Partnership Long-Term Care 4-Hour Refresher Course

United Insurance Educators, Inc.
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Partnership Long-Term Care Policies
4-Hour Refresher Course

Partnership CE Refresher Course

You need the 8-hour LTC course first.

Welcome to the 4-hour Partnership long-term care refresher continuing education course. If you have not previously completed your 8-hour Partnership requirement – **STOP**. Call us at 253-846-1155 and request a book exchange if you are completing this by mail or go to the 8-hour course if you are completing this course online.

In some states this course must be state approved with a specified certificate of completion issued. In other states, this will be a "training" requirement, but not a state CE requirement. In all states where this is a state requirement, requiring an issued certificate, the insurers that you are licensed with must accept this course; they may not deny you credit based on where you completed the CE. In the training states, where this is not a state requirement, usually any NAIC based course is acceptable; this course is an NAIC based course. By NAIC based, we mean it has followed the NAIC-required course contents. An agent who completes such a course may use it in any state that follows the same NIAC format (most states do). You may be required to complete a state specific CE supplemental, however.

Sound confusing? To clarify, Andy Agent completes his NAIC format Partnership course in Washington State, his current resident state. Six months later Andy Agent moves to Illinois. He can present the certificate from Washington to Illinois since both States follow the same NAIC format; he should not be required to retake the course under Illinois.

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Introduction

The Long-Term Care Pioneers

Today's long-term care insurance market is not for sissies! Long-term care policies are becoming a necessary step in financial planning. The long-term care agent is not only working for commissions – he or she is working to save our tax dollars! The states realize this; that's why Partnership policies are being developed. The federal and state governments are hoping agents will help reduce Medicaid spending by selling long-term care products. Partnership policies were developed to encourage consumers to buy long-term care products by offering asset protection (Partnership plans do not protect income).

It is likely that we will see a specialized agent emerging over the next few years: Partnership and traditional long-term care professionals. These agents will be well versed in long-term care services, Medicaid qualification, and insurance policies.

This course is the follow-up to the initial 8-hour course that was required prior to selling or marketing Partnership policies. If you have not previously completed the 8-hour course – STOP! Call your state or insurance product manager to see if you can complete this course and still be Partnership compliant.

We always acquire state credits for our courses, but many states do not require this. If your state requires "training" rather than continuing education in long-term care products your insurer may want to review this course prior to accepting it. Our courses may be viewed for free by logging in to www.uiece.com. It is not necessary to register prior to viewing the course in most states. Simply select a state, then click on the book icon by the course title to view course content.

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Chapter 1

Partnership LTC Program Creation

Our grandparents did not anticipate ever needing care in a nursing home. If they lived into their eighties 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 their daughters work outside of the home and may live in another state. Families also tend to have fewer children today than they did a generation ago, so there are fewer family members 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 various long-term care options, including care in a nursing home, assisted living facilities, and home care services.

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 expensive too. Today's families need to consider long-term health care as part of 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 their previous financial planning efforts 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.

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 the same as 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 typically 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 daily 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, which is the ability to move around independently. Many professionals felt omitting ambulation as a trigger for receiving policy benefits was unfortunate. The ability to move around independently is often a primary reason for needing some type of assistance.

Cognitive impairment is also used as a measure for collecting policy benefits. A cognitive impairment would be the inability to take care of oneself due to Alzheimer's disease, dementia, or some other mental incapability.

A long-term care policy will cover multiple types of care: custodial or personal care, intermediate nursing care, and skilled nursing care. *Medicare only covers skilled care*, and only for a short time, meaning it is not "long-term." No individual should rely on Medicare for their long-term care needs. Custodial or personal care is the least technical since it covers help with the daily activities of living. Skilled care is the highest level of technical care and can only be provided in the appropriate setting. The Medicare & You handbook, published by the Department of Health & Human Services, defines skilled nursing facility care as *"Skilled nursing care and therapy services provided on a daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor."*

While no one can precisely predict who will need long-term care it is known that the risk is high that this type of care will be needed as individuals age. As people live longer and healthier lives, they may need a nursing home simply because they become frail, not necessarily because they are ill. At one time, family members provided this care but, for many reasons, that is increasingly not the case today. While purchasing an insurance policy is not the only solution it is perhaps the most logical and least expensive choice.

Statistically, those most likely to end up in a nursing home are female, elderly, increasingly frail, and live alone although any person of any age can end up in a nursing home. According to HealthinAging.org, almost half of all people living in a nursing home are 85 years old or more. Most are women, and most of the women no longer have a spouse or partner.

Most people who reside in a nursing home also have some type of disability that has developed over recent years. This disability typically relates to loss of the ability to perform at least one of the activities of daily living. Losing one activity may allow the person to continue living at home, but as more abilities are lost, the need for a nursing home grows. Over 80 percent of nursing home residents need help with three or more activities of daily living according to HealthinAging.org. About 90 percent of nursing home residents who are able to walk still need assistance or supervision. More than a third of nursing home residents have lost their sight and/or hearing, requiring supervision even though they may otherwise be relatively healthy.

Physical disabilities are not the only problem. As people age, many develop mental conditions leading to nursing home confinements. Dementia remains the most common problem and affects an estimated 50 to 70 percent of nursing home residents. Over 75 percent of nursing home residents have difficulty making decisions necessary to remain at home and over 66 percent have difficulty with memory or knowing where they are. In some cases, people are sometimes able to remember but at other times they have difficulty doing so.

Again, according to HealthinAging.org, at least 66 percent of nursing home residents have behaviors that require supervision. These behaviors may include being verbally or physically abusive to other people, acting inappropriately in public, resisting necessary care, and wandering. It is also common to have communication problems. About half of nursing home residents have trouble being understood and understanding others.

Depression is also an issue as people age. That is not surprising since financial difficulties and personal difficulties emerge with aging. Going to a nursing home only increases the depression since everyone would probably prefer remaining at home. Research shows that depression occurs more in nursing homes than in any other setting.

Medicaid is the major payor of long-term care services. It is because of the increasing costs of covering those who have spent all their own assets (ending up on Medicaid) that the Partnership Program began. While asset conservation is a goal of the Partnership Program, another primary goal was reduced Medicaid spending.

Unfortunately, it turned out that the Partnership program would probably not provide decreased Medicaid spending. Individuals who bought Partnership policies tended to have sufficient assets to fund their nursing home confinements without applying to Medicaid, but they recognized the advantage of buying such a policy. In two of the four initial Partnership states, more than half of Partnership policyholders over the age of 55 had a monthly income of at least $5,000 (although Partnership plans never protect income, only assets) and more than half of all buyers had assets of at least $350,000 at the time they purchased their Partnership policy. In many cases, these individuals (80

percent) would have bought traditional long-term care policies if Partnership plans had not been available, reported the Government Accountability Office (GAO) in 2007.[1] We are far past 2007, but that trend seems to have continued to be the case.

Not everyone agreed with the GAO and believes that Medicaid has experienced savings from Partnership plans. HHS commented that the study results should not be considered conclusive since it did not adequately account for the effect of estate planning efforts, such as asset transfers. Health & Human Services (HHS) believes consumers would have found a way to qualify for Medicaid if the Partnership Program had not become available. Whether those who would have repositioned their assets would still have purchased a traditional long-term care policy is not known, of course, but one could theorize that high-income, high asset households often tend to be more aware of their options than those with less income and assets.

History of the Partnership for Long-Term Care

In the late 1980s, the Robert Wood Johnson Foundation (RWJF) supported the development of a new LTC insurance model, with the 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 face the greatest risk of future reliance on Medicaid, would cover their 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). Consumers would be protected from having to become impoverished to qualify for Medicaid, and states would avoid the initial burden of long-term-care costs.[2] The amount of costs avoided depends upon the amount of long-term care insurance purchased.

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

[1] Long-Term Care Insurance, GAO Report to Congressional Requesters, May 2007
[2] Issue Brief Long-Term Care Partnership Expansion: A New Opportunity for States

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 (never 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 were taken and more than 95,000 policies were sold in the initial four 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 our government realized the need to seek ways to fund 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, including restrictions on benefits for custodial care.

Many were surprised to learn that it was not just the so-called "poor" who were ending up dependent upon state and federal aid for their long-term health care needs; the middle class was finding themselves 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 was not expected to improve unless the general population accepted their financial responsibility by purchasing insurance or providing some financial avenue to pay for long-term care needs. Concern about the financing of long-term care was based on set predictions: the population of chronically ill elderly would inevitably increase along with the increasing population of those 80 years old and older. This was especially true when combined with all the medical advances being experienced. According to a study published during this time by the New England Journal of Medicine, 43 percent of all Americans would enter a nursing home at some time before they died.[3] Of these, 55 percent would stay at least one year, and 21 percent would stay at least 5 years. The average stay would last two and a half years. In 2021 the average cost of a nursing home in a semi-private room was $212 per day or $77,380 per year. Of course, some areas of the U.S. were more expensive than others (which is still true today) so many people would pay much more than listed here and others would pay less. Medicare paid very little of the long-term care costs since Medicare was never designed to cover care in a nursing home beyond a very short period of time.

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

Medicaid, the program that ends up paying the costs once a person becomes impoverished, is one of the largest items in most 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.

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 was 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 Policies Created

The national program office is located at the University of Maryland Center on Aging. Initially, 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.[4] Since the Partnership program protects assets (not income), it was well-received in the states that originally utilized Partnership long-term care programs.

A quick overview of the original Partnership Program states:

	California	**Connecticut**	**Indiana**	**New York**	**Total:**
Year Implemented	1994	1992	1993	1993	
Partnership Model	Dollar-for-Dollar	Dollar-for-Dollar	Hybrid	Total Asset Protection	
Number of participating insurers	5	8	13	8	17
Number of active partnership policies by 2003	64,915	30,834	29,189	47,539	172,477

GAO Analysis of Data from Robert Wood Johnson Foundation and state data of partnership plans

Some interesting initial Partnership facts:

- The average age of Partnership respondents was 58 and 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 policyowners 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 policyholders had incomes greater than $5,000 per month and total non-housing assets of more than $350,000.

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

The purchase of Partnership policies has 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 Partnership policies written were comprehensive, covering both nursing home care and home and community-based care.

Medicaid Continues to be the Largest Nursing Home Payor

Medicaid is the largest payor of nursing home bills for the elderly, covering half of all costs. 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, including the following.

1. Federal legislation: a federal legislative waiver is essentially a congressional mandate that gets written into public law.
2. By Administrative approval: The 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 state Medicaid 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.

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, and

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 program, 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.

To acquire asset protection the consumer buys a Partnership-qualified long-term care policy. The total amount of protection purchased determines the amount of assets that are protected (dollar-for-dollar protection). After the insured receives the full amount of insurance benefits purchased for long-term care services, he or she may apply for Medicaid benefits without spending down the portion of assets the Partnership policy protected. Any assets above the amount protected by the Partnership policy would still need to be spent on the insured's care prior to Medicaid application.

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 traditional non-partnership policies do not protect assets, such policies still have value. The benefits provided by non-partnership policies still allow the insured to keep assets *if the insured purchased adequate benefits for a substantial duration.* Even so, it would seem prudent (if the choice is available) to purchase Partnership policies since special 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 relations 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.

DRA of 2005 Provides Asset Protection

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 made it harder for individuals to give away money and property by lengthening the allowable time to move assets from three to five years, while also increasing the incentives to purchase long-term care insurance. Policies in the new program had to 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 was the lifting of the moratorium on Partnership programs. Under the DRA ***all states*** could implement LTC Partnership programs through approved State Plan Amendments if specific requirements were met. The DRA required

programs to include certain consumer protections, most notably, provisions of the National Association of Insurance Commissioners' Model LTC regulations. The DRA also required that policies include inflation protection when purchased by a person under age 76.[5]

OBRA 1993 Provisions Pertaining to The Partnership for Long-Term Care

The Omnibus Budget Reconciliation Act of 1993 contained language with a 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 14, 1993, had to follow the conditions outlined in OBRA '93. There are three sections with specific language pertaining to Partnership programs. The requirements in each section are as follows:

Sec 1917(b) paragraph 1 subparagraph C

Section 1917(b) paragraph 1, subparagraph C required any state operating a Partnership program to recover funds from the estates of all persons receiving services under Medicaid. The result of this language was ***lost asset protection occurring as soon as the insured died***. Only while he or she was living were their assets protected from Medicaid recovery. This meant assets would not pass on to the insured's heirs. After the participant died, states must recover what Medicaid spent on their care from the estate, including protected assets under Partnership policies.

Sec 1917(b) paragraph 3

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

Sec 1917(b) paragraph 4 subparagraph B

This section required a specific definition of "estate" 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),

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

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 assignments.

The above definition may vary from the current definition used by a state for estate recovery. States implementing a Partnership program may find 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.

Insurance Producers and Consumer Education

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 insurance producer education in the new state Partnership programs. Long-term care policies have so many options, gatekeepers, and limitations that even experienced insurance producers may not be fully educated on these contracts.

Most states are requiring insurance producers to obtain at least eight hours of education on Partnership plans initially, followed by four hours of "refresher" education on Partnership plans every renewal period thereafter. While some states require the education to be state-approved, other states have not made this a requirement. In these states, the eight and four hours respectively are called "training" requirements. The prudent insurance producer will seek out courses that not only qualify for these training requirements but have also received state credit (this course provides state credits). However, even if the training course does not have state approval it might still meet the requirements of the producer's state. In "training" states selecting a course that follows the NAIC requirements is generally the standard the states require, although this is not always the case. By selecting such a course, however, the insurance producer is likely to be compliant. In many states, the insurance companies that market Partnership plans are also required to monitor whether their insurance producers have met the Partnership training requirements. It is likely that most insurers will be requiring all courses completed by their insurance producers to follow the NAIC guidelines since that will then meet the federal training requirements.

Some states require Partnership training to be obtained in a classroom. In these states, internet study is only acceptable when internet training is classified as "classroom equivalent."

As it applies to consumers, the DRA addressed some issues relating to education for both consumers and insurance producers:

1. The secretary of Health and Human Services (HHS) was required to establish a **National Clearinghouse for Long-Term Care Information** that educates consumers about the need for long-term care and the costs associated with these services. HHS provides objective information to help consumers plan for the future. A 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 producers) 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 producers are closely aligned. Insurance producers 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."*

Policy Benefits

The type of benefits available in a long-term care policy depends 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. If additional benefits are chosen, then the policy will cost more too. Of course, the more benefits purchased also means more of the policyholder's assets will be protected from Medicaid spend-down requirements.

Inflation Protection

Inflation protection has recently gained recognition for its value as nursing home 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 (such as 3 percent or 5 percent per year) is left to the discretion of individual states. Policies purchased by individuals who are over age 61 but not yet age 76 must include some level of inflation protection, and policies purchased by those over age 76 may, but are not required, to provide some level of inflation protection.

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 an 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.

With ABI, the amount of coverage automatically increases annually by a contractually specified amount. The cost of those benefit increases is 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 upfront 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 maintained that the intent of the language in the DRA was to require **automatic** compound inflation protection for those under age 61, but some insurers believed that future-purchase option protections could also satisfy the requirement.

Reciprocity between Partnership 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 qualified for Medicaid in their new locale. Prior to this agreement asset protection did not transfer outside the state of policy issue, although the Partnership insurance benefits are portable (policy benefits are good in any state, but *not* the asset protection element of them). The asset protection specified in the agreement was limited to dollar-for-dollar plans, so Indiana residents, for example, who purchased total asset protection policies only received 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 required 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 would be treated the same by all Partnership states. States are held to these standards unless the state notifies the secretary in writing that it wishes to be exempt. Most states developed Partnership plans that are reciprocal, meaning the Partnership benefits *and asset protection* are good in any state that allows reciprocity.

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 made available in the DRA. The Long-Term Care Partnership Expansion project was underwritten by the Robert Wood Johnson Foundation.

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

The National Association of State Medicaid Directors (NASMD) was available to assist states with concerns or questions regarding the Partnership program implementation process.

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 he or she wishes to purchase. Just like traditional long-term care 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. A trained and caring insurance producer 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 $250 per day benefit or a $300 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 state's insurers must offer no less than a specified dollar amount per day of 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 policies following state guidelines might be non-tax qualified plans. Many states mandate specific insurance producer education prior to being able to market or sell non-partnership LTC policies. Insurance producers selling Partnership policies must certainly acquire additional education 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 premiums. Obviously, consumers may refuse any *optional* coverage offered. 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.

When a consumer decides to purchase a long-term care (LTC) policy, several buying decisions must be made. These might 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. Inflation protection protects 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 option can range from zero days to 100 days. A few policies may have a choice of a longer time period.
5. **Either a federally tax-qualified long-term care policy or a state non-tax-qualified** plan must be chosen. Partnership plans are always tax-qualified policies.

As every field producer knows, clients often prefer to have their insurance producers make selections for them, but this is not wise. Although the producer will be valued for the advice he or she gives, the actual benefit decisions need to be made by the consumer. Therefore, insurance producers must fully cover each option so the consumers can make informed choices.

Just as traditional LTC policies must be underwritten, so too must Partnership policy applications. Applicants must medically qualify to purchase Partnership plans. Why? Because it is the insurance companies that will be paying out benefits for long-term care services. Obviously, only the sickest consumers would apply if there were not any qualification requirements.

Daily Benefit Options

While there are many policy options, the *daily* benefit amount is usually the first policy decision, with the second choice being the *length of time* the benefits will continue. Both 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. For example, if Connie Consumer buys a long-term care policy that pays $200 per day for three years, she has protected approximately $219,000 in assets (365 days multiplied by $200 per day times three years).

The type of policy being purchased will affect 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 on 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 minimum benefit 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. By today's standards that would be extremely inadequate for nursing home care.

This daily benefit can have variations. Some policies will specify an amount (not to exceed the 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 on home care rather than a nursing home confinement, as long as the care met the contract's 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, but it can also quickly deplete funds in a wasteful manner.

The amounts paid will usually 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 type is gaining popularity where offered since consumers see it as a way to make health care choices more freely. 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 individual money to be used in any manner desired.

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 upon 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 lifetime benefit, three- or four-year policies are likely to do a good job for them and still be affordable.

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 were protected when a state-defined minimum benefit package was purchased by the consumer. In this case, as long as the individual bought the minimum required benefits under the state plan, all his or her assets were protected from Medicaid spend-down requirements even if the assets exceeded the total policy benefits purchased. Only New York and Indiana initially had this option. Total asset protection is 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. Total asset protection is available for policies with initial coverage amounts greater than or equal to a coverage level defined by the state.

With the passage of DRA 2005, all states in the Partnership program offered only dollar-for-dollar protection. Total asset protection was no longer available.

Policy Structure

We have seen legislation passed by many states regarding long-term care policies. Even the federal government has been involved in this with the tax-qualified plans. It is important to note that 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 are 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 its 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 insurance producer can have devastating consequences that will not be known for many years and, by that time, may be irreversible.

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 $400, the home care rate would be $200. 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. Individuals who purchase coverage 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 must weigh the cost of the additional premium option with the amount of increase in benefits that will be produced.

The rising costs of institutional care surpass the increase in the Consumer Price Index. There is little doubt that costs are rising so whatever the cost is today, costs are likely to be more tomorrow. Few retired people could afford to pay for nursing home care for several years out-of-pocket, so they turn to nursing home policies. Since such policies can be expensive, consumers might 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.

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 5 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 their insurance producer 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 plans 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 *producer* protection. It assures that the family of the insured will not later try to sue the insurance producer who sold the policy for failing to sell the inflation protection.

Elimination Periods in LTC Policies

In auto insurance and homeowner's insurance, higher deductibles are recommended as a way of reducing premium costs. The point is catastrophic coverage - not coverage for the small day-to-day losses. The same is true when it comes to health insurance. In long-term care contracts, there is 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 period 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 extremes will have varying amounts of premium; a 30-day elimination period will cost less than a 15-day elimination time period, 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 a thirty-day elimination

period is being considered with confinement (and the daily benefit chosen) costing $200 per day, by multiplying $200 by 30 days, it is possible to see what the consumer would first pay: $6,000 before his or her policy began. If this is something the consumer is comfortable with, then it may be appropriate to choose the 30-day elimination period. Again, a larger elimination (deductible) period will mean lower yearly premium costs.

Policy Type

The specific type of policy to purchase can be a harder choice. Many of the nursing home policies are basically the same, with differences being hard to distinguish. It is very important that the insurance producer 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 insurance producer has the responsibility of understanding the differences.

Many policies offer extra benefits, which insurance producers may 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 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 have what is called a **preexisting condition period**.

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 or result from that condition. 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 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. If the condition were disclosed at the time of application, all claims would 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 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; others allow it. In states that allow prior hospitalization, policies may still offer a non-hospitalization option for extra premiums.

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 the 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 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 qualified policy forms, ambulation tends to be the primary difference. Ambulation is the ability to move around without help or supervision 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 specified criteria:

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.

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

State regulators are giving nonforfeiture values a hard look. With rising premiums, many long-term care clients are finding they can no longer afford to keep their policy. 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 that were paid out over several years. This obviously means that insurers have benefited while consumers have merely wasted premium dollars. If they are forced, through rising costs, to abandon their policies as they approach the age of needing the benefits insurers have benefited unfairly. Federal law requires that companies at least offer a nonforfeiture provision to the prospective policyholder in 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 is often overlooked by consumers in favor of lower policy premiums. Even insurance producers 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 becomes 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 the 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

Forgetting to pay a bill can happen to anyone, but 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 for 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 be changed.*

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.

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 addiction, and
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 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 need to 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 insurance producer 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 insurance producer 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 insurance producer 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 the coverage provided to applicants or insured.

Policy Abbreviations

The reader 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

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

Truly 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 a tremendous cost as this segment of the population ages and needs long-term care services.

Medicaid does not grant asset protection for long-term care insurance policies purchased outside of the Partnership programs. Medicaid is jointly operated by the states and the federal government so both have a financial stake in the Partnership plans.

DRA provisions are intended, in part, to allow states to provide an incentive for individuals to take responsibility for their own long-term care needs rather than financially relying on the taxpayers.

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 generally 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] Although there are no firm statistics on how many consumers moved assets out of their name with the intention of transferring the cost of their long-term care costs to taxpayers, DRA addressed this issue by extending the time period people had to legally reposition their assets (usually putting them in their children's names).

Saving Assets from Medicaid Qualification

According to the National Association of Health Underwriters, prior to the enactment of DRA, there was legislative activity in 19 additional states to begin developing a Partnership-type program. At that time, there were only four states with active Partnership programs: California, Connecticut, Indiana, and New York.

Long-term care insurance is used to help cover the costs associated with long-term care needs. Individuals can purchase long-term care insurance policies directly from insurance companies, or through employers or other groups.

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

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

- 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 helps ensure that over time the daily benefit remains commensurate with the costs of care.

Accessing Policy Benefits

There can be a substantial gap between the time a long-term care insurance policy is purchased and the time its policyholder begins using the purchased benefits. During this time, the costs associated with long-term care can increase significantly. 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. That is why many professionals feel inflation protection is so important.

Purchasing automatic inflation protection increases the benefit amount by 5 percent annually on a compounded basis. A $150 per day benefit would be worth approximately $400 per day 20 years later if it has a 5 percent inflation rider. 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 at an extra cost. Some future purchase options do not allow consumers to purchase extra coverage once they begin receiving their insurance benefit 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.

The process of reviewing medical and health-related information furnished by an applicant to determine if the applicant presents an acceptable level of risk and 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.

Regulation of the insurance industry, including those 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 complies 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 were 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, for a long-term care insurance policy to be tax-qualified, HIPAA requires that a policy offer inflation protection.

Medicaid coverage for long-term care services is most often provided to individuals who are aged or disabled. To qualify for Medicaid coverage for long-term care 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. 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. Individuals with assets that exceed state specified thresholds can "spend down" their assets by paying for their long-term care services. 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 limits. For purposes of obtaining Medicaid eligibility, individuals are allowed to deduct medical expenses, including those for long-term care, to bring their incomes below the state-determined thresholds. It is important to realize that this text is talking in general terms; insurance producers and consumers must always explore their own state's specific requirements for Medicaid eligibility.

According to www.longtermcare.gov when states determine an individual's Medicaid eligibility some assets are counted, and others are not. Assets that count include checking and savings accounts, stocks and bonds, certificates of deposit, real property other than the residence, and any vehicles when there are more than one.

The primary residence, personal property, and household belongings, one vehicle, life insurance with a face value that is below a specified amount, limited burial funds, some types of burial arrangements, and assets held in specific kinds of trusts will not be counted towards Medicaid eligibility.

Just because the residence is not specifically counted towards the Medicaid eligibility does not mean it is not factored in. If Medicaid is sought for help paying long-term care services, it can be part of the equation. If home equity exceeds a certain level, Medicaid will not pay for the person's long-term care. The equity value is determined by the fair market value (in other words, the amount it would currently sell for) less any debts against the home such as home equity loans.

The applicant's equity interest is most important and that depends on whether he or she owns the home entirely or owns it jointly with another person. This would include the spouse.

Medicaid Estate Recovery

Even though Medicaid may pay for long-term care expenses, assuming the applicant meets eligibility requirements, that does not mean that Medicaid coverage is free. There are debt recovery measures that will probably be taken once the beneficiary dies. This is referred to as "estate recovery." Estate recovery relates to noncountable assets when determining eligibility.

It should not surprise anyone that Medicaid attempts to be repaid if assets exist that can pay for the benefits that were collected for long-term care services. After all, Medicaid benefits come from American taxpayers.

The federal government established policies requiring the individual states to recover the costs paid on behalf of people who received Medicaid benefits. As a result, all states try to recover long-term care costs, which include home health care services paid for by Medicaid. Individuals who are eligible for Medicaid benefits receive a notice that their state has the right to recover Medicaid-paid medical costs upon his or her death.

States vary in how recovery efforts are made, based upon state laws, but no matter what the state, recovery efforts must be made. There are two ways of recovering Medicaid expenditures for medical care: seizing the deceased person's estate or putting liens on the beneficiary's property. One or the other may be used, or both may be implemented.

Upon the beneficiary's death, it is common for the state to seek repayment from the estate. Each state defines the term "estate" based on state law. The state's definition, therefore, determines what the government's rights of property attachment are. Some states may be conservative while other states may have broader rights. Property must be within the deceased person's legally defined "probate estate." A probate estate includes property that is deemed to legally belong to the deceased person, where there is no joint ownership involved, or where the portion of an asset is deemed to legally belong to the deceased if there is joint ownership. Typically, financial accounts or contracts that have a designated beneficiary are not included in probate estates. That is why annuities listing a beneficiary other than the estate are protected assets. If the annuity's listed beneficiary names the estate, then that protective benefit is lost.

As stated, states term "estate" differently with some being more difficult than others for recovery. When there is a broad definition, the government may be able to take more assets. In some cases, even assets that were attempted to be assigned to someone else may be attached. These assets may include joint tenancy, tenancy in common, survivorship, life estates, and living trusts. The state would file a claim in the probate courts, just as any other creditor would. Under the more expansive definitions of estate,

the state would notify heirs of its rights under state law. Liens on real estate would be processed in the same manner as any other lienholder.

Of course, there are cases where a state is unable to recover its costs. Although states are required to recover Medicaid dollars when possible, there are certain prohibitions too on the recovery of funds. If there is a surviving spouse, for example, the residence home would not be taken by the state. The same is true if there is a minor (under age 21), blind or disabled child living in the home. In both cases, assets are protected from seizure.

Additionally, if a sibling caregiver lives in the home of the deceased and has for one year or more and continues to live there, he or she is considered to have equity in the home. The same is true for a child who has lived there for at least two years and can show that he or she provided care and either delayed or prevented institutionalization because of the care they provided.

There is also a chance that the state may waive recovery, meaning not try to collect repayment of benefits, when the deceased person's heirs can prove that recovery of Medicaid costs would cause an undue hardship. While "undue hardship" can vary by state, usually it means the inheritors have limited income and the estate would be their sole income-producing asset. This most often relates to a family farm or other family business that produces income that other family members rely upon. In these cases, usually, the state notifies the person's inheritors of its recovery rights and then the inheritors claim an exemption from estate recovery.

The state may also waive recovery if the cost of doing so is greater than the available assets. It would not make sense to spend more on obtaining the assets than they are worth. Each state may establish its own rules on what is not cost-effective, so it can vary from state to state.

States are not allowed to recover more than was received in Medicaid benefits.

Some assets that are considered might surprise people. For example, a joint checking account would be considered available in full for long-term care expenditures since either person can legally withdraw 100 percent of the funds it holds. Therefore, children that are listed on a checking account with their parents might want to remove themselves, especially if they financially contribute to it. It would be wiser to have separate accounts.

Asset Repositioning for Medicaid Qualification

To meet Medicaid's eligibility requirements, some individuals choose to reposition their assets. For example, individuals may believe that transferring assets to their spouses or other family members will qualify them 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 they look for illegal asset transfers) may incur a **transfer penalty**.

Medicaid long-term care applicants may not have sold under fair market values or given away assets in the 60 months (five years) prior to applying for Medicaid benefits. In short, it is not possible to sign over an asset to a child or sell an asset for less than fair market values and still qualify for Medicaid benefits. California and New York have shorter look-back time periods.

If that has happened, Medicaid benefits are not available for the length of time that the asset could have covered the cost of long-term care, including care at home. The state will look at the value of the asset and refuse Medicaid coverage until the length of time has passed.

Partnership Participation Does Not Guarantee Medicaid Qualification

The Partnership long-term care programs are public-private partnerships between states and private insurance companies. The programs are designed to encourage individuals, especially moderate-income individuals, to purchase private long-term care 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 their assets from Medicaid spend-down requirements. It is important to understand, however, that Partnership policyholders are still required to meet Medicaid income eligibility thresholds before they may receive Medicaid benefits. Those who purchase long-term care Partnership policies must still qualify both financially and physically for Medicaid just as individuals without Partnership long-term care plans must. The term "accessing Medicaid" is typically used to describe the point at which long-term care policyholders first begin receiving Medicaid payments for their long-term care.

Chapter 3

Basic Policy Considerations For Traditional LTC Policies

What is a *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 (but should never be considered a long-term care policy).

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 insurance producer, 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 producer 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 any 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.

Individuals of any age can require long-term care. While the elderly are most likely to utilize such care, those involved in accidents and with some types of illness, such as AIDS, may also find themselves in a nursing home facility or in community-based care. However, long-term care policies are typically designed with the elderly in mind. Coverage is designed to cover some aspect of long-term care, most often the nursing home. Such policies do not include coverage for the hospital or hospital related services. Nor do they cover the costs of care generally connected with benefits provided under Medicare and Medigap policies.

Qualified LTC Partnerships under DRA 2005 and Expansion of State Long-Term Care Programs

This legislation is specifically designed to encourage state expansion of Partnership programs with the goal of encouraging individuals to purchase insurance to cover their long-term care needs that typically arise as one ages. Prior to the passage of the DRA states could use the authority of section 1902(r)(2) of the Social Security Act to disregard benefits paid under an LTC policy when calculating income and resources for purposes of determining Medicaid eligibility. Under section 1917(b) of the Act only states that had state plan amendments approved as of May 14, 1993, could exempt the LTC Partnership benefits from estate recovery. The DRA changed that.

The DRA amends the Act to permit *all states* to exempt Partnership qualified LTC benefits from estate recovery, as long as the state has a plan amendment providing for qualified long-term care partnership insurance programs in place. The DRA has added section 1917(b)(1)(C)(iii) that defines “Qualified Partnership.”

Definition of Qualified State LTC Partnership

The definition of “Qualified State LTC Partnership” and relating requirements allowed all states to participate in the Partnership program. The new clause defined the term “Qualified State LTC Partnership” to mean an approved State Plan Amendment (SPA) that provides for the disregard of resources when determining estate recovery obligations

of the individual in an amount equal to the LTC insurance benefits paid to, or on behalf of, the person who has received medical assistance. A policy meeting all the requirements specified in a Qualified State LTC Partnership SPA is referred to as a "Partnership policy."

The insurance benefits that the disregard is based upon included benefits paid as direct reimbursement of long-term care expenses, as well as benefits paid on a per diem, or other periodic basis, for periods during which the individual received long-term care services. The DRA of 2005 did not require the benefits available under the Partnership policy to be fully exhausted before the disregard of resources could be applied, but in most cases, policy benefits would first be used before applying to Medicaid for assistance. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the insured individual as of the month of application, even if additional benefits remain available under the terms of the policy. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination (for every dollar of insurance purchased, one dollar in assets is protected from Medicaid spend-down requirements). *Income* is not protected by a Partnership policy.

Meeting Partnership Eligibility Requirements

The following are required to meet the definition of a Qualified Partnership Insurance plan:

1. The LTC policy must cover a person who was a resident of the Qualified Partnership State when his or her coverage first became effective. If the policy is exchanged for another, the residency rule applies to the issuance of the original policy.
2. The policy must meet the definition of a "qualified long-term care insurance policy" that is found in section 7702B(b) of the Internal Revenue Code of 1986.
3. The policy must not have been issued earlier than the effective date of the SPA.
4. The policy must meet specific requirements of the NAIC Long-Term Care Insurance Model Regulations and Model Act.
5. The policy must include inflation protection as follows:
    a. For individuals under the age of 61, compound annual inflation protection;
    b. For individuals aged 61 to 76 years old, some level of inflation protection must be included; and
    c. For individuals 76 years old or more, inflation protection must be offered but the buyer is not required to accept it.

The Qualified Partnership SPA must provide that the state insurance commissioner or some other appropriate state authority has certified to the state Medicaid agency that the policy meets or exceeds the specified requirements of the NAIC Model Regulations and Model Act. The State Medicaid agency may also accept certification from the same authority that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy. If the State Medicaid agency accepts the certification of the Commissioner or other authority, it is not required to independently verify that the policy meets these requirements.

An individual who has an existing long-term care policy that does not qualify as a Partnership policy due to the issue date is not able to exchange it for a qualified LTC Partnership plan earlier than the effective date of the Qualified Partnership SPA.

The state Medicaid agency must provide information and technical assistance to the state insurance department as necessary to achieve a qualified Partnership program. This information must be incorporated into the training of individuals who will sell the long-term care insurance policies in the states. In other words, insurance producers must acquire appropriate education in Partnership LTC plans.

Each state is required to provide assurance to the State Medicaid agency that those selling Partnership plans have acquired appropriate training. In states where Partnership education is a “training” requirement rather than a continuing education requirement monitoring is generally required of the insurance companies offering the LTC policies. Exactly what each insurer will require of their insurance producers may vary; some may simply require a Certificate of Completion as proof while others may require the course content first be approved by the insurer. In all cases, insurance producers must be able to demonstrate an understanding of Partnership policies and their relationship to public and private long-term-care coverage. Some states will additionally require insurance producers to gain education on that state’s Medicaid program.

The issuer of the policy must provide reports to the Secretary that includes notice of when benefits are paid under the policy, the amount of those benefits, a notice of termination of the policy, and any other information the Secretary determines to be appropriate.

States may not impose any requirement affecting the terms or benefits of a Partnership policy unless it imposes the same requirements on all other LTC insurance policies.

Grandfather Clause

A state that previously had long-term care insurance Partnership SPA approved as of May 14, 1993, was considered to have satisfied the requirements of Partnership plans. California Connecticut, Indiana, Iowa, and New York would, therefore, continued to be considered Partnership states.

NAIC Model Regulations

Partnership plans must meet the requirements of the NAIC Model regulations. These were developed in the 1980s with the intent of promoting the availability of coverage while protecting consumers that bought such policies. Generally, the NAIC Model Act and Regulation establish:

1. Policy requirements, including:
    a. Specific criteria for applications and replacement coverage,
    b. A standard Outline of Coverage format,
    c. Preventing cancellation of coverage due to an unintentional lapse due to nonpayment of premium,
    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.
2. Benefits requirements, including:
    a. Requiring companies to offer inflation protection; if the buyer refuses inflation protection, a rejection form may be required by the insurer,
    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 insurance contracts.
3. Suitability requirements:
    a. Explaining and reviewing a personal worksheet with new applicants, and
    b. Requiring that insurers deliver a shopper’s guide to potential buyers of long-term care insurance.

4. Insurer requirements:
    a. Reporting requirements,
    b. Licensing requirements,
    c. Reserve standards,
    d. Loss ratio standards (where applicable),
    e. Filing and actuarial certification requirements, and
    f. Standards for marketing.
5. Penalties and disclosure requirements.

The NAIC models had already been used by many states for passing general long-term care standards and regulations so it made sense to use them for Partnership policy standards and regulations as well. The models do undergo periodic revisions, but overall, they remain fairly constant.

A major change in many states was the shift from state monitoring of LTC insurance producer training to insurer monitoring, as it applied to Partnership long-term care policies. In those states requiring Partnership training versus continuing education the insurance companies issuing Partnership policies must monitor and certify their insurance producer's education as it pertained to marketing and selling Partnership plans.

Partnership Plans Protect Assets, Never Income

As previously stated, Partnership plans protect acquired assets, but not income. Income is still considered when applying for Medicaid benefits and at least part of the income would continue to be contributed towards the cost of long-term care services. The amount that would be applied would be based on several factors, including a spouse that still lives in the family home.

Age as an LTC Policy Factor

The age of the applicant has an impact on the cost of the long-term care policy, the older the applicant the more expensive the policy. Age matters because the less time the insurance company has to collect premiums, the greater the company's risk exposure is. Therefore, the price for a new policy is higher as the buyer ages. 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 grouped together. When each birthday 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 policy issue ages discontinue. Most companies will not issue a long-term care policy past a specified application age, usually between 75 and 80 years old. Of course, by this age, the policy cost is very high.

Contracts that use age banding usually go in groupings of 5:

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 age banding more advantageous.

Not all insurance companies will issue a long-term care policy past the age of 79. Our example shows an age banding of 80-84, but individuals must check with the company they are considering to see if they can obtain a policy if they are in that age bracket.

Reducing Benefits to Save Premium

When premium rates jump unexpectedly, not all consumers can absorb the additional premium cost, so some individuals will allow their policies to lapse. Others will strive to find a solution. Some states have provisions allowing policyholders to reduce their benefits, which reduces their premium. This is an attempt by the states to keep long-term care policies active even when the consumer must cut back on premium 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 his or her 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 premiums, insurance 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 $2,600 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.

Policy Renewal

It is not likely that a long-term care policy would be written with premiums guaranteed to remain the same for the duration of the contract. Most long-term care policies are now **guaranteed renewable**, meaning the premiums are subject to change. In a guaranteed

renewable policy, the insured's contract will remain in effect during his or her lifetime, as long as premiums are paid in a timely manner. The policy benefits cannot be changed without the policyholder's consent, but premiums may rise.

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 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 insurance producer or the issuing company. *All their premium must be returned to them if they decide not to keep the policy*. The consumer need not say why he or she has changed his or her 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 his or her policy for a refund if he or she is dissatisfied with those limitations.

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
5. the 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 (monthly, quarterly, semi-annually, or annually).

Understanding Policy Terms

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 terms:

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 that provides residential care, or
- a section of a nursing facility providing only residential care.

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.

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.

Adult Day Health Care

Adult day health care is a 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 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.

Medical Help System

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

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.

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.

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.

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.

Long-Term Care Facility

A long-term care facility is a place that:

- 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 that 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.

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.

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.

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 statistically 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.

Cognitive Impairment

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.

Pre-existing Condition

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

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.

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.

The previous definitions were listed in the order they are most likely to be seen in the policy. Some policies will alphabetize them.

Not all companies offer identical benefits. Therefore, benefits received under the terms of the policy contract will depend on the benefit options available at the time of application.

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 prospective 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 senile dementia. These diseases are determined by clinical diagnosis or tests.

Hospitalization Requirements

A 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, and
3. the nursing home admittance to begin within 30 days of the related hospitalization.

The Medicare & You booklet states: *"To qualify for skilled nursing facility care coverage, your doctor must certify that you need daily skilled care (like intravenous fluids/medications or physical therapy) which, as a practical matter, you can only get as a skilled nursing facility inpatient. Medicare does not cover long-term care or custodial care."*[1]

Many states require the nursing home policy to cover nursing facilities regardless of whether hospitalization occurred. These policies will state that no hospitalization is required. Of course, the policyholder must still meet all eligibility requirements of their long-term care policy. Since state laws vary, it is important that each insurance producer know how their particular state views hospitalization requirements.

Many existing LTC policies have hospitalization requirements. Due to this fact, many professionals feel insurance producers should periodically send out letters to their

[1] Medicare and You handbook 2021, page 28

existing clients outlining the benefits they purchased in the past. It allows them to be aware of policy requirements and add 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. The eligibility standards may have some variations, but typically they have specific requirements.

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 long-term care 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 percent of the institutional benefit. In other words, if $400 per day is paid for care in the nursing home, then $200 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 is because an integrated plan uses a "pool of money" that may be applied, as the insured desires. *An insurance producer should never take this for granted;* he or she should always check the policy or call the benefits 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 preserves their space in the facility and provides the security of returning to the same familiar surroundings following hospitalization.

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 insurance producer 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 do not have to pay them). Many policies will not refund any 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 premiums 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 for the policy to stay active.

Selecting Other Types of Care

Many insurers now offer an **alternative plan of care**, which is covered under the policy provisions. If the policyholder would otherwise need a long-term care facility confinement, 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 insurance producer 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 exceeds 100 percent 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. An individual cannot crash his or her 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 even be rescinded (voided).

Insurance producers 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 producer is truthfully listing all medical conditions. In some cases, the insurer may even refuse applications from a seemingly dishonest insurance producer. Insurance producers who knowingly fail to list all stated or obvious medical conditions are "clean-sheeting" the application.

There is another reason insurance producers 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 age 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 a 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 the 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 insurance producer. An insurance producer 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.

Section 6021:
Expansion of State LTC Partnership Programs

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 the 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.
Producer Education	Most states will be imposing some type of continuing education requirements for those insurance producers wanting to market Partnership plans. While these producer 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 marketplace 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 insurance regulators from all the 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.

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 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 insurance producers 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.[2] While most policies in the early days did not increase with increasing age, they did contain a clause allowing for premium increases if all similar policies are increased (they may not usually be increased individually due to advancing age).

[2] Georgetown University Issue Brief

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 regulations 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 penalize 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.

We might assume that an insurance company would not want to underprice 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 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 was hoped this would discourage underpricing 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.

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 insurance producers 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?

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 insurance producer is in the best position to determine whether the buyer is financially suitable for the policy being considered. 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.

Insurance producers must attempt to document whether 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 their insurance producers 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 insurance producer know if a policy is suitable for the buyer? Simple questions can help 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?

Insurance companies are required to develop and use suitability standards. Furthermore, they must train their insurance producers in their use. Copies of the suitability forms must be maintained and available for inspection.

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 insurance producer 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 is being considered. 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 insurance companies underwrite the potential risk 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, encouraging 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 long-term care 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 the policy meets the tax requirements. The statement must be included in the policy and in the corresponding outline of coverage.

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

"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."

Policy Replacement Notices

When an application is taken for long-term care insurance, the insurance producer must determine whether it will replace an existing long-term care contract. The method of determination is very specific. A list of replacement questions must be in 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 tax-qualified 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 canceled because of advancing age or deteriorating health.
- Policies must offer a nonforfeiture benefit that, if purchased, ensures the consumer that a lapsed or canceled policy means some benefits would still be available for a specified period of time.
- Policies must offer inflation protection that, if purchased, ensures benefits keep pace with inflation. This is especially important for those purchasing their policies at younger ages.

The 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 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.[3] 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.

[3] Act 2, Reg. 3

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
6. Such contract meets the requirements.

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 in the Contract

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 six months following the policy issue. There can be no exclusions or waivers, such as an 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.

Activities of Daily Living (ADL)

Policies must describe the ADLs in a clear unambiguous manner. Policies may be no more restrictive than using three ADLs or cognitive impairment for benefit payments. Of

course, policies may be more lenient in allowing the 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 certification is required.

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

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 an 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.

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 insurance producer, 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 insurance producer 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.

Any company marketing long-term care policies has standards that must be followed. There must be marketing procedures established and state training requirements for insurance producers must be followed. The NAIC recommends 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 insurance producers 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 previously discussed in this text, no policy covers everything. Long-term care policies must prominently display a notice to buyers that the policy may not cover all the costs associated with long-term care services. Even though insurance producers may have discussed what will not be covered, most claims occur ten or twenty years later. It would

be unlikely that the buyers would remember what their insurance producer said at the time and it certainly makes sense to state this in the policy as well.

Prior to the Sale

Insurance producers 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 the applicant has long-term care insurance or coverage elsewhere. If there is existing coverage, the insurance producer must find out if the applicant intends to replace their 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.

Twisting and High-Pressure Tactics are Just Plain Illegal

Some selling 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 his or her 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 allows 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. Insurance producers 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, 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 simply 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 misrepresentations, the time period for rescinding the policy is six months. For misrepresentations 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 the nonpayment of premiums, the insurer has some obligations. It must notify the insured 30 days after the premium is due and unpaid. After five 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.

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.

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 an 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.

Chapter 4

Financial Planning for Long-Term Care

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 the 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 to be 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 functions, and so forth.

No website can tell an individual whether he or she will actually end up in a nursing home or if he or she will be able to receive help at home (avoiding institutionalization). Each person has their own unique situation, but it is important to realize that individuals age and become frail, it is likely that long-term care will become part of their lives in some form. It simply makes sense to plan for an eventual need of long-term care services, and then hope it was useless planning (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 do not 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 the health or personal needs of daily living. The words, “long-term”, mean care for an extended period of time. 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 an 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 other 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 (ADL). Some types of illness or disability involve cognitive impairment, which would include such things as memory loss, confusion, or disorientation.

According to American Action Forum (americanactionforum.org), by 2030, 24 million Americans will need long-term care in some form, which is about double the current figures. Unfortunately, the number of health care workers is decreasing rather than increasing. As COVID-19 demonstrated, there is a severe shortage of health care workers in hospitals and that shortage is severe in other medical areas as well.

At one time, long-term care services that were required were fairly simple, but as our ability to provide better care developed, so did the complexity of providing long-term care services. Part of this is due to the types of chronic conditions people now have. The AAF, the benefits in long-term care policies often do not consider how costs are rising, making them inadequate to completely fund long-term care services.

More than 14 million people in the United States require long-term care services currently but that number is rising, according to the Department of Health and Human

Services (HHS). Seven in ten senior citizens who reach the age of 65 are likely to need and receive some form of long-term care services as they age. As we said, by 2030, it is expected that 24 million Americans will be requiring and receiving some form of long-term care services.

That equates to approximately 70 percent of individuals over age 65 that require some type of long-term care services during their lifetime. 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 hurt their own health by caring for ill husbands at home.
- **Lifestyle:** Poor diet and exercise habits 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, medical professionals, can look at averages to base their decisions on. We know from statistical information that 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 around three years of care. Service and support needs 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. Americans 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 at your 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 seldom pays 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.

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. Daily average costs vary even within the same state since some facilities offer more services, are newer, or are simply located where higher rates are accepted by the public.

The company, A-Place-for-Mom, says that nursing home costs run between $4,000 and $8,000 per month depending on where care is obtained. There is a difference between private-pay and Medicaid rates, of course. Private pay is the amount that an individual (receiving no public assistance) pays for care. What is termed "Medicaid reimbursement rates" are not the same as private-pay rates are. The Medicaid rate covers approximately half of all nursing home confinements in the United States, which puts Medicaid in a strong position to negotiate with nursing homes and therefore pay less than private individuals pay. It comes out to about 70 percent less of what private individuals pay.

The nationwide cost for nursing home care for all states is around $300 per day, but many states pay much more than that, while many other states pay less.

For 2020, (the latest year available at the time of printing) the American Council on Aging provided the following rates shown in the table. It should be noted that other sources did not exactly match their printed rates. This should not trouble the reader since each organization uses selected criteria that may vary from other studies. However, the

biggest reason rates might vary has to do with the location of services. For example, if one source uses Los Angeles, CA and another source uses Bakersfield, CA, then the stated rates may not be the same. Even if the entire state is used for an average, the rates that are stated can still vary, based on how the information is acquired and assembled. We are showing annual costs, not daily costs. Figures are rounded to the nearest thousand. For example, a semi-private room in Alabama was stated by the American Council on Aging as $82,855 per year, but in the graph below it is rounded to the nearest $1,000 increment, so it is shown as $83,000 per year.

State:	Shared Room:	Private Room:
Alabama	$78,000 per year	$83,000 per year
Arizona	$82,000 per year	$99,000 per year
California	$111,000 per year	$137,000 per year
Florida	$104,000 per year	$118,000 per year
Indiana	$86,000 per year	$102,000 per year
New York	$148,000 per year	$155,000 per year
Ohio	$86,000 per year	$99,000 per year
Texas	$60,000 per year	$77,000 per year
Wisconsin	$104,000 per year	$113,000 per year

Since we have not listed all states, this is only a general overview of nursing home costs. States can vary widely and even city to city varies within the state.

The rates listed today for nursing home costs may not be the same that would have been listed in six months. Since costs can change rapidly it is always important to check local costs prior to needing a nursing home, especially if an individual is deciding upon the benefits of a nursing home policy being considered for purchase.

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. Care for an extended period 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. But, as care and support need increase, paid care is usually needed to

supplement family provided services and supports, provide respite to family caregivers, or 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 or 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.

States Are Struggling to Deal with Medicaid Costs

All states struggle with the costs of Medicaid, the federal program that covers the costs of individuals who have no assets and cannot pay for their own care. Since each state pays for a portion of the care (not all costs are covered by the federal government), individual states may address the cost issue in their own way. For example, legislation was recently passed called the Long-Term Care Trust Act, with an effective date of January 1, 2022, was passed in Washington state. Similar legislation is expected to spread to other states as they wrestle with Medicaid costs.

As of January 2022, employees in Washington state will be assessed a premium of 0.58 percent of their wages to cover the costs of providing long-term care. Washington residents have a "qualified individual" status if they are at least 18 years old and have paid the premium for either three years within the last six years or for a total of ten years, with at least five of those ten years paid without interruption. To claim "qualified individual" status, at least 500 hours must have been worked during the year.

Not everyone will have to pay the assessment. If an individual has purchased long-term care insurance, then he or she may be exempt from paying the premium on their wages. Beginning January 1, 2025, a qualified person may become an "eligible beneficiary" if it is determined by the Department of Social and Health Services (DSHS) that at least three activities of daily living, referred to as ADLs exist. Approved services are long-term care services and support; it does not apply to other areas of medical care.

Coverage of Long-Term Care Services

Receiving payment for long-term care services can be a confusing topic for many senior citizens. The following chart gives a basic overview of how long-term care services might be covered financially.

Long-Term Care Service	Medicare	Private Medigap Ins.	Medicaid	Paying One's Own Way
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.
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 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 just ongoing personal care/ custodial care (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.

The graph above would not apply to individuals that have purchased long-term care insurance coverage. In that case, he or she should refer to their specific policy for

payment of benefits. Since policies vary, we are not able to supply a graph that would adequately apply to those with long-term care insurance policies.

On an aggregate basis, the largest share of nursing home expenses (approximately half of all care in nursing homes) is paid 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.

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 as likely to have any interest in the Partnership long-term care insurance program.

Chapter 5

Policy Terminology

Insurance policies are legal contracts. As such, the 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 include 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.

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: This 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 infirm 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 premiums 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/Nervous Disorders: Conditions that include 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: 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 that 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 provided 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.

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.

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