection, restoration of benefits, nonforfeiture clauses and so forth. Most people consider them more flexible since the benefits may be shared if one of the two needs them.

Joint long-term care contracts are usually considered more flexible than linked contracts since both can make a claim simultaneously and draw benefits up to the daily or monthly maximums allowed by the policy. There are also hybrid life and annuity contracts that do the same thing.

The main advantage of a joint long-term care policy is the lower premiums, when compared to a linked product. Also if both spouses need extended long-term care, a joint

policy still allows both to use the benefits until they are depleted. A shared care rider is not necessary.

The disadvantage is that too often insufficient benefits are purchased. Although it is not common for both insureds to be simultaneously collecting benefits it can happen. When a policy is purchased with the idea that only one of the two insureds will use the benefits many people tend to under-insure the risk. Even if both people are not using benefits at the same time, the first may use so many of the benefits that nothing of sufficient value is left for the second. By this time the second insured individual may not medically qualify for buying additional long-term care benefits so even if it is realized that too few LTC benefits exist for the second person it may be too late to correct it.

When joint long-term care policies are utilized it is wise to buy more than the daily benefit that might otherwise be purchased and to consider the best inflation rider available. For example if $150 per day benefit was purchased and both needed to draw from the policy each person would only be drawing $75 ($75x2=$150). Therefore, it is wise to buy a higher daily maximum to insure adequate coverage in case both insured parties needed care at the same time. A larger inflation rider will allow the pool to grow as much as possible.

Indemnity and Reimbursement Plans

A reimbursement long-term care policy reimburses the insured for actual charges, up to the amount purchased. In other words, if $250 per day is bought and the charge is $200 per day the insurer will pay the $200 per day. Most types of insurance do not allow the policyholder to make a profit, so the additional $50 (up to the maximum bought) would not be paid under a reimbursement plan since that would allow the insured to make a profit.

Under an indemnity long-term care policy the insured could actually make a profit since the insurance contract states a specified amount to be paid regardless of what the charge actually is. We are more likely to see this in cancer policies or dread disease policies where the goal is not payment of the bill but merely to add money to the pot, so to speak.

Critical Illness Policies

Critical illness insurance is not designed to pay for specific costs but rather to pay in addition to other coverage that might exist. It is an insurance product where the insurer makes a lump sum cash payment if the policyowner is diagnosed with one of several critical illnesses listed in the insurance policy. Critical Illness insurance might also be called dread disease insurance.

The policy may be structured to pay income at regular intervals or simply pay out a lump sum payment on a one-time basis. There are likely to be requirements, such as surviving a minimum number of days from when diagnosis first took place. Critical illness policies may have specific requirements regarding many aspects so they are often not considered valid consideration for long-term care requirements.

Health Savings Accounts (HSA)

Health Savings Accounts (HSAs) were created in 2003 so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses. Generally, an adult who is covered by a high-deductible health plan (and has no other first-dollar coverage) may establish an HSA.

Health savings accounts are like personal accounts but the money placed in them must be used for health care expenses, including long-term care costs. The individual, not their employer or the insurer, own and control the money in these accounts. Not everyone is eligible for a health savings account and many professionals recommend that people considering them obtain advice from their tax specialist. Usually the individual must have a high-deductible health care plan. It was hoped these accounts would help control health care costs.

For those nearing retirement health savings accounts may work well. Many people have no health coverage once they retire so these accounts can then be used to pay for medical expenses.

Partnership Long-Term Care Policies

Chapter 3

Policy Considerations

What is a Traditional Long-Term Care Policy?

Since long-term care benefits cover multiple types of care, a long-term care policy might cover home care, assisted living, community-based services, adult day care (both medical and non-medical), or a nursing home. As time goes by, other forms of care may be developed. With these various services in mind, a **long-term care policy** is a contract that provides benefits for an extended period of time in some location other than a hospital. The exact benefits will vary, but each contract will have a policy schedule that states precisely what is covered. It will include the elimination period, the maximum daily benefit for home and adult day care, the maximum nursing home benefit and the maximum lifetime benefit. Even life insurance policies may have a nursing home benefit provision.

Like other types of contracts, traditional and Partnership long-term care contracts contain specific items. There will be a copy of the original application, policy provisions and attachments, if any. The policy contract is a legally binding contract between the applicant and the insurance company. No one, including the agent, can change any part of the policy or waive any of its provisions unless the change is approved in writing on the policy or on an attached endorsement by one of the company officers.

Policy Issue

Issuance or rejection of the policy application will be based on the applicant's health and lifestyle. Both Partnership and traditional long-term care policies have underwriting.

Underwriting will be based on the answers provided to medical questions on the application and on the responses received from attending medical professionals. Intentionally incorrect or omitted information on the part of the applicant or agent can cause the policy to be rescinded or cause benefits to be denied. If the policy has been in force for less than six months an otherwise valid claim has the possibility of denial if information was knowingly omitted or given incorrectly.

Once the policy has been in force for two full years, only fraudulent misstatements in the application may be used to void the policy or deny a claim. All contracts must conform to the laws of the state of issue. They must also conform to federal law, especially if the contract is a tax-qualified form. If any provision conflicts with the laws of the issuing state, the provision is automatically changed so that it will comply with the minimum requirements of that state.

Comprehensive and Non-Comprehensive Options

The amount of benefits available depends, in part, on the type of policy purchased. A comprehensive policy provides benefits for nursing homes, assisted living facilities and home care while a non-comprehensive policy is more specific. For example, the policy might cover only the nursing home or only care at home or in the community.

Medicare Benefits

In some ways, it is easier to state what long-term care insurance is *not*. Unfortunately for many years senior citizens thought they had coverage for the nursing home when, in fact, they did not. This false sense of security was most often applied to Medicare and the supplemental insurances purchased. Medicare and the related policies do a good job on hospital and doctor bills, but neither covers the cost of a long-term nursing home stay. Let's take a look at the benefits provided by Medicare and Medigap policies.

It should be noted that even if a person continues to work past Medicare's qualifying age of 65, he or she can still apply for and receive Medicare benefits. In many cases, if the employer supplies medical coverage, Medicare will become the secondary payer.

Individuals that are nearing their 65th birthday but do not currently and have no plans to begin taking Social Security income yet will need to sign up for Medicare Parts A and B. If the individual already does or plans to begin drawing Social Security income, then usually they are automatically signed up for Medicare Part A. Part B will also begin unless the individual specifically refuses it. Individuals may sign up for Part A and B during the seven-month period that begins three months prior to the month in which the individual turns age 65. However, if his or her birthday is on the first day of the month, then coverage begins the first day of the prior month.

Medicare is not completely free: there is a premium that is due for Part B each month. Part A is free assuming adequate payments were paid into the Social Security program while working.

Partnership Long-Term Care Policies

Over the years there have been some changes in Medicare, many of them advantageous for Medicare's beneficiaries. Even the Affordable Care Act (ACA) provided expanded Medicare benefits.

The ACA expanded services, such as preventive care, cancer screenings, and yearly wellness visits, all of which cost the beneficiary nothing. Expanded drug coverage also began for the so-called "donut hole" that some beneficiaries had to deal with.

There is also a Medicare tool called Medicare's Blue Button, on MyMedicare.gov. Once registered, the Medicare beneficiary may see what has been charged, how much Medicare covered, and any balances that might be due.

Medicare health plans and prescription drug plans can change costs and coverage each year so anyone with Medicare health or prescription coverage should always review the materials their plan sends them. There are yearly open enrollment periods.

There was much concern with the adoption of the Affordable Care Act and the resulting Health Insurance Marketplace, that Medicare beneficiaries might lose benefits, but that is not the case. The Health Insurance Marketplace is certainly part of the Affordable Care Act, which became effective in 2014, but Medicare is not part of the Marketplace. This is true whether benefits are received through the Original Medicare or a Medicare Advantage Plan; benefits are not affected.

There are four parts to Medicare: Part A, Part B, Part C (which is actually Parts A and B combined), and Part D.

Medicare Part A (Hospital Insurance)

Part A helps to pay for:

- Inpatient care in hospitals;
- Inpatient skilled nursing facility care (never custodial or intermediate care);
- Hospice care;
- Home health care,
- Blood, and
- Inpatient care in a religious nonmedical health care institution.

It is important to remember that staying overnight in a hospital does not automatically mean it is covered by Medicare. A person only becomes an "inpatient" when the hospital formally admits the individual, which must be done under a doctor's orders. Going to the hospital's emergency room and receiving treatment is not considered inpatient care.

Medicare will pay the hospital costs in the following manner:

- Semiprivate room and board (meals).
- General nursing and miscellaneous services and supplies.
- Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.
- The first 60 days of confinement EXCEPT for the deductible. The deductible amount can change each January first.
- From the 61st day through the 90th day EXCEPT for the co-payment which must be covered by either the patient or their insurance company. Again, the amount of the co-payment can change each year, beginning on January first.
- From the 91st day and after:
    1. While using 60 lifetime reserve days. There is a co-payment that would not be covered by Medicare. The patient or their Medigap policy would cover this co-payment.
    2. Once lifetime reserve days are used, an additional 365 days will be covered by the Medigap insurance policy if there is one in place.
    3. Beyond the additional 365 days, there are no more hospital benefits under Medicare.

Skilled Nursing Care Covered Under Medicare

Medicare only covers **skilled nursing care**, with the supplemental insurance picking up the coinsurance amounts. Unfortunately, many consumers thought skilled nursing care was long-term care coverage; it's not. In fact, the amount of coverage allowed is quite small. In order to receive any nursing home benefits under Medicare, the recipient must meet Medicare's requirements. This includes 3 days of hospital confinement for a related illness or injury. The patient must enter a Medicare-approved facility within 30 days after leaving the hospital.

The Medicare beneficiary, upon entering the nursing home, will receive benefits for only skilled care. Coverage is not available for either intermediate or custodial care by Medicare or their Medicare supplemental insurance policy. Custodial care may also be called maintenance or personal care and is the type most commonly received. When the level of care received is skilled (not intermediate or custodial) Medicare will pay for the first 20 days entirely. Neither the patient nor their supplemental policy will have to cover anything, as long as the charges are **approved**. Approval is the key point. Anything *not approved by Medicare* will not be covered.

From the 21st day through the 100th day, Medicare will pay all charges except for a daily co-payment which either the patient or their Medigap policy must pay. After the 100th day, there are no benefits under Medicare or a Medigap policy. From that point on, even if the care being received is skilled care, there are no benefits due.

Obviously 100 days of coverage is not sufficient and cannot be considered "long-term." Even the federal definition of long-term care defines a care period of no less than 90 days. The consumer cannot and should not rely on Medicare or their supplemental Medigap policy for long-term medical needs in a nursing home facility.

Some Medicare recipients do receive skilled care benefits. To qualify for the nursing home care that is available under Medicare, the patient must meet certain qualifications, including:

1. The doctor must certify that the care is necessary.
2. Skilled care must be received, not intermediate or custodial care.
3. The facility must be Medicare approved or certified.
4. The facility's Utilization Review Committee cannot have disapproved the stay.
5. Finally, the care must be rehabilitative in nature.

Consumer's Report magazine stated that Medicare could be relied upon to pay very little for long-term nursing home care. Only two percent of those who required nursing home benefits received them through Medicare.

Not all quote the same statistics. According to the United States Department of Health and Human Services the average length of time in a nursing home is 456 days. Other sources will quote from 2.5 years to 3 years. The figure quoted will depend upon how the figures were gathered and organized. Many people require only three months or less in a nursing home, due to surgeries that require some rehabilitative treatment, such as physical therapy. When these short stays are averaged in, as they were by the Health and Human Services, average lengths of stays will appear shorter. What we do know to be true is that more people are using nursing homes than twenty years ago and people are staying longer due to the excellent care now available.

Home Health Care

Home health care may be covered under Part A of Medicare, again if all qualifications are first met. Home health care is provided on a part-time (never full-time) basis. It includes intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment, such as wheelchairs and hospital beds, medical supplies and other related services.

Hospice Care

Hospice care for the terminally ill is also covered under Part A of Medicare. It includes coverage for drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice and other services not otherwise covered by Medicare. Hospice care is typically provided in the patient's home, although Medicare covers some short-term hospital and inpatient respite care under specific circumstances.

Medicare Part B (Medical Insurance)

Medicare Part B helps to cover:

- Services from doctors and other health care providers;
- Outpatient care;
- Home health care;
- Durable medical equipment;
- Some types of preventive services; and
- Blood (this is covered under either Part A or Part B).

Part B of Medicare, called Medical Insurance, helps cover doctors' fees and services and outpatient hospital care. This includes doctor visits other than routine physical exams, outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment such as wheelchairs and hospital beds. Second surgical opinions are also covered. Clinical laboratory services such as blood tests, urinalysis, some screening tests, and blood are covered. It also covers some other medical services that Part A does not cover, such as physical and occupational therapists, and some home health care. In order for these services to be covered, they must be considered medically necessary under Medicare's guidelines.

There are now many preventive services available. The list is extensive:

Bone mass measurements are for determining bone density. This test helps to determine if the individual is at risk for broken bones and may be performed once every twenty-four months.

Breast cancer screening is mammograms, which are covered to check for breast cancer once every 12 months for all women with Medicare who are at least forty years old.

Medicare also covers comprehensive programs that include exercise, education and counseling for patients who meet specific conditions. They cover intensive cardiac rehabilitation programs that are usually more rigorous than regular cardiac rehabilitation

programs. Services are covered in the doctor's office or hospital outpatient setting. There will be a 20 percent copayment and of course the service must meet Medicare's guidelines. Cardiovascular disease behavioral therapy with the beneficiary's primary doctor is a covered service too so that the beneficiary can have his or her blood pressure checked as well as discussions regarding aspirin therapy or other means of controlling symptoms.

There is limited coverage for chiropractic services to help correct subluxation using manipulation of the spine. There will be a 20 percent copayment and again it must meet Medicare's guidelines for them to make a payment.

There are other covered services, such as EKG's, durable medical equipment such as walkers, glaucoma tests and hearing and balance exams. We will not cover all Part B services since they do not necessarily relate to long-term care services.

Each Medicare recipient should receive a copy of the current Medicare handbook from the federal government to learn precisely what benefits will be received.

There is a cost for Part B of Medicare, which is taken out of the individual's Social Security check each month (an automatic withdrawal). The cost of Part B changes each year. In some cases, the amount charged may be higher than normal if the recipient did not sign up for Part B when he or she first became eligible for the benefits. The cost goes up 10% for each 12-month period that the person was eligible, but did not enroll. The extra cost continues for as long as the recipient continues to have Part B.

Medicare Part B rates might also vary due to income. Those with higher incomes in the previous year will be assessed additional cost.

Each year Medicare uses the amount listed on the most recent Federal income tax return to decide the coming year's premium amount for the individual. However, Medicare never goes back more than three years. Medicare requests from IRS the tax filing status, the adjusted gross income, and the individual's tax-exempt interest income. Then they add the adjusted gross income together with the person's tax-exempt interest income to get an amount called the modified adjusted gross income (MAGI). This is compared with the income thresholds set by Medicare law.

The modified adjusted gross income may include one-time only income, such as capital gains, property that has been sold, withdrawals from individual retirement accounts or conversions from traditional IRAs to Roth IRAs. One time income affects only one year of Medicare premiums.

New premium rates become effective every January first of each year. While it is not required that costs go up, they inevitably do each year. Current premium rates may be found by going online at www.medicare.gov or by calling 1-800-MEDICARE.

Partnership Long-Term Care Policies

While Part A of Medicare is automatic and free, assuming adequate payment has been made through payroll taxes, individuals must sign up for Part B. If an individual is already receiving Social Security benefits, or Railroad Retirement benefits, he or she is automatically enrolled in Part B starting the first day of the month in which age 65 is attained. For those who are under age 65 and disabled, enrollment is automatic after 24 months of being on Social Security disability. An individual has to be disabled for five full calendar months in a row to qualify for Social Security benefits. A Medicare card will be mailed about three months prior to the person's 65th birthday or prior to the 25th month of disability benefits. Those who do not want to pay for and receive Part B Medicare benefits must specifically reject them by following the instructions that come with the Medicare card. Otherwise, enrollment will be automatic.

Those born on the first day of the month receive Medicare benefits effective the first day of the previous month. For example, a person born on November 1 receives Medicare effective as of October 1 of the year in which they turn 65 years old.

Medicare Part C (Medicare Advantage)

Medicare Part C includes all benefits and services covered under Parts A and B and are run by Medicare-approved private insurance companies and health maintenance organizations. It usually includes Medicare prescription drug coverage, which is Part D, as part of the overall plan. In some cases there is extra benefits and services available although it may cost more to include them.

Medicare Part D (Medicare Prescription Drug Coverage)

Medicare Part D helps cover the cost of prescription drugs. It is run by Medicare-approved private insurance companies. Part D may help lower the cost of prescription drugs and it helps protect against higher costs in the future.

Medicare Supplemental Policies

Supplemental policies do not pay for long-term care services. Although there are multiple choices, none of them are designed to cover long-term care needs. Every so often, Congress will address the growing needs of long-term care for the elderly, but cost is always a primary issue. With Medicaid facing the costs expected from the baby boom generation, it is hoped that Partnership plan sales will provide some relief.

When a person first signs on with Medicare they receive coverage for hospital and doctor bills, but Medicare does not pay for everything. There are two main ways to receive Medicare coverage: through the Original Medicare plan or through a Medicare Advantage plan. Those who choose an advantage plan should not buy any type of

Medicare supplemental insurance policy; in fact agents are not allowed to sell one to a person on this type of Medicare coverage.

Medicare Advantage plans combines Parts A and B to equal Part C; it also includes Part D in most cases. Therefore, Part C is merely a combination of Parts A and B under health maintenance organizations (HMO) or preferred provider organizations (PPO).

The Original Medicare Plan

The Original Medicare Plan covers most health care services and supplies, but it doesn't cover everything. Generally people choose to also buy some type of additional coverage (supplemental insurance). Original Medicare is a fee-for-service plan, which means the individual is charged a fee for each service they receive. This plan is managed by the Federal government and is available nationwide. Those enrolled in this plan use a red, white, and blue Medicare card when they receive health care so that the provider may bill Medicare from the information contained on the card. There is a monthly fee for Medicare Part B (which is subtracted from the individual's monthly Social Security income) plus a premium for the supplemental insurance coverage if one has been purchased from an insurer.

The Original Medicare plan is coverage provided directly from Medicare, without a middle man so to speak. The beneficiary may go to any Medicare-approved provider he or she wishes to without consent from an insurer organization or a primary-care doctor. There will be deductibles and copayments and there will be a Part B premium deducted each month from their Social Security income.

To receive prescription coverage the beneficiary must sign on with a Medicare Prescription Drug plan of their choice. There will be a cost for this.

The Original Medicare plan does not cover long-term nursing home care. It will pay for skilled nursing care under specific circumstances for up to 100 days. The individual pays for a co-pay amount from the 21st through the 100th day. The first 20 days are fully covered by Medicare as long as the patient qualifies for such care (only skilled care is covered).

The Original Medicare plan will pay for both home care and hospice care under specific circumstances. The individual will pay nothing for home care services if they qualify to receive them. Medicare fully covers the cost. The beneficiary will have to pay for 20 percent of the Medicare-approved amounts for durable medical equipment.

Hospice care is care for the terminally ill. The individual must pay a copayment for hospice care for outpatient prescription drugs and a percentage of the Medicare-approved amount for inpatient **respite care** (short-term care given to a hospice patient so the usual caregiver can rest).

The amount one pays for respite care can change each year. Medicare doesn't typically pay for room and board except in certain cases.

Medicare Advantage Plans

Medicare Advantage Plans require both parts A and B of Medicare be in place. Private companies' contract with the Medicare program to offer the coverage to those who feel this type of coverage benefits them. Belonging to this program does not mean that they have opted out of Medicare; they are still in Medicare.

Congress created Medicare Advantage Plans to provide the recipient with additional choices and perhaps even extra benefits than they would receive under the Original Medicare Plan. The beneficiary usually has to go to specific doctors, specialists and hospitals under Medicare Advantage. They are given a list of those that they may choose from. A primary doctor is chosen who then provides referrals when other specialists are needed.

Under this option, the beneficiary may choose from Medicare managed care plans or other qualifying organizations. The individual is still in the Medicare program regardless of the advantage plan selected. That means the individual still has Medicare rights and protections. The regular Medicare services are still available but some plans may provide additional benefits. However, in all cases, there is no coverage beyond that supplied by Medicare for long-term care services.

Decisions on which type of plan to join are usually made on the basis of cost and benefits. The ability to choose doctors independently may also be a factor.

Protecting Assets

Obviously, no one really wants to go to a nursing home. That is one reason for the popularity of alternative care options, such as assisted living. At one time, AARP reported that the majority of elder Americans believed the government would take care of them through Medicare. Today, most people realize that is not the case. In the past ten years, the sale of long-term care policies have increased as people sought ways to protect their assets from medical costs.

Protecting one's assets is a valid concern. Many elderly people do eventually qualify for Medicaid, but only after they have depleted most of their personal non-housing resources. Medicaid is the joint federal-state program that pays for health care costs for needy low-income residents of all ages (not just the elderly). Benefits are typically available to the poor, to certain disabled citizens, and to persons over the age of 65 who meet the economic means test. To meet this economic means test, the person must be

impoverished. Some items are exempt while still allowing qualification. One asset that would be exempt is the person's personal home, in which they have been residing. Also exempt are some personal items, one vehicle for transportation, and in a few cases, specific types of annuities. Income producing property may be exempt as long as the income goes towards the person's care. Since each state controls some aspects of Medicaid qualification, it is very important to understand your own state's guidelines. While each state pays approximately half of the cost (with the federal government paying the other half) the exact amount paid by the state varies depending on multiple factors. Each state also is allowed to administer many elements according to their own desires, as long as it does not clash with federal guidelines. As a result, what worked for Uncle Joe in California may not work for Aunt Mabel in New York.

There is one aspect of Medicaid that is uniform to all states: the fact that qualification depends upon "spending-down" assets if no Partnership long-term care insurance policy is in place. People who prided themselves on always paying their own way may find themselves in the position of having to ask for financial help.

Medicaid Benefits

Even though the states have general control of their Medicaid funds, they must also follow federal laws. Federal law requires states to provide a minimum level of services to Medicaid beneficiaries. Those services include such things as inpatient and outpatient hospital care, laboratory and X-ray services, skilled nursing home care and home health services for those aged 21 and older, examination and treatment for children under the age of 21, family planning and rural health clinics. About half of Medicaid spending goes for federally mandated services. States pay health care providers directly for patient services and almost invariably require doctors to accept the state fees as full payment. Doctors and other medical suppliers are legally required to accept the amount paid by Medicaid, which means they cannot bill their patients for any additional amount. Therefore, some medical providers may not accept Medicaid patients.

Medicaid funding, as well as Medicare funding, has become a real concern. As the baby boom generation reaches retirement, adequate funding may not be available under current funding procedures. About 45 cents out of every dollar goes to pay for nursing home care for only about 8 percent of the beneficiaries. That means that approximately 8 people out of every 100 Medicaid enrollees use nearly half of the Medicaid funds. Funds under Aid for Dependent Children and their parents make up about 70 percent of Medicaid's caseload, but they only receive about 30 percent of the total funding. Many argue that the largest amount of money should be spent on our younger Americans rather than the older, less productive retired group. While we might like to do that, where would that leave the older generation? They must be cared for. This has brought about much debate, but it has also brought about alternative developments such as assisted living facilities and community-based care programs that prevent institutionalization (which is the most

expensive type of care). It is likely that the future will bring even newer developments as we try to sort out the financial aspects of a graying nation.

All aspects of government have faced budget problems. Medicare and Medicaid perhaps face the greatest challenge since they must deal with the increasing elderly population. Rising medical costs also play a role. It is common to spend the most money on the last three months of our lives. Many of the medical procedures do nothing more than delay death. However, medical professionals are reluctant to do less than everything possible since lawsuits have become pervasive in the United States.

Nearly every state has faced severe budget deficits in their Medicaid funding. Some states have actually put a ban on building additional nursing homes in an attempt to curb the rising costs. The federal and state governments have attempted to control the rising costs in some way.

Fraud and abuse in the medical field has played a major role in the rising costs associated with Medicaid and Medicare. While Medicare has a single administrator (the federal government), Medicaid has 50 separate administrators, because each state is in charge of their own program. This makes it difficult to curb fraud and abuse of the Medicaid system. There is no doubt that part of the funds ends up in the pockets of dishonest medical providers.

Many elderly consumers believe the military will, in some way, provide for their nursing home needs. Due to a shortage of beds, even when the veteran might qualify, the chances of actually getting such coverage are small. It only takes a call to the military agency for them to confirm this.

The Patient Protection and Affordable Care Act

The Affordable Care Act, often known as Obamacare, was not designed specifically for those on Medicare, although some elements affect it. The ACA gives beneficiaries, according to the AARP website, more control of their health care by offering new ways to select coverage. The current job-based Medicare program has not changed. Although the Affordable Care Act mandated insurance coverage, that element did not affect Medicare beneficiaries (Medicare is their insurance already).

There was lots of talk about the new Health Insurance Marketplace, but Medicare beneficiaries were not affected by this. The marketplace was just for people who needed to buy private individual insurance policies, not for those on Medicare or Medicaid. The Marketplace is also not applicable to those in the military. However, if financial help is needed, then the Marketplace would be where the individual would go. Medigap policies are not sold through the Health Insurance Marketplace so Medicare beneficiaries would not go there to buy one.

Partnership Long-Term Care Policies

The Donut Hole

Most Medicare Part D prescription drug plans have a gap in coverage that is called the "donut hole." It got its name from the fact that initially there is coverage; then there is no coverage for a period of time; then there is coverage once again after a certain dollar amount is surpassed. Due to the Affordable Care Act the coverage gap is slowly closing and will completely disappear in the year 2020.

In General

Medicare has not changed due to the passage of the Affordable Care Act. The changes that did affect the program were improvements. Medicare coverage is protected so there was no need to replace any current coverage in place. There are certainly more preventive services however due to the ACA, so Medicare beneficiaries came out ahead.

Under the ACA, there is also a savings on brand-name drugs so those who are currently in the donut hole will pay less during their time of non-coverage. As previously stated, the donut hole closes completely by 2020.

Physicians will receive more support, allowing them to be paid for the extra time that elderly Americans often require. Under the care coordination of the ACA, doctors get additional resources to make sure the treatments of their Medicare patients are consistent.

The Affordable Care Act actually protected Medicare benefits for some time. The life of the Medicare Trust fund was extended to at least the year 2029, which was a twelve-year extension. The extension is primarily a result of reductions in waste, fraud and abuse, and Medicare costs in general. It is expected to also save on future premiums and coinsurance costs.

State Requirements

The insurance contracts offered vary with the state, since each state requires certain features. Each policy must follow the guidelines of the state where issued. There will still be similarities from state to state, but the actual benefit features will depend upon state requirements. Each policy has benefits, exclusions and limitations that are fairly standard. All will be within the limits of the state's regulations. Many states use the NAIC guidelines.

Most states will have adopted tax-qualified LTC policies, so there will be two types available: tax qualified and non-tax qualified. In a few states, there will also be partnership policies available. Partnership policies are a special kind designed to allow enrollees to avoid impoverishment due to a nursing home confinement. They require

special agent education to market them. They may not be marketed unless this education is completed.

Relying on Insurance for LTC Payment

Over the past ten years, insurance policies for long-term care needs have become increasingly popular for those who can afford them. Not all insurance policies are adequate for long-term nursing home care, however. The consumer must choose wisely. Since many states are now mandating certain requirements, if the consumer (and selling agent) selects a policy labeled Nursing Home Policy it will probably do an adequate job. Most states have mandated specific names for specific policies in an effort to make consumer selection easier. A policy might be labeled Home Care Only, Comprehensive, or Nursing Home Facility Only policy. Each state will have their own titles, but whatever your state uses, it is important that you understand the benefits each one contains.

Federal legislation, under HIPAA, has established policies that are "tax-qualified." These tend to be uniform from state to state. Therefore, consumers must choose between non-qualified and qualified forms. When we speak of qualified and non-qualified we are always referring to the tax implications. The tax-qualified plans meet certain tax qualifications; the non-tax qualified contracts do not. However, few people choose a long-term care plan based on a potential tax deduction. Luckily, the main focus is typically on the benefits provided. In many cases, non-tax qualified plans offer better home care benefits and better benefit qualification.

Insurance Pricing

Consumers play a role in determining the cost of their long-term care policy based on their selection of benefits at the time of application. We have already mentioned another pricing factor: application age. The benefit options chosen will also affect how much the policy costs. Obviously, if greater benefits are selected, the cost of the policy will reflect that. Policy options will be discussed further in another chapter, but basically the consumer can choose from a wide variety, including an inflation rider option, the daily benefit amount, home health care benefits and the deductible (called a waiting period or elimination period). Some companies may offer additional options. Premium can also be affected by whether or not the applicant smokes and whether or not both spouses are applying. Some companies offer discounts if both spouses take out a policy. Some companies may also offer a discount in premium for those that are considered extremely healthy physically and in their lifestyle.

Partnership Long-Term Care Policies

Premium Mode

Premium mode payment is similar to other types of policies in that they may be paid yearly, semi-yearly, quarterly, or monthly. When the consumer desires monthly payments, they might be required by the issuing company to use a monthly bank draft rather than direct billings. A few companies will allow the applicant to pay personally each month, but most companies require monthly payments to be through a bank draft. This makes good sense, since a person could easily overlook the payment of their premium if they were sick. As a result, someone who mailed in a check each month could allow their policy to lapse just when they needed it most. A few insurers allow only annually, semi-annually or quarterly payment modes, except in states that have specific payment requirements. California, for example, does not allow the agent to collect more than one month's payment at the point of application. The consumer can pay a larger premium mode later directly through the company.

Age as a Pricing Factor

The age of the applicant will have an impact on the cost of any long-term care policy since age directly relates to the insurer's risk; age matters because the less time the insurance company has to collect premiums, the greater the company's risk exposure is. Due to the increasing risk that age brings, older applicants must expect to pay more for their policy, whether it is a traditional long-term care contract or a Partnership long-term care contract.

There are two ways to price policy applications: by attained age and by age banding. Attained age relates to the age of the person at the time of application. Age banding also looks at the age at application, but rates are based on several ages banded together.

Attained age refers to the age of the individual at the time an insurance application is made. When attained age determines the rate, the policy rate book will show it as such:

Age:	Price:
65	$
66	$
67	$
68	$
69	$

This will continue until a point is reached where issue ages discontinue. Most companies will not issue a long-term care policy past a specified application age, usually around 80 years old. Of course, by this age, the policy cost is very high.

Contracts that use age banding typically go in groupings of five:

Age:	Price:
65-69	$
70-74	$
75-79	$
80-84	$

Age banded contracts quote the same price for each age within the banding. For example, an applicant aged 69 would pay the same premium amount as an applicant aged 65 would. The 65 year old may get a better buy if he or she purchased from a company that priced by attained age whereas the 69 year old may find banding more advantageous.

Not all companies will issue a policy past the age of 79. This example showed an age banding of 80-84, but individuals will want to check with the company they are considering to see if they can obtain a policy if they are in that age bracket.

A Younger Market Developing

When long-term care policies first came on the market no one expected any interest from consumers who were not yet receiving Medicare benefits (age 65 and older). Initially, they were probably correct in their assumption. Today, however, many individuals in their forties and fifties are expressing interest. The average Partnership applicant is between 50 and 60 years old. Surprisingly most American-based insurance companies do not sell, or even offer to sell, a policy to people under the age of forty. That is beginning to change. Since prices are always lower for the younger ages, buying early is attractive to those consumers who understand the need. This younger age interest is primarily coming from those between the ages of 50 and 60, when it is possible to get better benefits for less premium cost.

Our neighbors to the North, Canada, sell policies to their citizens at much younger ages and insurers actively promote their sale. America is beginning to promote sales to people at younger ages, but it can be very difficult since citizens in the United States do not seem interested prior to age fifty.

Additionally, some of the risks associated with sales to younger people have not been overlooked by the insurance industry. They are well aware of the possible financial effects that AIDS and other devastating diseases could bring to the long-term care costs in this country. Many experts feel that the insurers are hesitant to offer long-term care policies to younger ages for this reason. Insurers have good reason to worry. AIDS, as an example, is a disease that could cause younger people to overtake the elderly in the need for long-term care if it were to ever become wide spread in America. It is thought that underwriting may begin to use similar testing for long-term care that is currently used for life insurance products - a blood test. This may apply only to the under age 40 group or it may be applied uniformly to avoid discrimination claims. However such tests

end up being applied, most underwriters are expecting to initiate such medical procedures as part of the application process in the coming years.

Reducing Benefits to Save Premium

When premium rates jump unexpectedly, not all consumers will be able to absorb the additional cost. Some individuals will allow their policies to lapse. Others will strive to find a solution. Some states have provisions allowing the policyholder to reduce their benefits, which reduces their premium. This is an attempt by the states to keep long-term care policies in force even when the consumer has to cut back on costs. It is better for both the consumer and the state to have *some* benefits in place rather than no benefits at all.

There are several ways that benefits may be reduced:

1. Reduce the length of benefit payments (from lifetime to 4 years, for example).
2. Reduce the daily benefit amount.
3. Discontinue some benefits, such as home health care options.
4. Convert from one policy form to another, if the state has provisions that allow this.

The premium *reductions* are typically based on the policyholder's age at the time of original application. This may not be true where benefits are added rather than reduced. Where there are no state provisions allowing benefit reduction in order to reduce premium, companies may require a totally new application, which means that the reduction of benefits may not save any premium if the applicant is older now than when he or she originally applied for coverage.

Example:

> Bert is now 70 years old. He purchased his long-term care policy when he was 68 years old. Even though only two years have passed, the difference in age can make a great deal of difference when it comes to premium rates. Bert feels the current premium of $1,600 is more than he can continue to pay. As he explains: *"Every year I have to take this amount out of my savings. That's more than I earn during the entire year in interest. Either I have to lower my cost or drop the policy."*

If there is not a state requirement requiring Bert's issuing company to allow benefit reduction in order to save premium then a new application must accomplish this. A new application will be based on Bert's current age of 70. Even though he is only two years older, the extra premium caused by this additional age saves little, if any, premium even with fewer benefits. As a result, Bert still cannot afford a long-term care policy. Bert

may eventually have to rely on Medicaid to pick up any long-term care expenses. Because this is often the case, it is in the state's best interest to mandate that a consumer can lower benefits on an *existing* policy. Such a requirement is likely to save the state Medicaid dollars.

Although there will be policy variations, even within the same company, there will also be similarities. Of course, every policy must conform to state requirements.

Guaranteed Renewable

Long-term care policies are **guaranteed renewable**, meaning the contract is guaranteed to be renewed (cannot be canceled), but premiums are subject to change. In a guaranteed renewable policy the insured's contract will remain in effect during their lifetime, as long as premiums are paid in a timely manner. The policy benefits cannot be changed without the policyholder's consent.

Policy Review: 30-Day “Free Look”

While most people now realize the need to protect themselves from the costs of long-term care expenses, not everyone agrees that an insurance policy is the best avenue for doing so. Therefore, many people desire a time to review the actual policy and think it over. Companies issuing long-term care policies allow a 30-day period to do just that. It is commonly called the **"free look" period**. Within that 30-day period of time, they may change their mind and return the policy to either their agent or the issuing company. *All of their premium must be returned to them.* The consumer need not say why they have changed their mind. The refund must be issued within 30 days of the consumer’s notification to cancel the policy.

When a policy is returned during the applicant’s "free look" period, the policy is null and voided. This means the policy is considered as never having been issued. It also means the insurance company is not liable for any claims.

“Notice to Buyer”

Each issued long-term care policy is designed to cover specific costs related to aging. Under the heading of **"Notice to Buyer"** the insurance company will list the benefits that are provided by the policy. This statement may be specifically mandated by the state where issued or it may be a general statement made by the insurance company. This notice advises the insured to carefully review the policy's limitations. This should be done within the first 30 days so that the policyholder can return their policy for a refund if they are dissatisfied with those limitations.

Partnership Long-Term Care Policies

Policy Schedule

The policy schedule will list the insured's name and the options that were purchased by the insured at the time of application. Some of the possible items listed include the:

1. Elimination period (deductible expressed as days not covered);
2. Maximum daily home and adult day health care benefit;
3. Maximum daily nursing home facility benefit;
4. Maximum lifetime benefit, and the
5. Type of inflation benefit, if any.

There may be other types of benefits besides the five listed above.

The amount of premium due annually will be stated along with the amount of premium paid with the application. The amount paid with the application may be different than the annual premium stated, since the policyholder may have paid quarterly or semi-annually.

The Policy Schedule page will list the policy number and the policy effective date. The first renewal date may also be listed, which will reflect how the first premium was paid (quarterly, semi-annually or annually).

Policy Terminology

All insurance contracts are legal documents using legal terminology. As part of this, definitions used in the contract will be defined. While some terms may seem standard, this should not be assumed.

The exact listing of the page heading may vary, but probably it will state "definitions" somewhere. Whatever the page heading, it will state exactly what the policy terms mean or give the page number in the policy where the definition is listed.

The following is a list of commonly used definitions:

Activities of Daily Living
The activities of daily living are defined in each insurance contract. The federal government has also defined them for tax-qualified long-term care contracts. These may vary from company to company and between tax- and non-tax-qualified contracts. The activities listed are very important because they determine the conditions under which payment will be made. Policies that list seven conditions are more favorable for the policyholder than those which list only five (2 out of 7 are better odds than 2 out of 5). The following five are generally included:

1. Eating
2. Dressing
3. Bathing
4. Toileting & associated functions
5. Transferring to and from beds, wheelchairs, or chairs.

Adult Day Health Care

Adult day health care is community based group program that provides health, social and related support services in a facility that is licensed or certified by the state as an Adult Day Health Care Center for impaired adults. *It does not mean 24-hour care.*

Alternate Care Facility

An alternative care facility is one that is engaged primarily in providing ongoing care and related services to inpatients in one location and meets all of the following criteria:

1. Provides 24 hour a day care and services sufficient to support needs resulting from the inability to perform Activities of Daily Living or cognitive impairment;
2. Has a trained and ready to respond employee on duty at all times to provide that care;
3. Provides 3 meals a day and accommodates special dietary needs;
4. Licensed or accredited by the appropriate agency, where required, to provide such care;
5. Provides formal arrangements for the services of a physician or nurse to furnish medical care in case of emergency; and
6. Provides appropriate methods and procedures for handling and administering drugs and biologicals.

Many types of facilities would meet these criteria.

Caregiver Training

Caregiver training is training provided by a home health care agency, long-term care facility, or a hospital and received by the informal caregiver to care for the insured in his or her home.

Cognitive Impairment

A cognitive impairment is the deterioration of a person's intellectual capacity which requires regular supervision to protect themselves and others. This often must be determined by clinical diagnosis or tests. Cognitive impairment may be the result of Alzheimer's disease, senile dementia, or other nervous or mental disorders of organic origin.

Partnership Long-Term Care Policies

Effective Date of Coverage

The effective date of coverage is the date listed on the Policy Schedule page, which states the first date of coverage under the policy. It is not necessarily the date of policy application.

Elimination Period

An elimination period, also called a waiting period, is the number of days of qualified care received, but not covered by the policy due to the elimination period selected at the time of policy application. Once the designated number of days has passed, benefits will begin. This time period will be shown on the Policy Schedule page.

Home & Community Based Care

Home and community-based care is required and provided in a home convalescent unit under a plan of treatment, in an alternate care facility, or in adult day health care.

Home Convalescent Unit

Home convalescent units are NOT a hospital. It may be one of the following:

- The insured's home
- A private home
- A home for the retired
- A home for the aged
- A place which provides residential care; or
- A section of a nursing facility providing only residential care.

Home Health Care Agency

A home health care agency is an entity that provides home health care services and has an agreement as a provider of home health care services under the Medicare program or is licensed by state law as a Home Health Care Agency.

Inability to Perform Activities of Daily Living

An inability to perform the activities of daily living means the insured is dependent on another person to help them function on a daily basis. This may be the result of injury, sickness or simple frailty due to age.

Informal Care

Informal care is custodial care provided by an informal caregiver, making it unnecessary for the insured to be in a long-term care facility or to receive such custodial care in the residence from a paid provider.

Partnership Long-Term Care Policies

Informal Caregiver

An informal caregiver is a person who has the primary responsibility of caring for the patient in their residence. A person who is paid for caring for the patient cannot be an informal caregiver.

Long-Term Care Facility

A long-term care facility is a place which:

- Is licensed by the state where it is located;
- Provides skilled, intermediate, or custodial nursing care on an inpatient basis under the supervision of a physician;
- Has 24-hour-a-day nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN) or a licensed practical nurse (LPN);
- Keeps a daily medical record of each patient; and
- May be either a freestanding facility or a distinct part of a facility such as a ward, wing, unit, or swing-bed of a hospital or other institution.

A long-term care facility is not a hospital, clinic, boarding home, a place which operates primarily for the treatment of alcoholics or drug addicts, or a hospice. Even so, care may be provided in these facilities subject to the conditions of the Alternate Plan of Care Benefit provision, if one exists in the policy.

Maximum Lifetime Benefit

The maximum lifetime benefit is the total amount the insurance company will pay during the insured's lifetime for all benefits covered by the policy. This will be shown on the Policy Schedule page.

Medical Help System

Medical help systems is a communication system, located in the insured's home, used to summon medical attention in case of a medical emergency.

Medical Necessity

Care or services that are medically necessary include care that is:

- Provided for acute or chronic conditions;
- Consistent with accepted medical standards for the insured's condition;
- Not designed primarily for the convenience of the insured or the insured's family; and
- Recommended by a physician who has no ownership in the long-term care facility or alternate care facility in which the insured is receiving care.

Partnership Long-Term Care Policies

Plan of Treatment

A plan of treatment is a program of care and treatment provided by a home health care agency. Each company may include additional information that may include:

a) A requirement that it must be initiated by and approved in writing by your physician before the start of home and community based care; and

b) A requirement that it must be confirmed in writing at least once every 60 days.

Pre-existing Condition

A pre-existing condition is a health condition for which the insured received treatment or advice within the previous 6 months prior to application for coverage.

Respite Care

Respite Care is provided as a service for those who perform the primary care services for an individual. It includes companion care or live-in care provided by or through a home health care agency, to temporarily relieve the informal caregiver in the home convalescent unit.

Elimination Periods in Policies

The beginning date of the benefits will depend upon some options selected. One option affecting this would be the **elimination period.** The elimination period is a type of deductible. Instead of being expressed as a dollar deductible, however, it is expressed in days not covered. For example, in a major medical plan we commonly see a deductible amount of $500. This amount must be paid by the insured before the insurance company will begin paying for health care claims. In a long-term care policy, the deductible will be expressed as elimination days. A policyholder who selects 30 elimination days will not receive benefits (payment) from the insurance company until the insured begins receiving covered benefits on the 31st day. The first 30 days are not covered. Benefits begin to be payable on the 31st day for covered services. Of course, eligibility must also be established before benefits would be received.

Policy Termination

It would be hard to imagine a consumer terminating a policy when benefits are in process. It would be more likely that termination would happen during a period of good health. Even so, if termination did occur during eligibility of benefits, the insurance company would continue to provide benefits, subject to all policy provisions, until the insured had not received care for the amount of time specified in the policy, usually 180 consecutive days.

If termination occurred during benefit use, it is most likely that it would be due to a group long-term care policy that was terminated by the employing company.

Mental Impairments of Organic Origin

Some aspects of elder care are of specific concern to consumers. One of those is Alzheimer's care. As a result, some policies may specifically state that Alzheimer's disease is covered. It is common for a perspective client to specifically ask if this disease is covered by the policy. Long-term care contracts do cover mental impairments of organic origin. That would include Alzheimer's disease, and also senile dementia. These diseases are determined by clinical diagnosis or tests.

Hospitalization Requirements

Previous hospitalization is required under Medicare to receive their skilled care benefits in a nursing home. This is not necessarily true of long-term care policies. In the past, long-term care policies had options for hospitalization prior to a nursing home confinement. In other words, the consumer could choose to pay extra so that their long-term care policy did not require that they first be in a hospital for the same condition which put them in the nursing home. These policies usually require:

1. Hospitalization first for no less than three days;
2. Admittance to the nursing home for the same condition that caused the hospitalization;
3. The nursing home admittance to begin within 30 days of the related hospitalization.

The Medicare & You booklet states: *"Most long-term care in a nursing home or at home is custodial care (help with activities of daily living like bathing, dressing, using the bathroom, and eating). Medicare doesn't cover this kind of care if this is the only kind of care you need. Medicare Part A only covers skilled care given in a certified skilled nursing facility or in your home. You must meet certain conditions for Medicare to pay for skilled care when you get out of the hospital."*

Many states require the nursing home policy to cover nursing facilities whether or not hospitalization occurred. These policies will state that no hospitalization is required. Of course, the policyholder must still meet all eligibility requirements of their LTC policy. Since state laws vary, it is important that each agent know how their particular state views hospitalization requirements.

Many existing policies do have a hospitalization requirement. Due to this fact, many professionals feel agents should periodically send out letters to their existing clients outlining the benefits they purchased in the past. It allows them to be aware of policy requirements and change to increased benefits if they desire to.

Home and Community Based Benefits

Home and community based benefits are available in many LTC policies, either as part of the base plan or as an option that may be added for additional premium. Home and community based benefits are traditionally less expensive than a nursing home confinement so this type of care is less expensive for the insurer to cover. Even though such care is less expensive, however, eligibility standards still exist. Those eligibility standards may have some variations, but typically they require one of the following:

1. The care must be medically necessary.
2. The policyholder must be unable to perform one or more of the activities of daily living stated within the policy.
3. There must be some type of cognitive impairment.

Benefits payable under the policy will depend upon the options selected at the time of policy purchase. If home care is included in the contract, it will typically be paid at 50% of the institutional benefit. In other words, if $100 per day is paid for the nursing home, then $50 per day will be paid for home care. Many of the **integrated plans** pay the same daily amount for home and community based care as they pay for nursing home care. That's because an integrated plan uses a "pool of money" that may be applied, as the insured desires. *An agent should never take this for granted;* he or she should always check the policy or call the benefit department of the insurance company for details.

Bed Reservation Benefit

A **Bed reservation** benefit is included in many long-term care policies. A bed reservation benefit means the insurance policy will continue to pay the long-term care facility benefit to the nursing home while the policyholder is temporarily hospitalized during the course of their long-term care facility stay. This provides the security of returning to the same familiar surroundings following the hospitalization. It also prevents the family or hospital from having to locate another suitable nursing home facility.

The bed reservation benefit is for a *temporary* hospitalization. It would not continue indefinitely. Commonly, bed reservation benefits are limited to 21 days per calendar year. Unused days from one year can seldom be carried over into the next calendar year. It may be possible, however, to use bed reservation days to satisfy the elimination period in

the policy. *Again, the agent will want to check with the issuing company to make sure they allow this.*

Waiver of Premium

It is now common for long-term care policies to contain a **waiver of premium**. A waiver of premium has to do with renewal premiums during an institutionalization or while receiving benefits under the terms of the policy. When the policyholder has received benefits under the policy for the number of days specified, their renewal premiums will be waived (they don't have to pay them). Many policies will not refund premium that has already been paid, which is why only renewals may apply. Since this is not always the case it is important to understand the terms in each contract. Some policies will refund premium based on quarterly renewal periods. In other words, a policyholder who has paid a yearly premium will receive a refund each quarter of their policy after the conditions have been met qualifying them for a waiver of premium. Some policies also allow hospitalization days during a facility or benefit stay to count towards this waiver of premium.

How the elimination period is counted towards a waiver of premium will vary from contract to contract. Some policies allow the elimination period to be part of the time counted towards the waiver qualification while others do not. Those policies that do not allow the elimination period to count towards the waiver of premium require that benefits actually be due and payable under the policy (the insured must actually be eligible to receive payment from the insurer). Therefore, it would look like this:

Elimination Period + Benefit Days = waiver satisfaction.

For those who selected a 30-day elimination period when purchasing their policy and a 90-day waiver of premium, the equation would be:

30 days + 90 Days = waiver satisfaction

(120 days total time for waiver qualification).

Once the policyholder has not received benefits under their LTC policy for a specified time period (usually 180 consecutive days), the waiver of premium is no longer in effect. The insurance company will again expect premium payment in order for the policy to stay active.

Alternative Plan of Care

Policies may offer an **alternative plan of care** that is covered under the policy. If the insured would otherwise need care in a long-term care facility (nursing home), the

company will pay for an alternative service, devices, or benefits. The alternative plan of care must be medically appropriate and medically acceptable. This is determined by specific requirements, including:

1. It must be agreed to by the insured, the insured's doctor, and the insurance company; and
2. It must be developed by or with health care professionals (not the patient or the patient's family).

Contracts that allow alternative plans of care follow the policy payment schedule. Naturally, these benefits will count against the maximum lifetime benefits of the policy.

No Policy Covers Everything

As every agent knows, no policy covers everything. All policies, including long-term care contracts, have a section in the contract that lists exclusions (items not covered). It is often easier to understand a policy by reading what is NOT covered.

There are traditional exclusions that are in virtually every contract. Policies will not pay for:

1. Losses due to a condition for which the policyholder can receive benefits under Workers' Compensation or the Occupational Disease Act;
2. Losses due to the result of war or any act of war; and
3. Losses payable under any federal, state, or other government health care plan or law, except Medicaid. The company will reduce their benefits in direct relationship to the amount covered by any government health care plan or law to the extent that the combination of payments exceed 100% of the actual charge for the covered service.

Of course, no policy will pay for losses that occurred or began prior to the purchase of the policy. You can't crash your automobile and then go buy coverage for it.

All policies will list preexisting condition limitations. It is important to disclose all preexisting conditions on the application at the time of policy purchase. If this is not done, an otherwise valid claim could be denied during the preexisting period. If the undisclosed medical condition is serious enough, the policy may actually be rescinded (voided).

Agents who routinely do not disclose obvious or stated medical conditions risk being "red tagged" by the insurers. This means they underwrite all applications to a greater degree because the insurer is not confident that the agent is truthfully listing all medical conditions. In some cases the insurer may even refuse applications from a seemingly

dishonest agent. Agents who knowingly fail to list all stated or obvious medical conditions are "clean-sheeting" the application.

There is another reason agents and applicants need to disclose all known medical conditions: many issued long-term care policies will cover all medical conditions immediately (even those existing at the time of policy issue), as long as the condition was listed on the application. If the condition was not listed, it is then subject to any pre-existing time periods listed in the policy. If serious enough, the policy could still be voided as well.

Age Misstatement

Age misstatement on the application is seldom considered a serious offense, although it can be in specific situations. If the age is misstated downward (stating a younger age) any additional premium must be paid to keep the policy in force. An error in age upwards (stating an older age) will trigger a premium refund, if applicable. If a younger age was purposely stated, it is usually done to save money since so many LTC policy premiums are based on age at application. Obviously, the insurers do not allow this. Sometimes the premium cost is considerable between certain ages, such as between a 69-year old and a 70- year old. That is why it is so important to consider this type of coverage at younger ages.

Few companies rescind (void) a policy due to age misstatement. It may happen, however, if the age misstatement puts the applicant in an age bracket that is not acceptable for underwriting (an 80-year old who is listed as 79 might fall into this category). The company would, however, require that the additional premium be paid. If the correct age would have meant that the policy would not have been issued at all, then the premium that was paid will be returned to the consumer and the policy voided.

Third-Party Notification

Many policies now allow a third party notification when unpaid premiums are due. The third party is chosen by the insured, usually at the time of policy issue. The insured has the right to change the third party listing at each policy renewal, or at least yearly.

When the policyholder has listed a third party notification, that person would receive notice if the policy were in danger of lapsing due to nonpayment of premiums. The notice would be sent to them in writing at least 30 days prior to policy termination. The intent is to prevent an accidental policy lapse. This is most likely to happen as people age and forgetfulness becomes a problem. If that is the situation, a policy lapse can be especially distressful for the family.

There is one final safeguard if premiums are not paid on time: there is a 31-day grace period. This means that the policyholder has 31 days past the actual premium due date in which to make payment. The policy would remain in force and claims would be covered during this 31-day period. If a claim occurred, the premium would have to be paid in order to receive benefit payment.

Reinstatement of a Lapsed Policy

Under some circumstances, a lapsed policy may be reinstated (put back in force). Sometimes, simply paying the unpaid premium is enough to reinstate the policy. In other cases, a new application for reinstatement must be submitted and perhaps even underwritten. Any back premium will still be due.

Why would a person reinstate rather than simply apply for a new policy? The most likely reason is to keep the issue-age the same, since the policyholder was probably younger when he or she first applied for coverage.

Many states have mandated specific reinstatement requirements as a consumer protection measure. This would especially be true if the lapse were due to some cognitive impairment or some type of functional incapacity. **Functional incapacity** typically means the inability to perform a specified number of the activities of daily living. When this is the case, the insured will have six months following the policy lapse (due to nonpayment) to reinstate it. Such reinstatement is especially important in these cases, because the insured cannot qualify for a new policy due to their medical problems. Any person authorized to act on behalf of the insured may also apply for policy reinstatement due to cognitive impairment or functional incapacity.

The insurer will require proof of cognitive disability when the insured, or their family, requests policy reinstatement. They will accept clinical diagnosis or tests demonstrating that cognitive impairment or functional incapacity existed at the time the policy terminated. The insured must bear the expense (if any), in most cases, for supplying medical proof.

Long-term care policies can be intimidating to the consumer. Therefore, they rely on the knowledge of their agent. An agent who does not completely understand the long-term care contracts (policies) should not attempt to market them. The degree of possible error is just too high. When errors are made they may not be discovered until the insured needs to use the policy – the worst possible time to discover it.

Even when errors are discovered and the agent has left the insurance field, lawsuits may still be filed against the insurer. One of the reasons insurance companies have become so pro-active regarding agent education has to do with preventing lawsuits. Of course, if the policy is a Partnership contract there are also federal government regulations regarding

suitability. Issuing insurance companies are required to adhere to these mandates and in fact there must be a specific person that makes sure all issued policies follow federal requirements.

Section 6021:
Expansion of State LTC Partnership Program

The Deficit Reduction Act of 2005 (effective in 2006) provided some statutory Requirements that are important to the expansion of long-term care Partnership policies. This would include:

Dollar-for-Dollar Asset Protection	In order to provide asset protection, states must make necessary statute amendments that provide for the disregard of assets when applying for Medicaid benefits. An individual applying for benefits must be a resident of the state when the coverage first became effective under the policy. The Partnership policy will be a tax-qualified plan that was issued no earlier than the effective date of the state plan amendment allowing use of such LTC policies. They must meet the October 2000 NAIC model regulations and requirements for consumer protections.
Inflation Protection	Since most people will not use their long-term care benefits for many years after purchase, it is important to include inflation protection. Partnership plans have specific inflation protection requirements. The requirements were previously outlined in this course.
Plan Reporting Requirements	Partnership plan insurers must provide regular reports to the HHS Secretary and include specific information, including: • Notification of when benefits have been paid and the amount of benefits paid. • Notification of policy termination. • Any other information requested by HHS. The state may not impose any requirements affecting the terms or benefits on Partnership policies that were not also imposed on traditional non-partnership plans. States may require issuers to report additional information beyond those listed and there may be differences among the states.
Consumer Education	It is the responsibility of each state to properly educate their consumers so they are aware of their asset-protection options.

Partnership Long-Term Care Policies

Agent Education	Most states will be imposing some type of continuing education requirements for those agents wanting to market Partnership plans. While these agent requirements will vary, many states are adopting an initial requirement of 8 hours, with 4 hours required each license renewal period thereafter.
State Amendments Where Required	Policies are deemed to meet required standards of the model regulation or the model Act if the state plan amendment is certified by the state insurance commissioner in a manner satisfactory to the Secretary.
Reciprocity	States with Partnership contracts must develop standards for uniform reciprocal recognition of Partnership policies between participating states. This would include benefits paid under the policies (being treated equally by all states) and opt out provisions where states could notify the Secretary in writing if they do not want to participate in a reciprocity program.
State Effective Dates	Qualified state long-term care Partnership policies issued on the first calendar quarter in which the plan amendment was submitted to the Secretary.

NAIC 2000 Model Act

No one has argued against purchasing a long-term care policy to protect against the costs of receiving care for an extended period of time. However, like so many things, these early policies had many initial flaws that were not consumer friendly or, in some cases, even ethical.

Regulation is often necessary to correct industry flaws that were not corrected by the industry itself. The long-term care insurance market needed consumer protection to protect against product flaws, some intentional and some merely a result of issuing products in a new market place with little statistical data to guide the underwriters. The regulation reflected many issues, including consumer expectations, insurer pricing, and any number of other circumstances. The focus brought about recommendations by the National Association of Insurance Commissioners (NAIC), called the “model” laws and regulations.

The national Association of Insurance Commissioners is a non-profit organization made up of the insurance regulators from the 50 states, the District of Columbian and the four United States territories. They have worked with regulators, legislators, the insurance industry, and consumers to create a comprehensive uniform model law, often referred to as the NAIC Act, and related regulations for long-term care insurance.

Partnership Long-Term Care Policies

State laws can vary widely, but the Model Act and Related Regulations are generally adopted in some form (the state either adopts them as they are or includes language from the model).

Initially, it was the premiums that brought about the attention to this new market of long-term care insurance policies. Health insurance policies had many years of trial and error to smooth out the pricing so it was fair to both the consumers and the insurance companies covering the risks. Health insurance can be adjusted yearly as the insurers see the claims come in. Long-term care policies are issued without immediate access to claims experience. Usually these policies are not accessed for ten to twenty years after issuance. Initially, they were priced to remain constant for many years. Unfortunately, some agents actually marketed them as "never increasing in price." Since one in three purchasers of long-term care insurance is under the age of 65, long-term pricing becomes necessary.[1] While most policies did not increase with increasing age, they do contain a clause allowing for premium increases if all similar policies are increased (they may not usually be increased individually due to advancing age).

Premiums in Partnership plans may not increase individually or due to the characteristics of an individual policyholder (due to claims, for example), but policies may be increased if all such policies are increased. It was difficult for underwriters to accurately price long-term care policies since so little data existed. Additionally, a larger number of policyholders maintained the coverage than was expected. Why is this important? Because it meant that premiums companies expected to keep, without paying out claims, did not materialize. Since the policyholders kept their policies they could be expected to eventually collect benefits.

Any new insurance market may experience premium rating difficulties, but the long-term market was especially prone to this, due to the length of time between purchase and benefit submissions. In August of 2000 the NAIC adopted new regulatory requirements intended to encourage stronger state legal protections for the long-term care policyholder. The NAIC worked with various groups, including consumer groups and the insurers to develop regulation that would serve as a model for everyone. It was called the NAIC Long-Term Care Insurance Model Act and Regulation.

A major goal of the NAIC model act was premium stability. As amended in August of 2000, the model act and regulation financially penalizes companies that intentionally under-price policies (often called low-balling) and, furthermore, allow state regulators to prohibit insurers that repeatedly engage in such behavior from selling policies in their state. The new model required greater disclosure of premium increases and provided policyholders with more options when premiums did increase.

[1] Georgetown University March 2004 Issue Brief

Partnership Long-Term Care Policies

We might assume that an insurance company would not want to under price their policies, but in fact that can be a competitive strategy to lure in customers with relaxed underwriting and low premiums. At some point, the insurers know they will raise their premium rates. Since long-term care benefits are not accessed quickly (as major medical plans are, for example) insurers can low-ball policy issuances without fear of being hit financially. This is extremely bad for those who buy the policies since they pay in premiums for a policy they may have to lapse when premiums rise beyond their means.

"Level Premium" Does Not Mean Unchanging Rates

Many states have addressed the term "level premium" since this can mislead the consumer into believing that policy rates will never change. Rates can and do change in long-term care policies. This term means that rates will not be increased due to advancing age or increased claim submission.

Financial Requirements for Rate Increases

The NAIC model provided measures that would discourage under-pricing of policies, which would inevitably increase in premium at some point. Rules were established regarding the "loss ratio" (the share of premium the insurer expected to pay in claims). These were based on estimates of future revenues and future claims over the life of the policy for all those who purchased this particular policy form. Under the NAIC model, projected claims must account for at least the sum of:

(a) 58 percent of the revenues that would be generated by the existing premium, and

(b) 85 percent of the revenue generated by the premium increase.

Setting a higher loss ratio requirement for the premium increase than applies to the initial premium creates what is essentially a penalty for increasing rates. It is hoped it will discourage under-pricing from the beginning of the policy.

Rate Certification from the Insurer's Actuary

The Model Act requires insurers to obtain certification from an actuary that initial premiums are reasonable. When an insurer requests a premium hike the model also requires the actuary to certify that "no further premium rate schedule increases are anticipated." Reliance on this actuarial certification must assume, of course, that the actuary will use acceptable actuarial practices when evaluating the available data. It must further assume that unethical companies cannot find an actuary willing to make a certification that was inaccurate.

Partnership Long-Term Care Policies

Consumer Disclosure

The NAIC model requires insurers to disclose rate increase histories for the past ten years for long-term care policies of similar type. Since this has been such a forward-moving industry it is unlikely that the exact policy will have been issued for a steady ten years. There may be some cases where this is not required, as in the case of insurer mergers. It is hoped that this disclosure will help consumers select the policy they wish to purchase as well as the company they wish to deal with. The purchaser must also sign a form stating that he or she understands that premiums may increase in the future (this should prevent agents from stating that premiums will remain the same).

LTC Personal Worksheet

Insurers use a long-term care worksheet called the Long-Term Care Insurance Personal Worksheet. This is provided to applicants during the solicitation of a long-term care policy. The worksheet and rate information are provided to the Insurance Department's Office for review in most cases.

Is the Policy Suitable for the Buyer?

"Suitability" means appropriate for the situation. Therefore, a long-term care policy is suitable when the buyer can afford the premiums year after year, has assets or income to protect from Medicaid spend-down requirements, recognizes the possibility that they are likely to need coverage at some point in their lives, does not want to burden their family members, and has sufficient knowledge about the product to make a logical and informed buying decision.

A policy that is purchased and then lapsed a year or two later has benefited no one – not even the insurer in some cases since underwriting has costs associated with it. The selling agent is in the best position to determine whether or not the buyer is financially suitable for the policy they are buying. In other words, if the buyer has no assets to protect (income cannot be protected by Partnership policies – or any other type of policy) it may not be wise to purchase a long-term care policy in the first place.

Agents judge suitability on a specific set of criteria; it is not made on personal opinion alone, although there will be some aspect of that involved. Suitability refers to recommending and selecting products that are sensible or "suitable" given personal factors such age, risk tolerance and overall investment objectives.

Without specific guidelines each agent and buyer would make suitability determinations based on what they perceive to be important, whether that happens to be financial status, knowledge of products, or simply a product that appeals to the buyer. In fact, all of these components are important.

Partnership Long-Term Care Policies

Suitability regulations require agents to recommend only suitable LTC products. Suitability standards do not imply that the insurance producer is any type of fiduciary; suitability standards are entirely different than fiduciary standards. What it does mean however, is that the agent has inquired about sufficient income or assets and determined to the degree possible that the applicant can afford the premiums today and into the future. The applicant's goals and needs and the advantages or disadvantages for that particular applicant must be considered.

At the time of or prior to the insurance presentation agents must give the consumer a copy of the "Long-Term Care Insurance Personal Worksheet." It will contain the information necessary to make an informed decision. The insurer may request more information than that contained in the worksheet if necessary for a clear buyer decision or for underwriting purposes. The completed worksheet is included with the insurance application and a copy is also filed with the commissioner's office.

If the potential applicant refuses to answer questions regarding income, assets, and other financial information necessary to make an appropriate determination, then neither the selling agent nor the issuing insurer bears any responsibility if the decision to buy turns out to be a poor choice. The insurer can reject the application if the buyer has refused to supply necessary information, but is not required to do so. It can send out a letter outlining the need for the requested information and hope the applicant then provides the information. Either the applicant's returned letter or a record any alternative method of verification of information must be made part of the applicant's file.

Every insurer, health care service plan or other entities marketing long-term care products must develop and use suitability standards. Additionally companies must train its agents in the use of the developed suitability standards and maintain copies for the state to inspect if they wish.

Agents must attempt to document whether or not an individual should purchase a long-term care insurance policy, whether that happens to be a traditional long-term care contract or a Partnership contract. Most states require companies to develop suitability standards (which agents must follow) to determine if the sale of long-term care insurance is appropriate. These standards must be available for inspection upon request by the Insurance Commissioner.

How does an agent know if a policy is suitable? Simple questions can determine that: Is insurance appropriate for this individual? Can the applicant afford the premiums year after year, especially if the rates increase? Does the policy actually address the applicant's potential needs and desires? These questions may be referred to as "needs-based" selling, but whatever name is attached to it, agents and insurers must follow all state requirements.

Partnership Long-Term Care Policies

Consumer Publications

There are consumer publications that enable the buyer to determine themselves if a long-term care purchase is wise for their particular circumstances. "Things You Should Know before You Buy Long-Term Care Insurance" is a consumer publication. Also available is the Long-Term Care Insurance Suitability Letter for consumers.

The agent must provide a **Long-Term Care Shopper's Guide** to all prospective buyers of long-term care insurance, whether a traditional long-term care policy or a Partnership long-term care policy. This publication or a similar publication will have been developed by either the individual state or by the National Association of Insurance Commissioners for prospective applicants.

Post Claim Underwriting

Most policies underwrite the applicant at the time of application. The long-term care industry has not always done so. At one time some companies quickly issued the long-term care policy and delayed underwriting until a claim was submitted. Obviously, this was not good for the insured. No one wants to find out their policy is useless when a claim has been presented.

Most states prohibit post-claim underwriting since it is anti-consumer and encourages insurers to find a reason to invalidate the policy (since a claim has been submitted). Especially in long-term care policies it is important that the contract be underwritten at the time of application. In this way, the applicant can be sure that his or her policy is valid and will pay covered claims when they occur.

Additionally, many states mandate that applications contain clear and unambiguous questions on the application regarding the applicant's health status. Of course, the consumer must honestly answer the insurer's questions. A question that could be misunderstood puts the applicant in the position of possibly having their policy rescinded or a claim denied due to misrepresentation if the health questions are not worded in a manner that is easily understood.

Tax-Qualified Policy Statement

If it is a Partnership plan, then it is tax-qualified. If the insured files long-form for their federal taxes, he or she may deduct the premiums of his or her long-term care policy. Policies must include a statement regarding the tax consequences of the contract so that the insureds do not have to guess whether or not the policy meets the tax requirements. The statement must be included in the policy and in the corresponding outline of coverage.

Partnership Long-Term Care Policies

The Outline of Coverage is a freestanding document that provides a brief description of the important policy features. The statement may read similar to the following:

> *"This policy is intended to be a federally tax-qualified long-term care insurance contract under section 7702(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the policy may be taxable as income."*

Replacement Notices

When an application is taken for long-term care insurance, the agent must determine whether or not it will replace an existing long-term care contract. The method of determination is very specific. A list of replacement questions must be on the application forms and replacement notices. If replacement will take place, there is a specific format for the replacement process.

When a policy is replaced by another, the replacing insurer must waive the time period applicable to preexisting conditions and probational periods to the extent similar exclusions have been satisfied under the original policy. In other words, once a probational or preexisting medical period has been met under one policy, any subsequent contracts that replace the original must recognize the previous satisfaction of these conditional periods.

Policy Conversion

In some states it may be possible to convert a recently issued tax-qualified policy over to a Partnership policy if the issuing company offers Partnership policies. If this is the case, it is likely that there will be specified time limits for doing so. The insurer will mail out notices to their policyholders notifying them of this possibility. Some insurers may allow any tax-qualified policyholder to convert to a Partnership plan; benefits will remain the same since only asset protection will be added by the conversion.

When a policy is converted from one form to another states nearly always have conversion rules that apply. Typically the insurer may not impose new or additional underwriting, nor may they impose a new or extended preexisting period for claims.

An Overview

The Model Act provides guidelines for qualified long-term care policies, including:

- Policies may not limit or exclude coverage by type of illness, such as Alzheimer's disease.

- Policies cannot increase premiums due to advancing age. In other words, premiums may not increase when a policyholder has a birthday. Premiums may increase simultaneously for all who hold similar policies.
- Policies cannot be cancelled because of advancing age or deteriorating health.
- Policies must offer a nonforfeiture benefit that, if purchased, ensures the consumer that a lapsed or cancelled policy means some benefits would still be available for a specified period of time.
- Policies must offer an inflation protection that, if purchased, ensures benefits keep pace with inflation. This is especially important for those purchasing their policies at younger ages.

The NAIC Model Act Applies to All

All 50 states and DC have adopted the NAIC Model Act. The states have adopted the NAIC Model Regulation in some form, although they have not necessarily adopted all of the provisions.

The Model Act applies to all long-term care insurance policies and even to life insurance policies that have an acceleration benefit that may be used for long-term care services prior to the insured's death.[2] Any policy or rider that is advertised, marketed, or designed to provide coverage for no less than 12 consecutive months on an expense incurred, indemnity, prepaid or other basis is considered a long-term care policy if it is providing for one or more necessary long-term care services in a non-hospitalization setting.

So, what is a qualified long-term care insurance contract? For our purposes, it would include any insurance contract if:

1. The only insurance protection provided under such contract is coverage of qualified long-term care services;
2. Such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;
3. Such contract is guaranteed renewable;
4. Such contract does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed.
5. All refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

[2] Act 2, Reg. 3

6. Such contract meets the requirements of subsection (g).

Policy Renewable Provisions

These long-term care policies must have renewable provisions and include a statement of how they are renewed. If the policy contains a rider or endorsement, there must be a signed acceptance by the policy owner.

Payment Standards Must be Defined

Standards that refer to the payment of benefits must be defined. Such terms as "usual, customary, and reasonable" must be defined in a clear, unambiguous manner. In this definition, for example, the policy must state how the usual, customary, and reasonable charge is determined. Is it based on the local areas? How often are the fees updated to reflect current costs?

Preexisting Standards

Preexisting conditions limitations will be in most of the long-term care policies, but there are restrictions as to how they limit benefits. For example, the preexisting period may be no more than 6 months following policy issue. There can be no exclusions or waivers, such as exclusion on a particular heart condition of the insured. The applicant must be accepted or denied for coverage.

Policy Type Must Be Identified

The policy must clearly state whether it is a tax-qualified or a non-tax qualified long-term care policy. All Partnership policies will be tax qualified.

ADLs

Policies must describe the ADLs in a clear unambiguous manner. Policies may not be no more restrictive that using three ADLs or cognitive impairment for benefit payments. Of course, policies may be more lenient in allowing payment of benefits, but they may not be more restrictive than that.

Benefit triggers, the conditions that begin the benefit payment process, must be explained in the policy and the policy must specify whether or not certification is required.

There must be a description of the appeals process should a claim be denied.

Partnership Long-Term Care Policies

Life Insurance Policies with Accelerated Benefits

While many professionals feel it is best to keep benefits for death and benefits for long-term care separate, there are life insurance policies that will accelerate death benefits for use for long-term care services. When this is the case, disclosure of tax consequences of life proceeds payout must be in the policy.

How is one to know if the life policy has the option of accelerated benefits? Treatment of coverage provided as part of a life insurance contract, except as otherwise provided in state regulations, generally apply if the portion of the contract providing such coverage is a separate contract. While it is always necessary to refer to the actual policy, the term "portion" means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

Nonforfeiture Provisions

Generally a nonforfeiture provision must meet specific requirements:

1. The nonforfeiture provision must be appropriately captioned.
2. The nonforfeiture provision must provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the appropriate State regulatory agency for the same contract form.
3. The nonforfeiture provision must provide at least one of the following:
    a. Reduced paid-up insurance.
    b. Extended term insurance.
    c. Shortened benefit period.
    d. Other similar offerings approved by the appropriate State regulatory agency.

Extension of Benefits

When policies include extension of benefits, these must be available without prejudice regarding benefits that have already been paid for prior institutionalization or care.

Home Health & Community Care

Minimum standards and benefits must be established for home health and community care in long-term care insurance policies.

Partnership Long-Term Care Policies

Additional Provisions for Group Policies

Many companies are curtailing insurance benefits in major medical coverage so it is doubtful that group long-term care coverage will be offered to any great extent. However, where it is, there must be provisions for individuals to continue their coverage when they leave the group plan. Individuals who are covered under a discontinued policy must be offered coverage under a replacement contract.

Outline of Coverage

In general an Outline of Coverage must be provided at the time of the initial solicitation. As it pertains to the agent, it must be presented during the completion of the application. There is a prescribed standard format for the Outline of Coverage in a long-term care policy. The content of the Outline of Coverage is also stipulated. Use of specific text and sequence is mandatory as is a list of categories that include:

- Benefits and coverage;
- Exclusions and limitations;
- Continuance and discontinuance terms;
- Change in premium terms;
- Any policy return and refund rights;
- The relationship of cost of care and benefits; and
- Tax status.

There must also be consumer contacts within the Outline of Coverage.

Policy Delivery

Once the policy has been approved and issued, the buyer must receive it within 30 days of approval. The policy must also include a policy summary.

No Field Issued LTC Policies

There was a time when long-term care policies could be field issued by the agent because underwriting was completed when a claim was filed rather than at policy issuance. Field issued policies are not allowed under the Model Act and Regulation since it is not good for the consumer. Policies must be underwritten prior to policy issuance.

Policy Advertising and Marketing

Prior to advertising a policy for long-term care benefits, whether it will be viewed on television, heard over the radio, or read in print, it must be approved by the state's insurance commissioner's office.

Partnership Long-Term Care Policies

Any company marketing long-term care policies have standards that must be followed. There must be marketing procedures established and state training requirements for agents must be followed. The NAIC is recommending that states adopt a Partnership training requirement of eight initial hours of continuing education, followed by four hours each licensing renewal period thereafter.

The point of training agents is to ensure that marketing activities will be fair and accurate. Training will hopefully prevent a single person from over-insuring as well.

No Policy Covers Everything

As we previously discussed in this text, no policy covers everything. LTC policies must prominently display a notice to buyers that the policy may not cover all the costs associated with long-term care services. Even when agents have discussed what will not be covered, most claims will occur ten or twenty years later. It would be unlikely that the buyers would remember what the agent said and it certainly makes sense to state this in the policy as well.

Prior to the Sale

Agents and insurers have pre-sale responsibilities. They must provide the applicant with copies of personal worksheets and potential rate increase disclosure forms. They must also identify whether or not the applicant has long-term care insurance or coverage elsewhere. If there is existing coverage, the agent must find out if the applicant intends to replace the existing LTC policy with the new coverage.

The insurer must establish procedures for verifying compliance with the requirements. Written notice must be given that senior insurance counseling programs are available and provide contact information.

Such terms as “noncancellable” or “level premium” may be used only when the policy conforms. There must be an explanation of contingent benefits upon policy lapse.

Shopper’s Guide

A **Shopper’s Guide** must be given to the consumer prior to the application for long-term care coverage. If it is a direct solicitation, it must be provided at the time of application.

It’s Just Plain Illegal (Twisting, High Pressure Tactics and Misrepresentations)

Some practices are just plain illegal. This would include what is referred to as “twisting,” which means using the facts to suit one’s own needs (not the needs of the consumer). A person who uses twisting is either changing the facts to suit their own

needs or providing some facts, but omitting others in order to complete the sale. It might be omitting information that should be disclosed, or it might be stating facts in a way that will allow the consumer to assume that which is not true. Often twisting is used to make an existing policy appear unfavorable, when in fact the policy is appropriate for the consumer.

High pressure tactics are not new to the insurance industry, but it is illegal. Agents who pressure people into buying are not really helping themselves anyway, since these individuals are very likely to cancel the policy (which means lost commissions too).

Of course, any misrepresentation of the policies, the insurers, or any aspect related to the sale of insurance is illegal.

Association Marketing

There are also requirements for those who market to association members. Marketers must provide objective information, full disclosures, compensation arrangements and all brochures or advertisements must be truthful.

Following the Sale

The consumer's rights continue after the sale has been made. They have the right to return the policy if it does not meet their needs or even if they just plain change their minds. No reason for returning the policy needs to be given by the insured. As long as it is returned within 30 days a full refund will be received.

If the applicant failed to provide full information an incontestability provision exists. For material misrepresentation, the time period for rescinding the policy is six months. A misrepresentation pertaining to both material information and medical conditions the time period is two years for policy rescission. Information that was knowingly and intentionally misrepresented may cause a policy rescission for more than two years. When a policy is rescinded, benefits may not be recovered.

Failure to Pay Premiums

When a policy is in danger of lapsing due to nonpayment of premiums, the insurer has some obligations. It must notify the insured 30 days after the premium is due and unpaid. After 5 days of mailing the notice, it can be assumed that the insured has received it. Termination would be effective 30 days after the notice was given to the insured and the designated thirty-party.

Partnership Long-Term Care Policies

Ethical Considerations

The insurance industry has specific requirements to determine whether it is logical to place a long-term care policy of any type in a consumer's home. These are called "suitability" standards, but they could just as easily be called "ethical" standards.

These suitability or ethical standards begin the moment a product is presented. Agents must determine whether the person or couple is suited to buying a long-term care product. At least part of the consideration is: "can they afford the premiums?" It is not just a matter of affording them in the first year; they must be able to afford to pay premiums (that might increase over time) year after year. Insurers are required to monitor the applications submitted for suitability but ideally the field agents will recognize when an application should not be taken in the first place.

All agents must use a suitability worksheet but decisions are often made without the consideration that is recommended. Decisions to buy or not buy should never be a matter of guessing; there is enough information available that it should not be necessary. There are three primary steps to determining the necessity of long-term care coverage: the interview between the agent and buyer, the analysis of need based on that interview, and finally a presentation of the benefits and cost of the recommended product.

Some actions on the part of the insurance producer are just plain forbidden, such as twisting information, misrepresenting any insurer (theirs or another's), or pressuring a consumer to buy. Exaggerating what a long-term care policy can or will accomplish is certainly not allowed; this may be referred to as "puffing."

We have seen some situations where one topic is advertised but another topic is actually intended. For example, a public seminar may be advertised as a financial planning educational event when the true goal is a list of people who might be sold insurance products, such as annuities or long-term care policies. This is a bait-and-switch event; the "bait" is the financial information and the "switch" is the sales presentation of an annuity or long-term care product.

Consumers may not be tempted with an offering of free gifts and rebates are usually illegal in the states. There will not be any toasters offered to consumers who open an annuity or purchase a long-term care product. The only "gift" will be the knowledge that the buyer has protected his or her assets by purchasing a product that will pay their bills when long-term care is needed for a medical or cognitive condition.

Consumers often believe that agents can somehow waive their usual commissions but in fact most states do not allow rebates. The goal is to place products that are necessary and suitable; premium rates should not be the primary focus as they might be if rebates were allowed.

Partnership Long-Term Care Policies

Full Disclosure

It should not be necessary to state that insurance producers must provide full disclosure. While it would be impossible to cover every detail involved, sufficient information needed to make a logical buying decision must be provided. Company financial ratings, policy benefits, exclusions in coverage and realistic price information today and in the years to come must be provided. An agent's failure to do this will eventually be known but the real concern is the consumer's financial well-being. The financial necessity of having adequate long-term care coverage cannot be compared to a mistake when buying a dress or car. If a car under-performs the actions of the salesperson are not likely to have far-reaching consequences as an under-performing long-term care policy might.

In Conclusion

Long-term care insurance has been closely observed by the NAIC since the product's introduction. The NAIC developed its Long-Term Care Insurance Model Act and Regulation in the 1980s with the intent of promoting the availability of coverage, protecting applicants from unfair or deceptive sales or enrollment practices, facilitating public understanding and comparison of coverages, and facilitating flexibility and innovation in the development of long-term care insurance. *In short, the NAIC wants all placed products to be suitable for the purchaser and their financial situation.* Generally, the NAIC Model Act and Regulation establish:

- Policy requirements: (a) requiring a standard format outline of coverage; (b) requiring specific elements for application forms and replacement coverage; (c) preventing cancellation of coverage upon unintentional lapse in paying premiums; (d) prohibiting post-claims underwriting; (e) prohibiting preexisting conditions and probationary periods in replacement policies or certificates; and (f) establishing minimum standards for home health and community care benefits in long-term care insurance policies.
- Benefit requirements: (a) requiring the offer of inflation protection; (b) requiring an offer of nonforfeiture benefits; (c) requiring contingent benefit upon lapse if the nonforfeiture benefit offer is rejected; and (d) establishing benefit triggers for nonqualified and qualified long-term care insurance contracts.
- Suitability requirements: (a) explaining and reviewing a personal worksheet with applicants; and (b) requiring that insurers deliver a shopper's guide to buying long-term care insurance to applicants.
- Insurer requirements: (a) reporting requirements; (b) licensing requirements; (c) reserve standards; (d) loss ratios standards where applicable; (e) filing and actuarial certification requirements; and (f) standards for marketing.
- Penalties and disclosure requirements.

Partnership Long-Term Care Policies

Adequate long-term care insurance is financially important to the buyer but it is also financially important to every taxpayer. Certainly we want our homes protected from fire and we want liability to protect us if we have an automobile accident. It is just as important to have our assets protected (income is not protected) as we age and eventually require care in a nursing home, at home, or in the community.

Partnership Long-Term Care Policies

Chapter 4

Financial Planning for LTC

The National Clearinghouse for Long-Term Care Information is a website developed by the U.S. Department of Health and Human Services to provide information and resources for consumers. Their goal is to provide sufficient information to encourage purchase of long-term care insurance products. This site is provided to help individuals and their families plan for future long-term care (LTC) needs. To access this website go to www.longtermcare.gov.

The Importance of Planning

No one wants to believe they will ever need to be in a nursing home, but the facts tell us it is not only possible, but likely. At least 60 percent of people over age 65 will require some long-term care services at some point in their lives. As we know, Medicare is not designed to cover long term care needs. There are three levels of care in a nursing home: custodial (also referred to as personal care), intermediate and skilled. Only Skilled nursing care is covered by Medicare in the nursing home, which is the least likely level of care needed. Most people will require either intermediate or custodial nursing care, neither of which is covered by Medicare. Skilled care is the type requiring the most technical services while custodial care pertains to basic living needs, such as help getting in and out of bed, help with bathing and bathroom function, and so forth.

No website will tell an individual whether or not they will actually end up in a nursing home or if they will be able to receive help at home (avoiding institutionalization). Each of us has our own unique situation, but it is important to realize that as we age and become frail, it is likely that long-term care will be part of our lives in some form. It simply makes sense to plan for an eventual need of long-term care services, and then hope it is not needed (since we all really want to "die with our boots on" as they say).

The National Clearinghouse for Long-Term Care Information is primarily intended to offer information with the hope that individuals can make an informed decision. It provides information and planning resources for individuals who don't yet require long-term care, but realize that day might eventually come.

Long-term care can include multiple types of services that are necessary to meet health or personal needs of daily living. "Long-term," refers to care for an extended period of time.

Partnership Long-Term Care Policies

Most long-term care is non-skilled personal care assistance, such as help performing everyday Activities of Daily Living (ADLs), which include:

- Bathing,
- Dressing,
- Using the toilet,
- Transferring (to or from a bed or chair),
- Caring for incontinence or general bathroom activities, often referred to as toileting, and
- Eating.

The goal of long-term care services is to help the individual maximize their independence and functioning at a time when it may not be possible to remain fully independent.

Not everyone will need long-term care; some people will die suddenly, or soon after an illness or injury occurs. Some people have the good fortune of living independently during their lifetime, dying at home without ever needing health care assistance. However, this will not be the case for many people. Long-term care is needed when a person has a chronic illness or disability that causes him or her to need assistance with the Activities of Daily Living (ADL). Some types of illness or disability involve cognitive impairment, which would include such things as memory loss, confusion, or disorientation.

Approximately nine million Americans over the age of 65 will need long-term care services. By 2020, that number will increase to 12 million. Surprisingly, a large number of people receiving long-term care are adults between the ages of 18 and 64 years old. As some types of illnesses continue to spread, such as AIDS, this figure could rise. Even so, most people who need long-term care are those age 65 or older.[1]

Approximately 60 percent of individuals over age 65 will require some type of long-term care services during their lifetime, with 40 percent needing care in a nursing home. Factors that increase an individual's risk of needing long-term care include, but may not be limited to:

- Age: The older an individual is, the more likely that care will be needed in some form.
- Marital Status: Single people are more likely to need care from a paid provider.
- Gender: Because women live longer than men, they have a higher risk of requiring long-term care services. Additionally, they often damage their own health caring for someone else.

[1] National Clearinghouse for Long-Term Care Information, 5/25/2010

- Lifestyle: Poor diet and exercise habits will increase the risk of needing long-term care services.
- Health and Family History: inheriting good genes are a plus.

While it may not be possible to predict how much or what type of care an individual will require we can look at averages to base our decisions on. We know from statistical information than an individual who is age 65 today will need some form of long-term care services during his or her remaining lifetime. Furthermore, these statistics tell us they will need approximately three years of care. Service and support requirements vary from one person to the next and often change over time. Women need care longer than men do (on average 3.7 years for women versus 2.2 years for men). Twenty percent of today's 65-year-olds will need care for more than five years.

There are many types of services available. We are fortunate to have a greater variety of care services available today than our parents had access to. Many of these types of care have been developed to prevent institutionalization. Services might include:

- Services in the beneficiary's home from a nurse, home health/home care aide, therapist, or homemaker;
- Care in the community; and/or
- Care in any of a variety of long-term facilities.

Medicare does not necessarily pay for an individual's long-term care needs. If Medicare will pay, there is a specific criterion that must be met. The service is often paid for by the patient or his or her family if no insurance is in place. Medicare is designed to pay hospital and physician expenses; it was never designed to cover long-term care needs.

While an individual may suddenly require a nursing home, more often the need for personal care develops gradually as the person ages. Frailty is a major reason for receiving some type of long-term care service. Even if the individual is basically healthy, as he or she ages they become frail and with that frailty develops a need for personal help with the activities of daily living (ADL). Initially, they may need care only a few times a week, for such things as help with bathing for example. This may progress as the individual ages or the condition worsens. A chronic illness or disability may become more debilitating, causing the person to need care on a more continual basis, perhaps even daily. Continual help may be needed for preparing food and eating, toileting, dressing, and moving in and out of beds and chairs. Ongoing supervision may be needed due to progressive conditions such as Alzheimer's disease.

Some people will enter a nursing home for a relatively short period of time while they recover from a sudden illness, surgery, or injury; they may then be able to receive care at home. Others may need long-term care services continually. Some people may begin care at home, but eventually require a nursing home or other type of facility-based setting for

more extensive care or supervision. Such things as assisted-living facilities have enabled many people to get the supervision and care they need without going to a nursing home.

Cost of Care

An important part of planning for long-term care is deciding how to pay for services. Medical care in general is expensive and services dealing with long-term care needs are no exception. Figures for 2014 reveal the following:

Homemaker services, allowing people to remain at home longer, have a median annual rate of $19 per hour. This is a 4.11% increase from 2013.

Home Health Aide Services providing personal and home health aide services in the individual's home cost an average of $20 per hour, which is an increase of 1.59% over the previous year.

Adult Day Health Care (ADC) programs provide a social and related support service in the community (this care is not around-the-clock but rather for up to 8 hours per day on average) has a daily average rate of $65.

Assisted Living Facilities (ALF) are living arrangements that provide personal care and health services for those who need some help but can manage outside of a nursing home if there is help available. ALFs are called Residential Care Facilities in California. The level of care is less than that received in a nursing home but are often enough to keep the individual in a less restrictive living environment. In 2014 the average cost for the nation was $3,500 per month. It is much higher in some areas and this "average" should not be relied upon because of that.

Nursing Home Care refers to facilities specifically designed to provide a higher level of supervision and care than that offered by assisted living facilities. There is medical staff available 24 hours per day that provides medications and skilled nursing services.

Actual costs for any type of care will depend upon several factors so the costs listed here are simply averages from across the United States.

While some people may qualify for Medicaid immediately (the major payer of long-term care services) most people will first use all of their own assets. There are other federal public programs, such as the Older Americans Act, and state funded programs that pay some long-term care services. However, virtually all programs have some criterion that must first be met, such as poverty status. Like Medicaid they help those people with the most pressing financial need. Before Medicaid will pay a single dollar towards long term care expenses the applicant must have spent down all their personal assets. He or she will also be required to contribute at least a portion of any income they have access to. The amount of income contributed will depend upon several factors, including a spouse that might be partly or wholly dependent upon that income.

Partnership Long-Term Care Policies

Older Americans Act (OAA)

The Older Americans Act was passed in 1965 to provide protection for the most vulnerable older citizens. People who are 60 years old or more are eligible to receive services, but states are required to target those with the greatest economic need. This might include social needs as well as economic needs. OAA was particularly aimed at low income minority people, older people living in rural areas, low-income people in general and those who are frail.

Each state receives OAA funds according to a formula based on the state's share of our total population of those who are age 60 and older. The goal is to help them "age in place;" in other words the goal is to keep Americans in their homes and out of institutions when possible.

Funding for the Older Americans Act is small when compared to many other programs. It is certainly smaller by far than the budget for Medicaid, for example. However, senior citizens may be eligible for OAA even when they are not eligible for Medicaid. OAA provides long-term services that individuals could not otherwise receive.

Perhaps one of the most important goals of the Older Americans Act is helping people remain at home when they are at risk of entering the nursing home. We know that nursing homes are the most expensive places to receive long-term care services and we also know that few people really want to go there. According to 2012 data, more than 85 percent of those receiving OAA-funded home care and supportive services said it was the reason they were still at home instead of in an institution. Researchers at Brown University found that the states investing the most funds in home and community based services have the least custodial care (maintenance care) residents in nursing homes. In other words, investing in various types of care in older American's homes prevents the costlier care in facilities.

One of the main aspects of OAA is investing in hunger and food programs. More than 40 percent of the federal appropriation goes to meals provided in congregate settings, such as senior centers and adult day centers. A large part of the food program delivers meals directly to the homes of senior Americans, ensuring adequate nutrition. This is often referred to as "meals on wheels."

The Older Americans Act is also active in helping low-income senior Americans obtain community service employment and training in schools, libraries and senior centers. Nearly a fourth of the federal funding for this program goes to the Senior Community Service Employment Program (SCSEP) helping older Americans receive an income from employment.

Home and community based services are provided; this includes home care, adult day services, case management, transportation, and health promotion in general. Obviously the healthier an older person is the less likely he or she is to need long-term care in a nursing home. Even such things as transportation to and from medical appointments can make a difference.

In short, the OAA serves millions of senior Americans on a fairly small budget. These services play an important role in delaying or even preventing the need for care in a nursing home, which is the most expensive type of care. The low funding means the Older Americans Act is limited in what they are able to do and as the baby-boom generation hits retirement it is certain to leave the program short. Even so, whatever services they are able to provide will save dollars that would otherwise go to nursing homes.

A Woman's Issue

Paying for long-term care services from personal income and resources can be challenging. It is certainly a woman's issue since 71 percent of claim dollars are paid to female claimants. That represents the figure from those who have insurance; many more do not have coverage and will still be faced with the cost of long-term care services. Women make up, as of 2014, more than 80 percent of all nursing home residents. Even so, most claims begin with care at home. It is not unusual for an elderly wife to be caring for her elderly husband at home, ending up exhausted and eventually sick herself.

Some types of extended care can be provided by family and friends. For example, a daughter may be able to assist her mother several times a week with personal needs, such as bathing or housekeeping duties. Family and friends might be able to prepare meals that the individual can heat up in a microwave if they are unable to cook for themselves. LTC includes a broad range of health and support services that do not necessarily require employing a person or accessing a facility. The majority of services provided by family and friends involve personal care, such as assistance with activities of daily living. As care and support requirements increase, paid care is usually needed to supplement family provided services and supports, provide respite to family caregivers, or to pay for more extensive services in a facility, such as a nursing home or assisted living, when individuals can no longer be cared for in their homes.

Costs will always vary based on the extent of the services received. Home health and home care services, provided in two-to-four-hour blocks of time referred to as "visits," are generally more expensive in the evening, or on weekends and holidays. The costs of services in some community programs, such as adult day service programs, are often provided at a per-day rate, but vary based on overhead and programming costs. Many

care facilities charge extra for services provided beyond the basic room-and-board charge, although some may have "all inclusive" fees.

Individuals who have sufficient income and assets are likely to pay for their long-term care needs personally, from private resources. If the person meets functional eligibility criteria and has limited financial resources, or has already depleted all their personal resources, Medicaid may pay for their care. Those requiring skilled nursing care for a short time may receive coverage under Medicare (if all criterion is appropriately met). People generally use a variety of payment sources as their care needs and financial circumstances change.

Receiving payment for long-term care services can be a confusing topic for many senior citizens. It is best not to expect much payment from Medigap policies, which are not designed for long-term care services, or from public programs that require spend-down of assets prior to benefit qualification.

Medigap policies, also called Medicare Supplemental policies, supplement the payments made by Medicare (thus the name Medicare supplemental policies). If Medicare denies a claim, the supplemental policy will deny it also because there is nothing to supplement.

Even if Medicare might pay some portion of a nursing home stay, the stay must qualify under Medicare's guidelines. For example, Medicare requires that the individual first be in a hospital for the same condition that caused the nursing home confinement.

The following chart gives a basic overview of how long-term care services might be covered financially. If a person has long-term care insurance coverage, it is not addressed below. In that case, he or she would want to refer to their specific policy for payment of benefits.

Long-Term Care Service	Medicare	Private Medigap Insurance	Medicaid	Beneficiary Pays
Nursing Home Care	Pays in full for days 0-20 if care is in a Skilled Nursing Facility following a recent hospital stay. If the need for skilled care continues, may pay for days 21 through 100 after a daily co-payment is met by the patient.	May cover the daily co-payment if the nursing home stay meets all other Medicare requirements.	May pay for care in a Medicaid-certified nursing home if the patient meets functional and financial eligibility criteria.	If the patient needs only personal or supervisory care in a nursing home and/or has not had a prior hospital stay, or if the patient chooses a nursing home that does not participate in Medicaid or is not Medicare-certified.

Partnership Long-Term Care Policies

Assisted Living Facility (and similar facility options)	Does not pay	Does not pay	In some states, may pay care-related costs, but not room and board	Patient pays for this except as noted under Medicaid if eligible.
Continuing Care Retirement Community	Does not pay	Does not pay	Does not pay	Patient must pay for this type of care.
Adult Day Services	Not covered	Not Covered	Varies by state, financial and functional eligibility required	Patient pays for this (except as noted under Medicaid, if eligible).
Home Health Care	Limited to reasonable, necessary part-time or intermittent skilled nursing care and home health aide services, and some therapies that are ordered by the patient's doctor and provided by Medicare-certified home health agency. Does not pay for only on-going personal care or custodial care needs (help with activities of daily living).	Not covered	Pays for home health care, but the individual states have the option of limiting some services, such as therapy.	Patient pays for personal or custodial care, except as noted under Medicaid, if eligibility standards are met.

On an aggregate basis, the largest share of nursing home expenses is paid for by Medicaid following the patient's asset depletion. On an individual basis, it may feel to the patient and his or her family as though they are paying the major portion. Even if Medicaid ends up paying $100,000 in comparison to the patient's $50,000, when asset depletion occurs it may still feel unfair. Anyone with reasonable income and assets will pay at least a portion of their nursing home and other long-term care services.

Medicare pays only under specific circumstances. If the type of care required does not meet Medicare's rules, Medicare will not pay, leaving the patient and their family on their own to some way to cover the required or desired services. It should also be noted that neither Medicare nor private LTC insurance will pay for a service just because it would be convenient for the patient or their family. The service must be medically necessary and requested by the attending physician or some other qualified medical organization.

The public's understanding of how long-term care expenses will be paid is an important step in the sale of long-term care insurance policies. If the public does not realize how much they will pay out-of-pocket they are not likely to have any interest in the Partnership program.

Partnership Long-Term Care Policies

Financial Planning Strategies

Some so-called experts would have Americans believing that they can keep their assets and still have the government pay for their long-term care needs. Partnership long-term care policies are actually designed to do this to some extent but few other avenues can really promise to do so.

Asset Transfers

It only takes a few minutes on the internet to see many advertisements from attorneys who promise to provide avenues to keeping all assets while still qualifying for Medicaid. Perhaps the first question to be asked should be: *"Are you okay with saddling your grandchildren with the cost of your care?"* Anyone who promises to protect assets while still qualifying for government-financed care is doing exactly that. Unfortunately many people are willing to pass the cost on to their grandchildren (although they never call it exactly that) so the next step is determining if that is actually possible.

Unless asset ownership is transferred within a specified time period prior to needing care Medicaid will require individuals to pay their own way if they have the means to do so. Changing the ownership of assets is a tricky business as well. For example, let's say that Mildred, a widow, transfers all her assets except her primary residence to her son, Joe. Joe's assets are mingled with his wife's assets and after a few years both are on the title to Mildred's beach house where she likes to spend her summers. When Joe's wife files for divorce the beach house is awarded to her in the divorce. Since the title was not in Mildred's name there is nothing she can do about it.

Transferring assets is legal, which was not always the case. However they must be transferred within a specified time period for Medicaid to disregard them for Medicaid eligibility purposes. That time period, called the look-back period, has changed from time to time in an effort to make transfers difficult if the reason for them is to qualify for government aid when assets could have covered the costs, or at least part of the costs, for long-term care services.

DRA of 2006 changed asset transfers from 36 months to 60 months for purposes of applying for Medicaid. This look-back period determines how long the applicant must wait before he or she becomes eligible for Medicaid benefits, although even then benefits are never guaranteed since the individual must meet all qualifying criteria. The formula is based on the amount or value of the transfer. Whatever the value of the assets, that amount will be applied against the cost of care. For example, if real estate with an appraised value of $100,000 is transferred, then Medicaid may not be applied for until an equal amount of care has been received. If the care costs $10,000 per month, then application to Medicaid cannot be made for ten months ($10,000 x 10 = $100,000).

However, this is not the end of the story. There is another rule regarding the look-back period that says the penalty period will not begin until the individual has moved into a nursing home, spent down their assets for Medicaid eligibility, has applied for coverage, and has been approved for the coverage, but not for the transfer. This is a complicated matter so asset transfers should not be made without help from an attorney in many cases.

When transfers are made for reasons other than Medicaid eligibility, it may not be necessary to seek out an attorney, but it is always necessary to be aware of the laws that apply. At older ages, the individual must be aware of the Medicaid eligibility laws even when he or she is not transferring as a means to shift the burden from themselves to the taxpayers. There is no way to know when health will decline so anyone over the age of 60 should certainly be aware of asset transfer laws.

When asset transfer is made in an effort to qualify for Medicaid (saving the assets while still receiving Medicaid-sponsored care) there are many factors to consider. The average cost of long-term care should be considered; this will require some knowledge of costs in the person's area of residence since costs vary greatly across the United States. Since it is not possible to know exactly when care might be needed, the transfer penalty must also be considered. In some cases the penalty will extend beyond the five-year period if the value of the transferred assets was high. Income and living expenses must also be considered since income is never transferable. Partnership policies do not protect income either; they only protect assets.

If asset transfers are not correctly handled there may be tax consequences. For example if assets are transferred to the individual's children, they may be responsible for all taxes. If asset values appreciate the tax consequences may be more than they bargained for. There are tax breaks when assets are received through an estate.

In many cases transferring the primary residence does not make sense because it is possible to qualify for Medicaid even when the applicant owns his or her own home. However, if this is a concern it can be transferred to a trust, although many professionals recommend against it. Usually the best transfer for a home is to the spouse that is not having health issues (although a heart attack can change that in a heartbeat). When assets are changed to one of the two spouses it is often necessary to change the wills as well. If the spouse that is not in the nursing home suddenly dies and all assets revert to the spouse that is in the nursing home, Medicaid eligibility may be lost since there are now assets available.

Some assets can be transferred at any time without affecting Medicaid eligibility, since they are exempt from the look-back period. After entering a nursing home it is possible to transfer assets to the spouse, a child who is disabled, or into a trust for the benefit of someone with a permanent disability. If a sibling has equity interest in the home and has

lived there for one year or more prior to the individual entering a nursing home, it is a legal transfer at any time and will not affect Medicaid eligibility.

Many people have questioned whether it is ethical to shift the responsibility of long-term care costs over to the taxpayers, especially when there are assets in place that could have paid for the care. Obviously it was never Medicaid's goal to allow individuals to shift the cost when they could have paid for it. Medicaid is a welfare program that was designed with the poor of all ages in mind. Since there are not any other programs covering long-term care costs Medicaid has ended up paying them after the beneficiary depletes all of his or her own assets (becoming impoverished). So, if a person artificially impoverishes him or herself, is it fair to expect our children and grandchildren to shoulder the responsibility of their care? This is certainly a fair question since the individual could have used some of their assets to buy a Partnership long-term care policy. That avenue would have preserved assets and provided financial coverage through an insurance policy. Of course it is important that the individual buy sufficient long-term care insurance benefits; otherwise we arrive back where we started when the policy's benefits run out.

Eldercare attorneys may argue that as long as it is legal, then it is also ethical. Not all agree with that opinion. Our history is full of situations that were certainly legal but just as certainly unethical. All can agree, however, that Medicaid laws are often confusing. Even so, confusion about the various aspects does not remove an ethical responsibility to do the best we can to cover our needs as we age. It is unlikely that a grandparent would take out a credit card in their grandchild's name and then use it for their own enjoyment, knowing the grandchild would be left with the payment; shifting their long-term care costs to their grandchild amounts to the same thing.

It is unfortunate that Medicaid, a program intended for poor people of all ages, has become recognized as the long-term care insurance of America's middle class. As more money must be spent to care for America's elderly there is little doubt that poor children must receive less help; there is only so much money available so if they shift to the old, then the young goes without. Since states have discretion when it comes to Medicaid spending there may be differences between the states, but primarily the elderly consume the most.

There are no easy answers. For those who worked their entire life to accumulate modest savings, asset transfers seem fair. For taxpayers paying an increasingly larger tax bill there can be resentment towards those consuming the most. In the end, Partnership long-term care policies may be the best answer for everyone.

Partnership Long-Term Care Policies

Reverse Mortgages

Reverse mortgages may be used for anything, not just long-term care expenses. In many states it may be difficult to qualify under Medicaid for anything other than institutionalized care. When Medicare does pay for home care and community services, it may not be sufficient. Additionally, many people do not want taxpayers to cover their costs. They paid their own way their entire lives and they prefer to continue doing so. Whatever the case, reverse mortgage money is often a solution.

For individuals who are at least 62 years old and own their own home, reverse mortgages should at least be considered. Reverse mortgages were specifically designed for older Americans, allowing them to make financial arrangements that takes the equity in their home and turns it to liquid cash. That does not mean the home has been sold; the homeowners continue to live there and no payments are required to repay the loan.

The reverse mortgage loan does not have to be repaid until the last surviving borrower dies, sells the home, or permanently moves out. It is important that both spouses be on the deed however. Otherwise, when the one that is named on the deed dies, the other surviving spouse would have to move or repay the loan in full. The homeowners must also continue to pay property taxes and maintain homeowner's insurance.

Reverse mortgage loans are usually made through a local bank, based primarily on the value of the home at the time the loan is made, the age of the borrower, and current interest rates. If the interest rates are low and the borrower is older, the loan amount will be higher than for younger borrowers with higher interest rates.

Money from the loan may be received in a variety of ways: in a lump sum, as a line of credit, or in a series of regular payments to the homeowners. Any combination of the three may also be used. The most popular choice has been a line of credit since it allows the homeowners to use it as necessary. No interest is charged on the untapped balance which is also an advantage.

As we said, reverse mortgage money can be used for anything, not just healthcare. There are no restrictions, which can be both good and bad. Obviously if the money is squandered on nonessential items the funds could be used up far too soon. On the other hand, money could be used to make the home wheelchair friendly, pay taxes, make home repairs or simply for world-wide travel (as long as residence is maintained at the home).

Borrowers have not sold their home; they still own it. The borrower's estate usually repays the loan, plus interest. That's why the line of credit that does not charge interest on untapped funds is an advantage at the end when the loan is repaid from the estate. The repayment amount cannot exceed the value of the borrower's home at the time the loan is repaid.

Partnership Long-Term Care Policies

A reverse mortgage cannot be taken out on any debt against the home; it must be equity that is free of debt. That means that either the old mortgage must be paid off prior to taking out the reverse mortgage or some of the loan must be used to pay it off. Either way, only the reverse mortgage may exist against the home's value.

The most widely available reverse mortgage has been the Home Equity Conversion Mortgage (HECM). It was the only one available that was insured by the Federal Housing Administration (FHA). A disadvantage was that it set a ceiling on the amount that could be borrowed against a single-family home that was determined on a county-by-county basis. High-end borrowers needed to look for a proprietary reverse mortgage market since it does not impose loan limits.

In April 2013 the federal government stopped allowing homeowners to apply for HECM Standard fixed-rate, *lump-sum* reverse mortgages. Borrowers can still apply for a line of credit or monthly payments at an adjustable interest rate under the HECM Standard program however.

Why was the change made? Unfortunately there were more defaults with this type of loan when compared to other types. While it is not possible to default on the actual reverse mortgage loan, homeowners who did not pay property taxes often lost their property, causing a default. The high number of defaults indicated to the Federal government that many reverse mortgages were taken by people as a last resort, meaning they did not have the means to pay property taxes and future insurance premiums. The money was used up quickly to solve existing debt. Then when taxes and insurance came due there was no money remaining to pay these costs of home ownership. Reverse mortgages must be part of a continuing financial plan rather than a method of quick income to solve existing debt that depletes the funds too quickly.

It is not always existing debt that causes the money to be spent immediately; too often Americans have trouble budgeting. When a lump sum of money is deposited into their hands they may spend it foolishly. Foolish spending is not something only the young are guilty of; many older Americans never learned to handle money even though they had their entire lives to develop good money habits.

Borrowers will still be able to get lump-sum loans from other sources and from HECM Saver programs that pay out a smaller percentage of the home's value compared to the Standard loan program.

Partnership Long-Term Care Policies

Annuities

Annuities are valuable estate planning tools, but their advantages are often overlooked when it comes to Medicaid planning. Immediate annuities work especially well for spouses of nursing home residents since they can provide needed income. Immediate annuities do not work as well for single individuals but for married couples they should be considered. In simple terms, immediate annuities are contracts with insurance companies under which the buyer pays an amount of money to the insurer and the insurer then sends the policyowner a monthly check for life or for a specified time period, which is chosen at the time of annuitization by the policy owner. When a life annuitization option is chosen by the buyer beneficiaries are eliminated, since the issuing insurance company becomes, in effect, the sole beneficiary of the policy. Under other payout options beneficiary listings are still available.

In most states the purchase of an annuity is not considered an asset transfer because an annuity is termed an investment. Therefore, a man and wife owning real estate could sell the real estate and deposit the money received into an immediate annuity under the name of the community spouse, producing an income for the non-institutionalized partner. Depending upon all financial factors, the income may be required to partially fund the nursing home stay but the entire amount would not be at risk. The annuity transforms otherwise countable assets into a non-countable income stream. It is important to understand, however, that the income must be in the name of the community spouse, not in the name of the person in the nursing home.

There are some basic requirements for this action to be free from transfer penalties:

1. The annuity must be irrevocable, meaning the annuitant may not take funds out of the annuity except through monthly payments (an income stream), which is why it must be annuitized.
2. When annuitized for a life option, at least the amount paid into the annuity must be returned; the insurer may not receive the bulk of the money if the annuitant dies prematurely. If an individual is expected to live another 15 years then at least 15 years of payments must be received. This would be called a “Life with 15 Years Certain” option. The wording might vary slightly but it would state specifically that 15 years of payments are guaranteed.
3. If the annuitization option chosen has a “term certain” (“life” is not part of the title) the term selected must be shorter than the actuarial life expectancy. That means that an individual expected to live another 15 years might select a 10 year certain payout period. In many cases the state must be named as the remainder beneficiary up to the amount of Medicaid benefits paid to the beneficiary.

Most money managers recommend that the annuity not be purchased until the unhealthy partner moves to a nursing home. That is because it is difficult to know who might go to

a nursing home first. Just because one partner seems sicker than the other is not always accurate criteria for knowing what the future will bring.

All annuities must be disclosed on the Medicaid application whether it is irrevocable or not. Reporting the existence of the annuity will not affect Medicaid eligibility if it has been correctly set up. When information is withheld the state must either deny or terminate coverage for long-term care services or Medicaid eligibility.

Single Americans seeking help from Medicaid do not benefit from annuities the way married couples do. Like so many financial vehicles, a powerful tool for one person may not provide any protection for another.

It is also important to understand that only immediate annuities (providing income) work with Medicaid qualification. Deferred annuities would have no purpose in the context of Medicaid eligibility because an income is not being taken.

An important note: some states are changing how immediate annuities are viewed so it is very important to know the rules in the state of residence. As states experience severe budget shortages more states are likely to restrict some types of assets from being ignored during Medicaid eligibility application.

Medicaid Spend-Down

Each state has specific financial criteria regarding Medicaid eligibility. While some elements remain fairly standardized from state to state, other elements vary. Although Medicaid is a joint venture between the federal and state governments, each state has the ability to administer the program as they desire, as long as federal requirements are also followed.

For example, generally speaking applicants may have no more than $2,000 in countable assets, but the dollar figure may be higher in some cases, depending upon the state.

Applicants and their spouses may protect some of their savings by spending them on Medicaid non-countable assets. This would include prepaying their funeral expenses, paying off the existing mortgage, making home repairs or making the home suitable for wheelchair use, replacing a car with a newer model, buying home furnishings, paying for home care services, or even buying a new home. In the case of married individuals, it may be best to wait until the ill spouse is actually admitted to the nursing home since spend-down resource allowances for the community spouse could otherwise be affected. In many cases it makes sense to consult with an elder-care attorney. This is a person that specializes in legal issues for elderly people.

Partnership Long-Term Care Policies

Relying on Medicaid for Long-Term Care Payment

Although it was not the original intention of Congress, Medicaid has become the insurance company for long-term care. This is true not just for the poor, but also for the middle class in America. We are not the only country struggling with this, of course, but it is little comfort to know that other nations have the same problems as we do.

According to www.longtermcare.gov, when the states consider an individual's Medicaid eligibility, some assets are counted and others are not. Checking accounts, savings accounts, stocks and bonds, certificates of deposit, real estate except for the primary residence, and extra vehicles will be considered usable assets. Only one vehicle is allowed so extra vehicles must be sold with the proceeds contributing to the patient's care.

The primary residence is not considered for eligibility, but it is factored in. In many cases a lien will be placed against the home so that Medicaid benefits can be repaid when it is sold. If there is sufficient equity in the primary residence Medicare will not pay for the person's long-term care since that equity can be withdrawn and used to cover the costs of care. Equity value is determined by the fair market value, which is the amount it would currently sell for minus any debt against it such as a mortgage.

When there is a noninstitutionalized spouse half of the home equity belongs to that community spouse. Therefore home equity of $300,000 would also belong to the spouse; therefore $150,000 would be considered for Medicaid eligibility. There are exceptions; if the spouse or a child under the age of 21 is blind or disabled and living in the home, then the home equity rule does not apply since it might cause an undue hardship.

When a joint checking account is held, the entire amount is considered as available for nursing home costs since either person can withdraw the full amount it contains. In other words, either the husband or the wife could withdraw the funds in full; therefore the full amount contained in the checking or savings account may be applied to long-term care.

If an outside person, such as a child, is also on the account and contributes funds to it, he or she should consider an alternative for the amount they contribute. Even if he or she can prove they provided the funds since they are in the account Medicaid will consider it to be long-term care available.

Each state will have some version of qualifications for Medicaid eligibility. While each state must follow federal guidelines they have more discretion than one might imagine in managing the funds and eligibility criteria. Primarily each state must fairly consider each applicant. In other words, all individuals that apply must have to meet identical criteria to receive benefits.

Partnership Long-Term Care Policies

Using Insurance for Long-Term Care Expenses

Every agent selling long-term care insurance policies is hopefully also in favor of using insurance to cover end-of-life medical care. It is simply a practical idea. Over the past years there have been a surprising number of authors who seem to think buying insurance to pay for long-term care should be avoided. Of course, policies are often expensive but so are long-term care services. I guess the real question is whether the individual can afford to pay the costs out-of-pocket. If he or she can, then perhaps it is not necessary to buy insurance, but for all who cannot pay three to five thousand dollars each month for long-term care services insurance is a practical maneuver.

Paying LTC Expenses Out-of-Pocket

While the majority of people cannot afford to cover the large costs of care over a long period of time, some people can do so. There is nothing wrong with using assets to cover the costs of living, including the possibility of care in a nursing home, rather than leaving them for beneficiaries. In fact, for many high-income people or those with many assets it is a prudent course of action.

Kiplinger reported in 2012 that many investment advisers are telling their wealthy clients to set aside approximately $250,000 specifically for the potential cost of long-term care services, which is the average cost for three years of care. Of course we know that many people are requiring such care for more than five years, but at least three years should be planned for.

Advisors have reported that even when individuals have the means to pay for their long-term care expenditures, most do not want to. Low interest rates and higher than anticipated claim rates have made long-term care policies expensive, but a choice must be made: pay out-of-pocket or pay high premiums. For many, a compromise seems to be their choice: buy enough insurance to defray the cost of care over a long period of time but plan to pay part of the fees out-of-pocket. For example, the individual might decide to cover the costs of a nursing home through insurance, but not the cost of home care or assisted living. This will keep premiums lower while still covering the most expensive type of care (a nursing home).

Rates have skyrocketed over the last few years for long-term care policies. The lower interest rates available from investments have meant that insurance companies are not making the income they had previously. Additionally there have been many more claims than originally anticipated; both of these have caused premium rates to go up and many insurance companies actually left the market entirely.

Partnership Long-Term Care Policies

Some insurers no longer offer options they once did. For example, a lifetime of coverage proved much more expensive than originally expected. Although the "average" length of stay might be stated as three years, it became quickly known that many people stay beyond five years in nursing homes and the quantity of people that experience this are increasing. This is the result of many things, but primarily improved care.

Facility rates for care are also increasing. Improved care costs more than inferior care. Many states have mandated specific standards of care, which no one objects to of course, but these standards come at a price. It is not unusual for a month of care to cost $7,000 in some areas of the United States. At that rate it does not take long to become impoverished and end up applying for Medicaid.

Financial advisers know that long-term care costs will likely be the largest threat to any retirement plan put in place. No matter how good the plan originally was, paying out thousands of unplanned dollars for long-term care will destroy it. It is easy to see why those with assets and a sound financial plan for retirement are willing to buy a policy and combine that with out-of-pocket payments.

Critical Illness Policies

Critical illness policies are more popular in Canada than they are in the United States. Under these policies, benefits may be paid directly to the insured and used for any reason; it is not necessary to use them to pay long-term care expenses or for any medical expense. However, it is a medical condition covered by the policy that triggers benefit payments.

Critical illness insurance coverage is an insurance product that pays a lump sum cash payment if the insured is diagnosed with one of the conditions listed in the policy. Cancer policies would be considered a critical illness policy for example.

Health Savings Accounts (HSA)

A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit.

Created in 2003, the intent is for individuals covered by high-deductible health plans to receive tax-preferred treatment of money saved for medical expenses. There are limitations as to how much may be placed in these accounts and there have been some recent changes regarding them so it is important to check on current limitations and requirements.

Partnership Long-Term Care Policies

Life Insurance with Accelerated Death Benefits

In some cases, individuals might purchase life insurance policies that include long-term care availability. If the insured needs care in a nursing home, life insurance benefits may be used if all requirements are met. These might be referred to as combination products, but whatever the name the life contract will also pay towards long-term care nursing home expenses. Usually the life policy pays only a percentage of the death benefits rather than the entire death benefit. Only a few will pay for any type of long-term care cost so it is important to know what is being purchased. The idea is that the policy buyer will receive benefits in one way or another: either in a nursing home or to beneficiaries upon their death. When long-term care benefits are paid out, these are deducted from the death benefits.

Accelerated Death Benefits (benefits paid for long-term care services) may be included in the policy or there may be an additional cost for them. There are different types of ADBs and it is important that the agent fully explain what their clients will receive. Some pay only if the insured is terminally ill or receives a life-threatening diagnosis. Most policies pay only if the care is for a specifically stated period of time, such as six months or more; they are trying to avoid shorter-term care periods. Nearly all of these types of policies rely in some way on the activities of daily living (ADL).

Although there are variances among insurers, most policies of this type pay only up to a stated percentage of the total death benefit, such as 50 percent for example. Since that is not necessarily true of all life insurance combination policies agents and buyers need to know exactly what they are getting for their premium dollars. Some policies allow benefits for care outside of a nursing home (typically home care). In these cases there might be a cap of the life policy's total face value for care in a nursing home, with home care often being half of that amount. For example, if the life insurance policy allows two percent of the face value paid out for the nursing home, then home care would be allowed at one percent of the total face value.

When health conditions prevent qualification for the standard long-term care policy, life insurance policies might still issue a policy with accelerated death benefits, allowing the applicant to receive coverage for long-term care services. Of course, life insurance policies do not provide long-term care benefits as their primary goal, so benefits will not be as broad or comprehensive as a long-term care policy would be.

In some cases the face value of a life insurance policy is not going to be enough to allow accelerated death benefit payments. If that is the case, the life contract should not be considered adequate coverage for long-term care requirements as the insured ages.

It would be unlikely that a life insurance policy would offer inflation protection against the rising costs of care. For those who buy life insurance to cover long-term care they must be aware that what is sufficient today may be insufficient in ten years.

Since long-term care payments are deducted from the death proceeds of the life insurance contract it is conceivable that beneficiaries will suffer if that is a goal of the life insurance policy. Also life insurance benefits that are available through an accelerated death benefit clause may affect Medicaid eligibility since it would probably be counted as a usable asset.

Life and Viatical Settlements

In some cases, the insured under a life insurance contract may be able to sell the policy and receive cash in return for it. These are called life and viatical settlements. The policy owner sells his or her life insurance policy, but remains insured under the contract. When a life insurance policy is sold the beneficiary becomes the policy buyer, which is usually a corporation or some other business entity. If the entire policy is purchased then the insured can no longer leave the proceeds to any of their family members or anyone else he or she might otherwise name. The proceeds of the sale of the life policy may be taxable so this should be discussed with the insured's accountant beforehand.

Under a life settlement agreement the insured is not required to have a terminal condition (although the buyer is looking for a situation that is short-term rather than long-term), but under a viatical settlement agreement, the insured must be terminal.

A viatical company pays the insured a percentage of his or her policy death benefit, based on their life expectancy. The company will require medical documentation; the insured's assurances are not sufficient. The viatical company will take over payment of future premiums to make sure the policy remains active.

Unlike life settlements, viatical settlements are tax-free as long as life expectancy is no more than two years. The viatical company buying the policy must typically be licensed to do business in the state where the life policy was purchased, and meet all legal requirements of the state. It is not necessarily easy to find a viatical company willing to buy the life insurance policy; on average less than 50 percent are accepted. Viatical companies expect to make a profit and screen policyowners to purchase only those that meet their requirements.

In 2007, the NAIC (National Association of Insurance Commissioners) adopted and copyrighted specific recommendations for viatical settlement agreements.

States are not obligated to use the NAIC model when drafting viatical legislation, but they often do draw some aspects from them. Called the **Viatical Settlements Act**, the NAIC viatical settlement model act created recommended legislation for:

1. Viatical related definitions;
2. State licensing procedures, including a recommendation for 15 hours of biennial continuing education on viatical procedures and contracts;
3. Rules for license revocation or denial if circumstances warrant it;
4. State specified contract and disclosure forms;
5. Reporting requirements on an annual basis of contracts written and death proceeds that have been paid;
6. Rules of investigation following complaints, and establishment of retention requirements;
7. Adoption of viator disclosure forms;
8. Adoption of insurer disclosure forms;
9. Establish general rules that apply to viatical settlement procedures and contracts;
10. Adoption and clarification of prohibited practices and conflicts of interest;
11. Adoption of advertising regulations;
12. Fraud prevention and control;
13. Injunctions, civil remedies and cease-and-desist orders;
14. Establishing the state commissioner's ability to act and promote legislation.

Any type of legal document is going to have definitions that apply to the Act or legislation. The following are definitions that apply to the NAIC recommendations.

Business of Viatical Settlements

An activity involving but not necessarily limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner, acquiring an interest in a life insurance policy by means of a viatical settlement contract.

Chronically Ill

1. Being unable to perform at least two activities of daily living, such as eating, toileting, transferring from beds to chairs, bathing, dressing or continence.
2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairments; or
3. Having a level of disability similar to that described by the Secretary of Health and Human Services.

Partnership Long-Term Care Policies

Policy

A policy is an individual or group policy, group certificate, insurance contract, or legal arrangement of life insurance usually issued by an insurance company to a resident of the state.

Related Provider Trust

A viatical provider trust may have various names, but whatever the name it is a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. They typically have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with statutory and regulatory requirements.

Many states will have legal requirements of viatical trusts, which they must follow in order to operate within that state.

Special Purpose Entity

A special purpose entity is a corporation, partnership, trust, limited liability company or similar entities formed solely to provide either directly or indirectly access to institutional capital markets.

Terminally Ill

A terminally ill individual is a person having an illness or sickness that can reasonably be expected to result in his or her death within twenty-four months or less.

Viatical Settlement Broker

A person who works exclusively on behalf of a viator and receives a fee, commission, or other valuable consideration for offering or negotiating viatical settlement contracts between the viator and one or more viatical settlement providers or one or more viatical settlement brokers. A broker, despite receiving compensation from the viator, is considered to represent only the viator – not the insurer or viatical settlement provider. The broker owes the viator a fiduciary duty to act according to the viator's instructions and in the best interest of the viator. A viatical settlement broker would not include an attorney, certified public accountant or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

Viatical Settlement Contract

A written agreement between a viator and a viatical settlement provider or any affiliate of the viatical settlement provider establishing the terms under which compensation or anything of value is or will be paid. The compensation will be less than the expected

death benefits of the policy; in return the viator will give his or her present or future assignment, transfer, sale, devise or bequest of the death benefits or ownership of any portion of the insurance policy or certificate of insurance.

A viatical settlement contract includes a premium finance loan made for a life insurance policy by a lender to a viator on, before, or after the date of issuance of the policy wehre the viator or insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy or they agree on the date of the premium finance loan to sell the policy or any portion of its death benefits on any date following the issuance of the policy.

A viatical settlement contract would not include a policy loan or accelerated death benefits made by the insurer according to the policy terms.

Viatical Settlement Provider

A viatical settlement provider is a person, other than the viator, that enters into or effectuates a viatical settlement contract with a viator.

Viatical Settlement Purchase Agreement

This is a contract or agreement entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, for the purpose of deriving economic benefits.

Viator

A viator is the owner of an individual life insurance policy or certificate holder under a group policy who resides in the state and enters or seeks to enter into a viatical settlement contract. If there is more than on owner of the policy and the viators are residents of different states, the transaction will be governed by the laws of the state in which the viator having the largest percentage of ownership resides. If the viators hold equal ownership, the viators may agree in writing to use the state of residence of one viator.

License and Bond Requirements

Those wishing to act as a viatical settlement provider or broker must obtain a license from the state he or she resides in. Since each state may have specific licensing requirements, of course the provider or broker must meet all their state's licensing qualifications, including continuing education if appropriate.

A person wishing to become a viatical settlement investment agent must first obtain a license from the commissioner of the state of residence of the viatical settlement purchaser. If there is more than one purchaser on a single policy, residing in different states, the viatical settlement purchase agreement must be governed by the laws of the

state in which the purchaser having the largest percentage of ownership lives or the state that is agreed upon in writing by all purchasers.

Under the NAIC model laws, life insurance producers who are licensed as a resident insurance producer with a life line of authority for at least one year is deemed to have met the licensing requirements to operate as a viatical settlement broker. Within 30 days of first operating as a viatical settlement broker, the life insurance producer must notify the commissioner that he or she is acting as a viatical settlement broker, using the form prescribed by his or her state. This notification will probably include an acknowledgement that the agent will act within the laws of his or her state. There is likely to be a licensing fee payable at the same time.

Some states may require insurance producers to obtain separate licensing. Therefore, the agent may not necessarily meet the licensing requirements to operate as a viatical settlement broker merely because he or she has been a licensed agent for at least a year. As always, it is vital that insurance producers know the laws of their particular state.

The insurance company issuing the life insurance policy is not responsible for any act or omission of a viatical settlement broker or provider resulting from their connection with the viatical settlement transaction, unless compensation is received by the insurer.

An individual licensed as an attorney, certified public accountant or financial planner (accredited by a nationally recognized accreditation agency) who is retained to represent the viator may negotiate viatical settlement contracts on the viator's behalf without having to obtain a viatical settlement broker's license, as long as compensation is not paid directly or indirectly by the viatical settlement provider.

Viatical licenses are renewable each year on the anniversary date. There will be annual fees specified by each state that must be paid at the time of license renewal. Of course, if the fees are not paid, the license will lapse for nonpayment.

Applicants must provide information on forms that are specified by the individual state insurance departments. The commissioners have the authority, at any time, to require the applicants to fully disclose the identities of all stockholders, partners, officers, members and employees. If the commissioner is not satisfied with any one of these individuals or if that person is deemed to have influence over the applicant's conduct, the commissioner may refuse to issue or renew a license.

A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers, viatical settlement brokers, or viatical settlement investment agents. All individuals that will act as providers, brokers, or investment agents must be named in the application and on any supplements to the application.

Upon filing the application and paying any applicable fees, the commissioner will investigate each applicant and issue a license if the commissioner determines the applicant:

1. For viatical settlement providers, has provided a detailed plan of operation;
2. Is competent and trustworthy and will act in good faith in the capacity of the license type issued;
3. Has a good business reputation and has had experience, training, or education qualifying him or her in the business for which the license applies;
4. For viatical settlement providers and brokers, has demonstrated evidence of financial responsibility in a format prescribed by the state's commissioner through either a surety bond executed and issued by an insurer authorized to issue them or a deposit of cash, certificates of deposit, or securities or any combination thereof in the amount of $250,000.

Surety bonds are to be issued in favor of the state and will specifically authorize recovery by the commissioner on behalf of any person who sustained damages due to erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices against the viatical settlement provider or broker.

The commissioner may ask for evidence of financial responsibility any time it appears necessary to do so.

If a viatical settlement provider or broker experiences change in the officers, stockholders holding 10% or more of the stock, partners, directors, members or designated employees, the provider must notify the commissioner of the change within 30 days.

The NAIC Model Act recommends that states adopt a continuing education requirement of fifteen (15) hours of training related to viatical settlements and viatical settlement transactions. Assuming the state has adopted the NAIC recommendation, an individual that fails to obtain the required education for his or her viatical settlement broker license would lapse due to noncompliance.

License Revocation and Denial

The state commissioner, under the NAIC Model Act, could refuse to issue, suspend, revoke or refuse to renew the license of a viatical settlement provider or broker if the commissioner finds that:

1. There was any material misrepresentation in the license application;

2. The licensee or any officer, partner, member or key management personnel has been convicted of fraud or dishonest practices, or is otherwise proven to be incompetent or untrustworthy;
3. The viatical settlement provider has demonstrated a pattern of unreasonable payments to viators;
4. The licensee or any officer, partner, member or key management personnel has been found guilty of or pleaded guilty to any felony or misdemeanor involving fraud or moral turpitude, regardless of whether a conviction has been entered by the courts;
5. The viatical settlement provider has entered into any viatical settlement contract that has not been approved under the laws of the Model Act, if adopted by the state.
6. The viatical settlement provider has failed to honor contractual obligations specified in the contract or purchase agreement;
7. The licensee no longer meets the requirements for initial licensure;
8. The viatical settlement provider has assigned, transferred or pledged a viatical policy to a person other than a viatical settlement provider licensed in the state, viatical settlement purchaser, an accredited investor or qualified institutional buyer; or
9. The licensee or any officer, partner, member or key management personnel has violated any provision of the Model Act, as adopted by the state.

The commissioner may suspend, revoke or refuse to renew the license of a viatical settlement broker or producer if the commissioner finds the individual has not followed state requirements or engaged in bad faith with one or more viators.

If the commissioner denies a license application or suspends, revokes, or refuses to renew a license of a viatical settlement provider, broker, or life insurance producer operating as a viatical settlement broker, the commissioner will conduct a hearing according to the state's administrative procedure act.

Viatical Settlement Contracts and Disclosure Statements

All viatical contracts and disclosure statements must be approved by the state's insurance commissioner prior to use. If the forms fail to meet all requirements, are unreasonable, contrary to the interests of the public, or in any way misleading or unfair to the viator, they will be disapproved. If the commissioner feels it necessary, he or she may also require the submission of advertising material for approval.

Reporting Requirements and Privacy

Each viatical settlement provider must file an annual statement on or before March 1 of each year with the commissioner relating to all transactions for viators that are residents of the state. The report must contain all information required by that state's regulations. Any individual data that could compromise the insured's or viator's privacy of personal, financial, or health information will be filed with the commissioner on a confidential basis.

Except as allowed or required by law, no party may disclose the identity of the insured, his or her financial or medical information to any other person, unless the disclosure:

1. Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have given prior written consent to do so;
2. Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have given prior written consent to do so;
3. Is provided in response to an inquiry by the state's commissioner, any other governmental officer or agency, or under mandatory reporting requirements of fraudulent viatical settlement acts;
4. Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;
5. Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and inured have provided prior written consent to do so.
6. Is necessary to allow the viatical settlement provider or broker, or their authorized representative, to make contacts for the purpose of determining health status; or
7. Is required to purchase stop loss insurance coverage or financial guaranty insurance.

As states consider adoption of the NAIC Model Act, they have the chore of protecting the privacy of those involved in viatical settlements while still keeping the legal language broad enough to allow licensed entities to notify the commissioner's office of unlicensed viatical activity. Insurers must also be able to make necessary disclosures without violating privacy laws.

Examination or Investigations

The Model Act says: *"The commissioner may conduct an examination under this Act of a licensee as often as the commissioner in his or her discretion deems appropriate after considering the factors set forth in this paragraph."*[2]

When a state commissioner or the commissioner's representative is considering conducting an examination he or she will consider consumer complaints, results of any financial statement analyses and ratios, changes in company management or ownership, actuarial opinions, independent CPA reports, and other relevant criteria. The commissioner may examine or investigate any person or business entity that is material to the licensee. If the licensee is not a resident of the state, the commissioner may accept an examination from the licensee's domicile state or port-of-entry state. Investigations will be made in cooperation, as far as practical, with the insurance supervisory officials of other states where the licensee transacts business.

Those licensed to work in the viatical settlement industry must retain copies for five years of all paperwork associated with the viatical settlement contracts or proposals of contracts. This would include proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications. They must, as stated, be kept for five years from the date of the proposal, offer, or execution of the contract or purchase agreement, whichever is later.

All checks, drafts, or other evidence and documentation related to the payment transfer, deposit or release of funds from the date of transaction must also be kept, as well as all other records and documents related to viatical settlements. In short, anything related to viatical settlement business should be kept for five years. It is better to keep more than necessary rather than less. If in doubt, keep it. Even after the five year period, if the commissioner requests these documents *and the individual still has the material,* he or she is obligated to turn them over.

All records must be legible and complete. Records may be kept in a paper format, by photograph, micro-process, magnetic, mechanical, or electronic media. Any process that accurately keeps the records and allows reproduction of them is acceptable.

When it is determined that an examination is prudent, the commissioner will issue an **examination warrant** appointing one or more examiners to perform it and instruct them as to the scope of the examination. The examiners will observe the guidelines and procedures in the Examiners Handbook adopted by the National Association of Insurance Commissioners (NAIC), unless the state has adopted different procedures or the commissioner feels other guidelines are appropriate.

[2] NAIC Model Act Section 7, subparagraph A(1)(a)

All individuals working in the viatical field that are contacted during the investigation must provide requested information in a timely and convenient manner. There must be free access at the individual's office to requested information at all reasonable hours. This would include access to books, records, accounts, papers, documents, assets, and computer recordings related to the licensee being investigated. The refusal of a licensee, his or her officers, directors, employees, or agents to submit to examination or to comply with reasonable written requests will be grounds for suspension or refusal of, or non-renewal of any license or authority to continue in the viatical settlement business *or any business subject to the insurance commissioner's jurisdiction.*

The commissioner has the power to issue subpoenas to any person, to administer oaths, and examine under oath any individual on any matter pertinent to the examination. If an individual refuses to obey a subpoena the commissioner may petition a court of competent jurisdiction and, with proper showing, the Court may enter an order compelling the person to appear and testify or produce requested evidence. Should the individual fail to obey the court order, he or she will be punished under contempt of court statutes.

The commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accounts, or other professionals as examiners. The reasonable cost of these individuals must be paid by the licensee being examined. Findings of fact and conclusions made as a result of the examination will be *prima facie*[3] evidence in any legal or regulatory action. The commissioner may terminate or suspend an examination in order to pursue other legal or regulatory actions that would apply to the state's insurance laws. The commissioner may also use and, if appropriate, make public any final or preliminary examination report or other documents as he or she considers appropriate for the situation, unless the state has confidential statutes in place that would prevent such actions.

Examination reports are comprised of only facts gathered from books, records, or other documents of the licensee, its agents, or other persons connected to the investigation. Only conclusions and recommendations the examiners find to be reasonably warranted by the facts will be included.

The examiner in charge will file a verified written report under oath with the commissioner within sixty days following completion of the examination. The insurance commissioner will then transmit the report to the licensee, with a notice providing a reasonable opportunity of up to thirty days to make a written submission or rebuttal with respect to any matters in the examination report. If the commissioner feels regulatory

[3] *prima facie:* Latin for "as it first appears"

action is appropriate for the situation, he or she may initiate any proceedings or actions allowed by state law.

Confidentiality of Examination Information

Names and identifying information of all viators must be considered private and confidential information. They may not be disclosed by the commissioner, unless required by law. All examination reports and other documents related to the licensee's investigation are confidential and generally are not subject to subpoena. Such information would not be subject to discovery or admissible in evidence in any private civil action.

Documents or other information in the possession or control of the NAIC and its affiliates and subsidiaries are confidential by law and privileged, not subject to subpoena, and not subject to discovery or admissible in evidence in any private civil action if they are:

1. Created, produced, or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination or assisting a commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or
2. Disclosed to the NAIC and its affiliates and subsidiaries by a commissioner.

None of the individuals connected to the examination, including the NAIC and its affiliates and subsidiaries, are permitted to testify in any private civil action concerning any confidential documents, materials or information obtained during the investigation. The commissioner may share documents and other information, including confidential and privileged documents, with other state, federal, international regulatory agencies and authorities, and the NAIC as long as they agree to maintain the confidentiality and privileged status of all information.

The commissioner may receive communications, including confidential and privileged documents, from the NAIC and from regulatory and law enforcement officials of other jurisdictions. The commissioner will maintain all material and information as confidential or privileged, as long as its confidential or privileged status was communicated.

Conflict of Interest

The commissioner may not assign any individual as an examiner if he or she has either a direct or indirect conflict of interest. A person who is affiliated with the management of or owns a pecuniary interest in any person subject to examination would constitute a conflict of interest. This does not necessarily mean an examiner could not also be a viator, an insured in a viaticated insurance policy, or a beneficiary in a policy that was viaticated.

Immunity from Liability

The commissioner, his or her authorized representatives, and any authorized examiner are immune from liability for statements made or conduct performed associated with his or her duties during an investigation as long as they acted in good faith. Nor is any person or company liable that communicated or delivered information or data to the commissioner, per his or her request, due to an examination as long as the service was performed in good faith and without fraudulent intent.

Despite the immunity afforded, a person who is still named as a party in a civil cause action for libel or slander is entitled to an award of attorney's fees and costs incurring as a result of that action in most cases.

Disclosure to Viator

With each application for a viatical settlement, under the NAIC Model Act, by the time the contract is signed, the viatical settlement provider or broker must provide the viator with at least the following disclosures:

1. There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy;
2. That a viatical settlement *broker* represents exclusively the viator – not the insurer or viatical settlement provider. He or she owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator.
3. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes. It may be wise to get assistance from a professional tax advisor.
4. Proceeds of the viatical settlement could be subject to the claims of creditors.
5. Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements. It would be wise to seek advice from the appropriate government agencies.
6. The viator has the right to rescind a viatical settlement contract before the earlier of sixty (60) calendar days after the date upon which the viatical settlement contract is executed by all parties or thirty (30) calendar days after the viatical settlement proceeds have been paid to the viator. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given and the viator repays all proceeds and any premiums, loans and loan interest paid on behalf of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract will be considered rescinded, subject to repayment of all viatical settlement proceeds including any premiums,

loans and loan interest that was paid on the viator's behalf. These funds must be repaid within sixty days of the insured's death.

7. Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the group certificate has been transferred and the beneficiary has been designated.
8. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium, to be forfeited by the viator. It may be wise to consult with a financial adviser.
9. The viator must receive a brochure describing the process of viatical settlements. The NAIC's form for the brochure will be used unless another form is developed or approved by the state's commissioner.
10. The disclosure document will contain the following language: *"All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."*
11. Following execution of a viatical contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number. This contact will be limited to once every three months if the insured has a life expectancy of more than one year. The insured may be contacted no more than once per month if the insured has a life expectancy of one year or less. All such contact must be made only by a viatical settlement provider licensed in the state in which the viator resides at the time of the viatical settlement or by the provider's authorized representative.

A viatical settlement ***provider*** must give the viator at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosure must be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

1. The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy that will be viaticated;
2. The name, business address and telephone number of the viatical settlement provider;

3. Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement purchaser;
4. If a life insurance policy has been issued as a joint policy or involves family riders that cover the life of anyone else other than the terminally ill individual, the viator must be informed of the possible loss of coverage on the other lives under the policy and he or she must be advised to consult with his or her insurance producer or the issuing insurer for advice on the proposed viatical settlement.
5. It must state the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider must also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract; and
6. State whether the funds will be escrowed with an independent third party during the transfer process. If so, it must state the name, business address, and telephone number of the independent third party escrow agent and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

A viatical settlement ***broker*** must provide the viator with at least the following disclosure by the time the viatical settlement contract is signed by all parties. It must be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

1. The name, business address and telephone number of the viatical settlement broker;
2. A full, complete and accurate description of all offers, counter-offers, acceptances and rejections relating to the proposed viatical settlement contract;
3. A written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer n connection with the proposed viatical settlement contracts;
4. The amount and method of calculating the broker's compensation. The term **"compensation"** includes anything of value paid or given to a viatical settlement broker for the placement of a policy; and
5. If any portion of the viatical settlement broker's compensation is taken from a proposed viatical settlement offer, the broker must disclose the total amount of the offer and the percentage that will be the broker's compensation.

If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider must notify the insured of the change in writing within twenty days after the change.

A viatical settlement provider or its investment agent must provide the viatical settlement purchaser with at least the following disclosures prior to the date the purchase agreement is signed by all parties. The disclosures must be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or investment agent and must make the following disclosure to the viatical settlement purchaser:

1. The purchaser will receive no returns, such as dividends and interest, until the insured dies and a death claim payment is made.
2. The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual "guaranteed" rate of return cannot be determined
3. The viatical life insurance contract should not be considered a liquid asset. It is not possible to predict the exact timing of its maturity; funds are not usually available until the death of the insured. There is no established secondary market for resale of such products, so there may be no possibility of selling the purchase to another.
4. The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.
5. The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the purchase agreement. These costs may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party must be disclosed.
6. The purchaser is responsible for payment of the insurance premiums and other costs related to the policy if the insured returns to health. The amount of the premiums must be disclosed, if applicable.
7. State the name, business address and telephone number of the independent third party providing escrow services and the relationship to the broker.
8. The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser must be disclosed.
9. State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract if the policy is later determined to be null and void.
10. Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, and name the party that would be responsible for payments of additional premiums. If

a group policy is terminated and replaced by another group contract, state that there may be no right to convert the original coverage.

11. Disclose the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits if the insurer rescinds the policy within the contestability period.
12. Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary. If the purchaser is only the beneficiary (not also the owner) disclose the special risks associated with that status, including the risk that the beneficiary may be changed or the premium may not be paid.
13. Describe the experience and qualifications of the person who determines the life expectancy of the insured, such as independent physicians or specialty firms that weigh medical and actuarial data, the information this projection is based on, and the relationship of the projection maker to the viatical settlement provider, if any.
14. Disclosure to an investor must include distribution of a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure may be used unless one has been developed by the state.

At the time of an assignment, transfer, or sale of an insurance policy, in part or whole, the viatical settlement *provider* or its investment agent must provide the purchaser with at least the following disclosures no later than the time of the transaction. The disclosures must be contained in a document signed by the viatical settlement purchaser and provider, or the provider's agent.

1. It must disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.
2. It must state whether premium payments or other costs related to the policy have been escrowed, and if so, the date upon which the escrowed funds will be depleted. It must further state whether the purchaser will be responsible for premium payments and other policy costs after the funds have been depleted. If he or she will be responsible, the amount of premiums and other costs must be stated.
3. If the policy premiums and other costs have been waived, it must state whether the investor will be responsible for premium payments if the issuing insurer terminates the waiver. The amount of the premiums must also be stated.
4. It must disclose the type of life insurance policy being sold, such as whole life, term, universal or a group policy certificate. It must also state any additional benefits that are in the policy and the policy's current status.
5. If the policy is a term life insurance policy (having no cash values) it must disclose the policy's special risks, including the purchaser's responsibility for

higher premiums if the viator continues the term policy at the end of the current term (many term policies increase in cost at each policy renewal anniversary).

6. It must state whether the policy is contestable. Policies still in the contestable time period contain additional risk for the purchaser.
7. It must state whether the policy's issuing insurance company has any rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what those rights are, and under what conditions the insurer's rights could be activated.
8. It must state the name and address of the person responsible for monitoring the insured's condition. It should describe how often contact is made with the insured and how the date of death is determined. It should also state how and when this information will be relayed to the purchaser of the life insurance policy.

Under the NAIC Model Act, the viatical settlement purchaser has three days from the time the disclosures are received to void the purchase agreement. During these three days, the purchaser should completely read the disclosures and seek council if any of them are not fully understood.

Disclosure to Insurer

Viatical settlement providers and brokers must fully disclose their plans, transactions, or series of transactions to the policy's issuing insurer before initiation of the viatical settlement during the first five years of the policy. As always, if the state has mandated different time periods or procedures it is the responsibility of the provider or broker to know and follow their state's laws and regulations.

General Rules

When a viatical settlement provider enters into a viatical settlement contract, he or she must first obtain a written statement from the viator's licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into the contract. The provider must also obtain a document from the insured releasing their medical records to the licensed viatical settlement provider, broker, and life policy's issuing insurance company.

Within 20 days after the viator executes the documents required to transfer rights under the insurance policy or within 20 days of entering any agreement, option, promise, or any other form of understanding, whether expressed or implied, to viaticated the life insurance policy, the viatical settlement provider must give written notice to the issuing insurer that the policy has or will become a viaticated policy, along with a request for *verification of coverage*. A copy of the insured's medical release and a copy of the

viator's application for a viatical settlement should be included. The NAIC's form for verification of coverage would be used, unless the state has developed its own form.

The insurer must respond to the verification of coverage request within 30 calendar days of the date the request was received. The company would indicate whether, based on medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer must accept a request for verification of coverage made on an NAIC form or any form approved by the state's commissioner. The request (on the proper form) may be made by facsimile (fax), email (electronic copy) or by mailing the original to the insurer, accompanied by the viator's signed authorization.

Prior to, or at the time of execution of the viatical settlement contract, the viatical settlement provider must obtain a witnessed document in which the viator consents to the contract, represents that the viator has a full and complete understanding of the viatical settlement contract, has full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the contract freely and voluntarily and, where applicable, acknowledges that the insured has a terminal or chronic illness, which was diagnosed after the life insurance policy was issued.

If the viatical settlement broker performs any of these activities that are required of the provider, it is not necessary for the provider to also complete them. All medical information obtained by any licensee is subject to all applicable provisions relating to confidentiality.

All viatical settlement contracts, under the NAIC Model Act, must allow the viator the absolute right to rescind the contract before the earliest of *sixty calendar days* following the date the contract was executed by all parties, or *thirty calendar days* after the viatical settlement proceeds have been sent to the viator. The viator may be required to give notice and repay the viatical settlement provider all proceeds, including any premiums, loans and loan interest that were paid on his or her behalf.

If the insured dies during the rescission period the viatical settlement contract will be deemed rescinded. The viatical settlement provider or purchaser will be reimbursed for any proceeds, premiums, loans, or loan interest that he or she paid on behalf of the insured within 60 calendar days of the insured's death.

If a viatical settlement contract is rescinded, any commissions or other compensation that was paid to a viatical settlement broker must be refunded to the viatical settlement provider within five business days following receipt of written demand from the provider. The viator's notice of rescission or notice of the insured's death (if rescinded due to death within the applicable rescission period) must be sent with the repayment demand.

The viatical settlement purchaser has the right to rescind a viatical settlement contract within three days after the disclosures have been received.

The viatical settlement provider must instruct the viator to send the required executed documents necessary to change policy ownership, assignment, or beneficiary designation directly to the independent escrow agent. Within three business days from the date the provider or escrow agent receives them the provider must pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). When the settlement proceeds have been paid into the escrow account, the escrow agent must deliver the original change in ownership, assignment, or beneficiary change forms to the viatical settlement provider or related provider trust or other designated representative of the provider. Upon receipt of the acknowledgement of transfer, the escrow agent will pay the settlement proceeds to the viator.

If payment is not made to the viator for the viatical settlement contract within the time requirements, the viator may void the contract for lack of payment. Once payment is made the contract may be accepted by the viator and reactivated. Funds are considered to be paid as of the date the escrow agent either releases funds to the viator through wire transfer or sends a check to the viator through the US postal service or some other nationally recognized delivery service.

Periodically contact will be made with the insured for the purpose of determining current health status. Such contact may only be made by the viatical settlement provider or broker licensed in the state. Contact *for the purpose of checking health status* is limited to once every three months for insured's having a life expectancy of more than one year and no more than once per month for those with a life expectancy of less than a year. The provider or broker must explain contact procedures at the time the contract is entered into. Contact for reasons other than determining current health is not limited and may be made as often as necessary in the process of conducting business. Viatical settlement providers and brokers are responsible for their authorized representatives; if such representatives contact viators more often than allowed for health status purposes they will be held accountable.

Prohibited Practices

It is a violation, under the NAIC's Model Viatical Act, to enter into a viatical settlement contract prior to the application or issuance of a life insurance policy that will be used for the contract. It is also a violation to do so within a five-year period beginning with the date of issuance of the policy or certificate, unless the viator certifies to the settlement provider that one or more of the following conditions have been met within that five-year period:

1. The policy was issued upon the viator's exercise of conversion rights from a group or individual policy, provided the total time covered under the conversion plus the time covered under the prior policy was at least 60 months (thus meeting the five year requirement). Group policies will be calculated without regard to any change in insurance carriers, provided the coverage was continuous and under the same group sponsorship.
2. The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions were met within the five year period:
    a. The viator or insured is terminally or chronically ill;
    b. The viator's spouse died;
    c. The viator divorced;
    d. The viator retired from full-time employment;
    e. The viator is not able to maintain full-time employment due to a physical or mental disability, confirmed by a physician;
    f. A final order, judgment or decree is entered by a court of competent jurisdiction, on the viator's application of a creditor, adjudicating the viator bankrupt or insolvent, or approving a petition seeking the viator's reorganization or appointing a receiver, trustee or liquidator to all or a substantial part of the viator's assets.
3. The viator enters into a viatical settlement contract more than two years following the policy's issuance date and meets the following conditions:
    a. Policy premiums were exclusively funded with unencumbered assets;
    b. There is no agreement or understanding with any other person to guarantee liability or to purchase the policy, including forgiveness of a loan; and
    c. Neither the insured nor the policy has been evaluated for settlement.

All required evidence must be submitted to the insurer with a request for verification of insurance. The copies must be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct. The copies sent to the issuing insurer will be deemed to conclusively establish that the viatical settlement contract meets legal requirements and the insurer must timely respond to the request.

In responding to the request for verification of coverage, the issuing insurance company may require the viator, insured, viatical settlement provider or broker to sign any forms, disclosures, consent or waiver forms that have not been expressly approved by the state's commissioner for use in connection with viatical settlement contracts. Upon receipt of a properly completed request for change of ownership or beneficiary designation, the insurer must respond in writing within 30 calendar days with written acknowledgement confirming the requested changes have been made or stating reasons why they cannot be completed. Insurers may not unreasonably delay making changes in ownership or beneficiary designations or in any way interfere with lawful viatical settlement contracts.

Conflicts of Interest

Viatical settlement ***brokers*** may not solicit an offer from, effectuate a viatical settlement with or make a sale to any viatical settlement provider, purchaser, investment agent, financing entity, or related provider trust if he or she has current control, previous control, or common control with them. This refers only to viatical settlement contracts or insurance policies.

Viatical settlement ***providers*** may not knowingly enter into a viatical settlement contract with a viator if, in connection with the contract, anything of value will be paid to the viatical settlement broker that is controlling, controlled by, or under common control with that provider, purchaser, investment agent, financing entity, or related provider trust. If either a viatical settlement broker or provider does so, it will be deemed a fraudulent viatical settlement act.

Viatical settlement providers may not enter into a contract unless the viatical settlement promotional, advertising and marketing materials have been previously filed with the state's insurance commissioner's office. Under the NAIC Model Act, at no time may any marketing materials state or make any reference to the insurance being "free" for any period of time. The inclusion of any reference in the marketing materials that might cause a viator to reasonably believe the insurance is free for any time period is considered a violation of the NAIC Act.

Unless it is provided in the life insurance policy, no life insurance producer, insurance company, investment agent, viatical settlement broker, or provider, may make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder.

Advertising for Viatical Settlements and Purchase Agreements

This section of the NAIC Model Act is designed to provide prospective viators and viatical settlement purchasers with clear, understandable statements in the viatical settlement advertisements and to assure the clear, truthful and adequate disclosure of benefits, risks, limitations, and exclusions of viatical settlement contracts or viatical settlement purchase agreements that are bought or sold. They intend to accomplish this by establishing guidelines and standards of permissible and impermissible conduct when advertising viatical settlements to assure that product descriptions are presented in a way that prevents unfair, deceptive or misleading advertising and lends to providing accurate presentation and description of viatical settlements.

Partnership Long-Term Care Policies

These rules apply to any viatical settlement contract advertising and to any related products or services intended for dissemination in the state, including Internet advertising viewed by people located in the state. If there are federal regulations that apply these requirements would not minimize or diminish them, but rather are designed to minimize or eliminate conflict.

Every viatical settlement licensee must establish and maintain a system of control over the content, form, and method of dissemination of all advertisements of its viatical contracts, products and services. Regardless of who writes, creates, designs, or presents the advertisements responsibility rests on the viatical settlement licensees, along with the individual who created or presented the advertisement. A system of control must include regular notification of existing requirements at least once each year to agents and others authorized to produce advertising. They should also be reminded routinely that advertisements must be approved by the commissioner, if that is the case in their state.

Advertising must be truthful; there should not be any misleading facts or implications. The form and content of an advertisement for viatical settlement contracts, viatical settlement purchase agreements, products, or services must be sufficiently complete and clear to avoid deception or misunderstandings. It should not have the capacity or tendency to mislead or deceive, which will be determined by the state's commissioner from the overall impression left by the advertisement based on a person of average education or intelligence within the population segment the ad targets.

Certain viatical settlement advertisements are considered false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include, but are not necessarily limited to, the following representations:

1. Words such as "guaranteed," "fully secured," "100 percent secured," "secure," "fully insured," "safe," "backed by rated insurance companies," "backed by federal law," "backed by state law," "backed by state guaranty funds," or similar representations;
2. Phrases such as "no risk," "minimal risk," "low risk," no speculation," "no fluctuation," or similar representations;
3. Representations such as "qualified or approved for individual retirement accounts, Roth IRAs, 401(k) plans, simplified employee pension plans, 403(b), Keogh plans, TSA, other retirement account rollovers," "tax deferred," or similar representations;
4. Utilization of the word "guaranteed" to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;
5. Statements like "No sales charges or fees" or similar representations;
6. "High yield," "superior return," "excellent return," "high return," " quick profit," or similar representations; and

7. Purported favorable representations or testimonials about the benefits of viatical settlement contracts or purchase agreements as an investment that has been taken out of context form newspapers, trade papers, journals, radio and television programs, and all other forms of print or electronic media, such as the internet.

Information that is required to be disclosed should not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertising so as to be confusing or misleading.[4]

Advertisements may not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the possibility of misleading or deceiving viators or contract purchasers. The fact that viators and contract purchasers have the ability to inspect the contract prior to the sale, may have a "free look" period, or receive a refund if not satisfied does not remove the legal requirements regarding truthful advertising. An advertisement may not use the name or title of a life insurance company or policy unless the advertisement has been approved by the insurer.

An advertisement may not say that premium payments will not be required in order to maintain the policy of a viatical settlement contract or purchase agreement, unless that is the actual fact. Advertisements may not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable or in any manner incorrect or an improper practice.

The words "free," "no cost," "without cost," "no additional cost," "at no extra cost," or words of similar text may not be used with respect to any benefit or service, unless true. Advertisements may specify the charge for a benefit or service or may state that a charge is included in the payment or use other appropriate wordage.

Testimonials, appraisals or analysis used in advertisements must be genuine, represent the current opinion of the author, and be applicable to the viatical settlement contract or purchase agreement, product or service advertised. It must be accurately stated with sufficient completeness to avoid misleading or deceiving prospective viators or purchasers as to the nature or scope of the testimonials, appraisals, analysis or endorsements. When testimonials, appraisals or analysis are used, even though they may have originated with another person, the licensee is responsible for them, and the statements are subject to all provisions. When an endorsement refers to benefits received under a viatical settlement contract or purchase agreement, all pertinent information must be retained for five years following its use.

If the person making the testimonial, appraisal, analysis or endorsement has a financial interest in the party making use of them through a related entity, that fact must be

[4] Nothing in this education course should ever be used in advertising or for the purpose of making a sale.

prominently disclosed in the advertisement. Advertisements may not state or imply that any organization or entity has given their endorsement, unless that is the fact; the relationship between the organization and the viatical settlement licensee must be disclosed.

Information used in advertisements must accurately reflect recent and relevant facts. The source of all statistics must be stated in the ad. The name of the viatical settlement licensee must be clearly identified in all ads about the licensee or its viatical settlement contract or purchase agreement, products or services. Contracts must be identified by form number or some other appropriate description.

Advertisements are not allowed to disparage insurers, viatical settlement providers, brokers, investment agents, insurance producers, policies, services or methods of marketing.

If an application is part of an advertisement, the name of the viatical settlement provider must be shown on the application. Ads may not use names that might mislead or deceive readers of the true identity of the licensee or create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation.

Advertisements may not use symbols, colors, or materials that would lead a prospective viator or purchaser to assume it was connected in some manner to a government program or agency. Nor may the ad suggest or create the impression that viatical contracts are recommended or endorsed by any government entity. The ad may state that the licensee is licensed in the state where the advertisement appears, as long as it does not exaggerate that fact or suggest that competitors are not licensed. The ad may suggest the reader consult the licensee's web site or the department of insurance to find out if the state requires licensing and confirm their licensed status.

The name of the actual licensee must be stated in all of its advertisements. They may not use trade names, group designations, names of any affiliates or controlling entities, service marks, slogans, symbols or other devices that would be misleading or deceptive to the reader as to the ad's sponsor.

If the advertiser emphasizes the speed with which the viatication will occur, the ad must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator. If the ad emphasizes dollar amounts payable to viators, it must state the average purchase price as a percent of the policy face values obtained by viators contracting with the licensee during the past six months. All of this is designed to prevent false assumptions by viators and purchasers.

Fraud Prevention and Control

It should be no surprise that the NAIC Viatical Model Act prohibits fraudulent viatical settlement activity. Additionally, individuals may not knowingly or intentionally interfere with the enforcement of the provisions of the Model Act or investigations of suspected or actual violations of it. An individual in the business of viatical settlements may not knowingly or intentionally hire, contract with, or permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

Fraud Warnings

Contracts, purchase agreement forms, and applications for viatical settlements, regardless of the form of transmission, must contain the following statement or a substantially similar statement:

> *"Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison."*

The actual statement will vary based on its reference. For example, there will be a difference between a viatical settlement contract and a purchase agreement.

Individuals are required to report any suspected fraudulent viatical settlement activity to the state commissioner. This is certainly true of those working in the viatical settlement industry, but it is also required of those outside the industry.

Immunity from Liability

A person who reports suspected fraudulent viatical settlement activity does not have civil liability for doing so as long as the suspicion is reported to the state's insurance commissioner. It is important, in maintaining immunity, to follow required procedures. Calling the newspaper rather than the commissioner *could cause liability*, for example. Immunity would also not exist for those who made statements *with actual malice*.

Immunity will exist for reporting suspicion of fraudulent viatical acts if the information is provided to or received from:

1. The insurance commissioner, his or her employees, agents, or representatives;
2. Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;
3. An individual involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees or representatives.

4. The National Association of Insurance Commissioners (NAIC), National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents or representatives, or other regulatory bodies that oversee life insurance, viatical settlements, securities or investment fraud; or
5. The life policy's issuing life insurance company.

If suit is brought against an individual who followed correct procedures in reporting suspected fraudulent viatical activity, he or she is entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort coming from reporting their suspicions.

Confidentiality

Any information given to the commissioner or other authorized party regarding suspected fraudulent viatical acts is privileged and confidential; it will not be made part of any public record. Information obtained in an investigation will not be subject to discovery or subpoena in a civil or criminal action. This does not prohibit release by the commissioner of documents and evidence obtained in an investigation or actual fraudulent viatical settlement acts:

1. In administrative or judicial proceedings to enforce laws administered by the commissioner.
2. To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlements acts or to the NAIC.
3. At the discretion of the commissioner he or she may give information to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

The NAIC Model Act does not preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law.

Viatical Settlement Antifraud Initiatives

Viatical settlement providers and brokers must have antifraud initiatives in place that can reasonably be expected to detect, or prevent fraudulent viatical settlement acts. The commissioner may order modifications that could reasonably be expected to prevent or detect fraud.

Antifraud initiates include:

1. Fraud investigators, who may be employees or contractors of the provider or broker or
2. An antifraud plan that must be submitted to the commissioner.

An antifraud plan should include, but is not limited to:

1. A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures to resolve material inconsistencies between medical records and insurance applications;
2. A description of the procedures for reporting suspected fraudulent viatical settlement acts to the commissioner;
3. A description of the plan for antifraud education and training of underwriters and other personnel; and
4. A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

Antifraud plans that are submitted to the state insurance commissioner are privileged and confidential. They will not be made public record and are not subject to discovery or subpoena in a civil or criminal action.

Injunctions; Civil Remedies; Cease-and-Desist

The state commissioner may seek an injunction in a court of competent jurisdiction in addition to the penalties and other enforcement provisions contained in the NAIC Model Act. He or she may apply for temporary and permanent orders that the commissioner determines are necessary to stop the individual from continuing to commit violations. Those harmed by the acts of another may bring a civil action against them.

If a viatical settlement purchase agreement violates any of the Acts, the purchase agreement becomes voidable and subject to rescission by the viatical settlement purchaser, upon return of the policy he or she received. Suit for the rescission may be brought in a court of competent jurisdiction or where the alleged violator lives or has a principal place of business or where the alleged violation occurred.

The commissioner may issue a cease-and-desist order when an individual is violating any provision of the NAIC Act or state regulations. If the commissioner feels activity violates this act and presents an immediate danger to the public, he or she may issue an emergency cease-and-desist order reciting the facts that require immediate action. The cease-and-desist order then becomes effective immediately upon service of a copy on the respondent and remains effective for 90 days. If the commissioner begins non-

emergency cease-and-desist proceedings the emergency cease-and-desist order remains effective, unless discharged by a court with jurisdiction.

A person convicted of a fraudulent viatical settlement act must be ordered to pay restitution to those harmed. Restitution must be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

Fines and imprisonment might include:

1. Imprisonment for not more than 20 years or to payment of a fine of not more than $100,000, or both, if the value of the viatical settlement contract is more than $35,000;
2. Imprisonment for not more than 10 years or to payment of a fine of not more than $20,000, or both, if the value of the viatical settlement contract is more than $2,500 but not more than $35,000;
3. Imprisonment for not more than five years or to payment of a fine of not more than $10,000, or both, if the value of the viatical settlement contract is more than $500 but not more than $2,500; or
4. Imprisonment for not more than one year or to payment of a fine of not more than $3,000, or both, if the value of the viatical settlement contract is $500 or less.

Unfair Trade Practices

Violation of the Viatical Model Act, including commission of fraudulent viatical settlement acts, will be considered an unfair trade practice under the state's Unfair Trade Practices Act, subject to the penalties stated.

Authority to Promulgate Regulations

The state's commissioner has the authority to promulgate regulations implementing the NAIC Viatical Model Act, establish standards for evaluating reasonableness of payments under viatical settlement contracts for those who are terminally or chronically ill, and establish appropriate licensing requirements, fees, and standards for continued licensure of providers, brokers, and investment agents. The commissioner may require a bond or other mechanism for financial accountability for providers and brokers. He or she may also adopt rules governing the relationship and responsibilities of insurers and viatical settlement providers, brokers, and investment agents during the viatication of a life insurance policy or group certificate.

If any portion of the Act or any Model Act amendments are held invalid by a court, the remainder of the Act or its applicability to other persons or circumstances will not be affected.

Partnership Long-Term Care Policies

Filial Responsibility Laws

Few people are familiar with filial responsibility laws because they have seldom been enforced, even when they are active laws. Around thirty states have laws on their books making adult children responsible for their parents if the parents cannot afford to take care of themselves financially. These laws may begin to be focused on by private industry when they are unable to collect fees. We are referring primarily to nursing homes that took care of people who were not on Medicaid, receiving care as a private-pay person.

In May of 2012 a Pennsylvania appeals court found a son liable for his mother's $93,000 nursing home bill under that state's filial responsibility laws. This can be looked up under Health Care & Retirement Corporation of America v. Pittas (PA. Super. Ct., No. 536 EDA 2011, May 7, 2012). Of course it was appealed but in March 2013 the state's Supreme Court declined to hear the case, which meant the son remained liable since the ruling was deemed final.

It is interesting that the mother left the nursing home after rehabilitation and moved to Greece. She also had two other adult children but the nursing home went only after the one son since he had substantial assets. In other words, they looked at where the money was and pursued it. During the appeals process, the Pennsylvania Superior Court agreed with the trial court that he could be held liable. The law does not require it to consider other sources of income or wait to see if Medicaid will eventually pay the claim. It further said the nursing home had every right to select which adult child to sue for the money.

The Deficit Reduction Act (DRA) of 2005 made it much more difficult for the elderly to transfer assets in order to qualify for Medicaid so we may be seeing more lawsuits of this type in states with filial responsibility laws. Nursing homes have few options; when a resident is unable to pay and Medicaid is not paying the bills this type of lawsuit may be their only option.

This is not something that legal minds are unaware of. In 2005 Matthew Pakula said he expected more companies to begin going after adult children for payment of their parent's medical bills. Filial responsibility statutes establish a duty of adult children to care for their elderly impoverished parents. When enforced, the statutes require the child or children to do so. The states could also legally use the laws to require children to reimburse state programs, such as Medicaid, although we currently do not expect that to happen.

There are no uniform federal filial responsibility statutes so this would most likely occur under individual state laws as states feel the crunch of the arriving baby-boom generation

eating up their budget for Medicaid. State laws usually allow either a one-time payment from the child or allow them to make installment payments. It is very unlikely that the federal government would seek to enact filial responsibility laws so this will remain a state issue.

In the past filial responsibility laws have rarely been used by the states so we can expect the primary users of it to be institutions such as nursing homes. Since the 1960s federal law (United States Code Title 42) has prevented the states from considering anyone other than a legal spouse when determining eligibility of an applicant or recipient of Medicaid or other poverty programs. Realize this law only applies to *eligibility of a program*, not payment after services have been received from private parties.

Our filial responsibility statutes come from England's Elizabethan Poor Relief Act of 1601. It required the "father and grandfather and the mother and grandmother and the children of every poor, blind, lame, and impotent person" to support others within their family as they were able to. Supporting family members has been largely considered a moral requirement, not a legal one. The duty to care for parents is statutorily created and does not exist in common law.

The question then becomes: when is a parent (or any person for that matter) considered impoverished? State statutes define this in a variety of ways and how it is defined may become extremely important as the numbers of elderly increase over the next ten years. Some states define it in terms of income rather than assets but most laws combine the two in some way. For example, in 1994 the case of Savoy v. Savoy (PA) concerned an elderly woman whose income from Social Security was not enough to maintain "reasonable care and maintenance." The court termed her indigent and made her relatives liable for her support; being poor does not always mean an individual has no income, as this case indicated.

Less than a third of Americans have adequately prepared for two or three years of nursing home costs or home care, according to AARP. As the baby-boomers enter the elder years we can be sure this lack of preparations will hit the nursing homes. Some of the patients will be covered by Medicaid but not all of them.

As previously stated, many Americans (although fewer than we might have guessed) use asset transfer laws as a means shifting assets for Medicaid qualification. Usually the assets are transferred to their children as a sort of "inheritance protection plan." Now those same children may find themselves sued by nursing homes under their states filial responsibility statutes. If this begins happening regularly, asset shifting will become irrelevant.

Partnership Long-Term Care Policies

Statistically, few people as a percentage of the whole, shift assets. Most people spend down what they have before an individual ever reaches the stage of needing care in a nursing home.

Each state approaches filial responsibility statutes in their own way, although all of the laws have some similarities. Some use the civil courts to obtain financial support, called "cost recovery," and others specify a criminal penalty for filial nonsupport. A few states use a mix of both.

The statutes may also limit the amount of the children's liability using a variety of specifications such as whether or not the child has adequate income for their own support and make allowances for financial changes that happen in their lives. In other words, if a child is initially required to supply support, but then loses a job, he or she can request a re-qualification of their situation. Many states also look at whether the parent deserted or abandoned their child as a qualification of filial responsibility.

The following is a list of the states with filial responsibility statutes. Since these laws are being looked at by many states do not depend on this list; check your state to be sure.

1. **Alaska** Stat. 25.20.030, 47.25.230 (Michie 2000)
2. **Arkansas** Code Ann. 20-47-106 (Michie 1991)
3. **California** Fam. Code 4400, 4401, 4403, 4410-4414 (West 1994), California Penal Code 270c (West 1999), California Welf. & Inst. Code 12350 (West Supp. 2001)
4. **Connecticut** Gen. Stat. Ann. 46b-215, 53-304 (West Supp. 2001)
5. **Delaware** Code Ann. tit. 13, 503 (1999)
6. **Georgia** Code Ann. 36-12-3 (2000)
7. **Indiana** Code Ann. 31-16-17-1 to 31-16-17-7 (West 1997); Indiana Code Ann. 35-46-1-7 (West 1998)
8. **Iowa** Code Ann. 252.1, 252.2, 252.5, 252.6, 252.13 (West 2000)
9. **Kentucky** Rev. Stat. Ann. 530.050 (Banks-Baldwin 1999)
10. **Louisiana** Rev. Stat. Ann. 4731 (West 1998)
11. **Maryland** Code Ann., Fam. Law 13-101, 13-102, 13-103, 13-109 (1999)
12. **Massachusetts** Gen. Laws Ann. ch. 273, 20 (West 1990)
13. **Mississippi** Code Ann. 43-31-25 (2000)
14. **Montana** Code Ann. 40-6-214, 40-6-301 (2000)
15. **Nevada** Rev. Stat. Ann. 428.070 (Michie 2000); Nev. Rev. Stat. Ann. 439B.310 Michie 2000)

16. **New Hampshire** Rev. Stat. Ann. 167:2 (1994)
17. **New Jersey** Stat. Ann. 44:4-100 to 44:4-102, 44:1-139 to 44:1-141 (West 1993)
18. **North Carolina** Gen. Stat. 14-326.1 (1999)
19. **North Dakota** Cent. Code 14-09-10 (1997)
20. **Ohio** Rev. Code Ann. 2919.21 (Anderson 1999)
21. **Oregon** Rev. Stat. 109.010 (1990)
22. **Pennsylvania** Cons. Stat. 1973 (1996)
23. **Rhode Island** Gen. Laws 15-10-1 to 15-10-7 (2000); R.I. Gen. Laws 40-5-13 to 40-5-18 (1997)
24. **South Dakota** Codified Laws 25-7-28 (Michie 1999)
25. **Tennessee** Code Ann. 71-5-115 (1995), Tenn. Code Ann. 71-5-103 (Supp. 2000)
26. **Utah** Code Ann. 17-14-2 (1999)
27. **Vermont** Stat. Ann. tit. 15, 202-03 (1989)
28. **Virginia** Code Ann. 20-88 (Michie 2000)
29. **West Virginia** Code 9-5-9 (1998).
30. **Puerto Rico**

At one time there were 45 U.S. states with filial support laws so it is important to know if your state currently has them. Some states repealed theirs after Medicaid took a larger role in the lives of elderly Americans. We sometimes hear these laws referred to as "poor laws."

Although filial support laws have mostly been ignored we are entering a new era: the baby-boomers are entering retirement. As long-term care costs escalate and nursing homes increasingly find themselves caring for patients without financial means, many financial and legal experts expect to see more lawsuits using these old statutes. There is likely to be a future debate on whether or not we should expect children to pay for their parent's support. We may see, as lawsuits increase, children increasingly willing to fund Partnership policies for their parents as a preventative measure against future lawsuits.

So far lawsuits have appeared in both Pennsylvania and South Dakota. Initially these lawsuits concerned what is referred to as "unclean hands;" this means the children engaged in fraudulent conduct such as illegal transference of parental assets. That has changed; now courts are finding children responsible for their parent's bills without any evidence of wrongdoing on the part of the child.

Partnership Long-Term Care Policies

Any child reading this is probably wondering "Could I be liable?" As we've said, filial support laws vary from state to state so it is necessary to seek out the laws on a state-by-state basis and we have included the statutes that need to be looked up. We have not included any amendments that might exist so that should also be considered.

Some legal minds wonder if the success of lawsuits will sway more nursing home corporations to seek support from adult children with financial means. Few believe the states will seek Medicaid reimbursement from children but there is no way to know for certain that they will not. We know that some states allow for wage garnishment of adult children when they do not financially support their parents and liens may be placed against property.

The future will probably look closer at opportunities filial responsibility laws provide for both institutions and states when nursing homes have increasing losses and states are unable to balance their budgets. The money must come from somewhere; we cannot expect nursing homes to tack increasing costs on other patients to cover their losses from the poor. We cannot expect poor children to shoulder the costs of their state's elderly nursing home population.

Filial responsibility laws are complicated and if such a lawsuit is levied the adult child should certainly seek legal advice. However, it seems that prevention might still be the best policy. Partnership long-term care policies protect assets while still providing benefits for a wide range of elderly circumstances: home care, community care, assisted living, and nursing homes.

It should be noted that these laws can go in the reverse direction as well. In Pennsylvania an elderly couple's son died at age 47 leaving numerous unpaid medical bills. Debt collectors began pursuing them for payment of their son's bills under the filial responsibility laws.

It is likely that most cases using filial laws will be against children for their elderly parents who have entered the nursing home, but they can be used between any family members. Not all states may have the ability to sue any family member; some will specify who can be sued regarding unpaid bills. In the case of Pennsylvania, it states:

> *"All of the following individuals have the responsibility to care for and maintain or financially assist an indigent person, regardless of whether the indigent person is a public charge: (i) The spouse of an indigent person, (ii) A child of an indigent person; and (iii) A parent of the indigent person."*

We do not know if all states allow lawsuits to go in any direction and have made no attempt to verify on a state-by-state basis. Each person will need to check with their own particular state regarding this.

Partnership Long-Term Care Policies

Chapter 5

Terminology

Insurance policies are legal contracts. As such, terminology is very important. Long-term care policies must follow state and federally mandated terms. In the case of Qualified Long-Term Care plans, the definitions must satisfy those as amended by the U.S. Treasury Department.

Activities of Daily Living: Qualified long-term care policies have six activities of daily living. They are: bathing, continence, dressing, eating, toileting, and transferring.

Acute Condition: The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the patient's health status.

Adult Day Care: A program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the home.

Ambulation: In some policies, ambulation is considered an activity of daily living (ADL), but not in all contracts. Tax-qualified LTC policies have eliminated this as an ADL. Ambulation is the ability to move around independently, without help from others.

Assets: As it applies to the Partnership definition, assets mean savings and investments but exclude income. Medicaid qualification considers everything as assets, including income.

Automatic Benefit Increase Option (ABI): An inflation protection clause where the amount of LTC coverage increases automatically on an annual basis by a contractually specified amount. The increase may be on either a simple or compound basis, depending upon policy terms. The premium remains fixed since the increases were automatically built into the original premiums.

Bathing: Washing oneself by sponge bath or in either a tub or shower, including the task of getting into and out of the tub or shower.

Partnership Long-Term Care Policies

Benefit Trigger: Also known as a Policy Benefit Trigger, it is the condition or circumstance that "triggers" policy payment or Medicare payment.

Cognitive Impairment: A deficiency in the person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

Copayment: An amount paid in some Medicare plans and Medicare prescription drug plans for each medical service, such as a doctor's visit or prescription.

Custodial Care: Non-skilled personal care, such as help with the daily activities of living. It may include care that most people do for themselves, like using simple medications or nonprescription products. Medicare does not pay for custodial care.

Deficit Reduction Act of 2005: Signed by President George W. Bush in 2006, DRA allowed long-term care insurance Partnership models to be used in all 50 states. It increases the incentives to purchase long-term care insurance. This act also changed the asset transfer time period from three to five years making asset transfer more difficult if done for the purpose of Medicaid qualification.

Dollar-for-Dollar Asset Protection: In Partnership LTC policies, the amount of protection (benefits) purchased by the consumer protects an equal amount of assets (never income) from Medicaid qualification requirements. Therefore, since it matches dollar-for-dollar, an individual who buys $50,000 of insurance is also protecting $50,000 of assets from Medicaid spend-down requirements.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Elimination Period: Also called a waiting period, it is a long-term care policy deductible expressed as time not covered. It is the first days of confinement or benefit qualification that must be covered by the insured prior to the policy paying benefits.

Exceptional Increase: Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to

changes in laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

Extension of Benefits: When an insured is receiving qualified benefits under their policy at the time the policy cancels, most states require benefits to continue through the duration of the policy terms.

Future-Purchase Option (FPO): An inflation protection clause where the consumer agrees to a premium for a set amount of coverage. At specified time intervals the insurer offers to increase existing coverage for additional premium, but does not underwrite the increase.

Guaranteed Renewable Policy: A guaranteed renewable policy gives the insured the right to continue their coverage as long as they pay their premiums in a timely manner. The insurer may not unilaterally change the terms of the coverage or decline to renew. Premiums rates can (and often do) change.

Hands-On Assistance: Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

Home Health Care Services: Medical and non-medical services, provided to ill, disabled, or inform persons in their residences. Such services may include homemaker services, assistance with the activities of daily living and respite care services.

Hybrid Partnership Plans: Hybrid plans offer both dollar-for-dollar and total asset protection. The type of asset protection depends on the initial amount of purchased coverage. Total asset protection is available for policies with initial coverage amounts equal to or greater than a level defined by the state.

Income: For Medicaid purposes, income is anything received during a calendar month that is used or could be used to meet food or shelter needs. It includes cash, savings accounts, stocks, or property that can be converted to cash.

Indemnity Insurance Contracts: Indemnity plans pay a set amount of money per day or per covered ailment, but will not exceed the actual cost. In LTC policies, this would be expressed as $100 per confinement day, for example.

Inflation Protection: There are two types of inflation protection used in LTC policies (1) future purchase options (FPO) and (2) automatic benefit increase options (ABI). Refer to FPO or ABI.

Integrated Long-Term Care Policies: Integrated policies offer a more relaxed benefit formula than other models since they offer a “pool” of benefits that allow the policy

owner to make personal care choices, as long as those choices qualify under the terms of the policy contract. Once the pool of money is exhausted, the policy ends.

Level Premium: This term might be taken to imply that premiums will not increase, which is not necessarily true. Depending upon state language, level premium means that premium will not increase due to advancing age or increased claim submission, but claims can increase if they do so for all policyholders.

Long-Term Care: A variety of services that help people with health or personal needs and activities of daily living for an extended period of time (federally defined as no less than 90 days). Such care may be provided in a nursing home, but also in the patient's home, in an assisted living facility or some other community setting.

Look-Back Period: The period of time during which assets may be successfully transferred to another without affecting Medicaid eligibility. Previously set at three years, the Deficit Reduction Act of 2005 extended that time period to five years. If an individual transfers assets for less than their fair market value within this "look-back" period, he or she becomes ineligible for Medicaid benefits for the length of time those assets would have covered their medical care. The DRA also changed the beginning date of the penalty period.

Medicaid: A joint Federal and state program that helps with medical costs for those who have limited income and assets. Medicaid programs vary from state to state, but most health care costs are covered if the individual meets the criterion.

Medicare: "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended" or "Title I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

Mental or Nervous Disorder: A condition that includes more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Non-Cancelable Policies: Non-cancelable means the insured has the right to continue their coverage as long as they pay their premiums in a timely manner. The insurer may not unilaterally change the terms of the coverage, decline to renew, or change the premium rates. The fact that premiums do not increase is the outstanding point of non-cancelable policies and the reason that it would be rare to find an LTC policy with this contract clause.

Nonforfeiture Values: A policy feature that provides a specified paid-up benefit or returns at least part of the premiums to a consumer who cancels the policy or lets it lapse.

Partnership Long-Term Care Policies

Partnership Long-Term Care Policies: A tax-qualified long-term care policy purchased through the Partnership program that provides asset protection on either a dollar-for-dollar method or a total asset protection method. There may also be hybrid models. The purpose of asset protection is to allow the specified amount of assets to be disregarded for the purpose of Medicaid qualification.

Personal Care: Hands-on assistance with the activities of daily living. This may also be called custodial care.

Pre-existing Condition: A preexisting condition is one for which the policyholder or applicant has received treatment or medical advice within a specified time period prior to policy issue or prior to receiving policy benefits.

Respite Care: care which gives families temporary relief from the responsibility of caring for family members who are unable to care for themselves. Respite care is provided in a variety of settings, including in the patient's home, at an adult day center, or in a nursing home.

Skilled Nursing Care: A level of care requiring the daily involvement of skilled nursing or rehabilitation staff, and provided under the instruction or supervision of a physician or skilled medical person. This type of care must be performed in an institution that is licensed to deliver such care.

Suitability Standards: Guidelines issued by an insurer that help consumers determine whether a long-term care insurance policy is appropriate for them.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing the associated personal hygiene.

Total Asset Protection: Available only in New York and Indiana, these Partnership LTC policies provide total protection of all personal assets as long as the insured has met the minimum policy requirements, such as three years of nursing home care, or six years of home health care.

Traditional Long-Term Care Insurance: A long-term care policy that was purchased on either a tax-qualified or non-tax qualified basis that does not offer asset protection for Medicaid qualification purposes.

Transferring: Moving into or out of a bed, chair, or wheelchair.

Partnership Long-Term Care Policies

Underwriting: The process of reviewing the applicant's medical and health-related information to determine if he or she presents an acceptable level of risk for insurance coverage.

Waiting Period: Also called an elimination period, it is a long-term care policy deductible expressed as time not covered. It is the first days of confinement or benefit qualification that must be covered by the insured prior to the policy paying benefits.

Waiver of Premium: Offered in many LTC contracts, a waiver of premium waives the premium requirement once the insured begins to collect qualified policy benefits. The waiver of premium clause is subject to the listed conditions in the policy.

United Insurance Educators, Inc.
8213 352nd Street East
Eatonville, WA 98328

Website: www.uiece.com
Email: mail@uiece.com