Chapter 7 Partnership Program Benefits

Program Benefits

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

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

Making Benefit Choices

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

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

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

-Daily benefit amounts: this is the daily benefit that will be paid by the insurer if confinement in a nursing home occurs.

-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.

-Inclusion of an inflation guard: Non-partnership plans will not require this, while Partnership plans have inflation protection guidelines that must be followed. An inflation protection guards

against the rising costs of long-term care by providing an increasing benefit according to contract terms. Partnership plans have two types: an increase based on a predetermined percentage and an offer at specific intervals allowing the insured to increase benefits without proof of insurability.

-The waiting period, also called an elimination period, must be selected. This is the period of time that must pass while receiving care before the policy will pay for anything. It is a deductible expressed as days not covered. The most common options range from zero days to 100 days. Insurers may offer longer time periods as well, up to six months.

-Dollar-for-Dollar Partnership asset protection or Total Asset protection, if both are available. A Hybrid model may also be available. Not all states offer all options since DRA specified all new LTC Partnership plans to offer only dollar-for-dollar models, in the hope of keeping premiums affordable for lower and medium income individuals.

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

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

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

Daily Benefit Options

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

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

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

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

Expense-Incurred and Indemnity Methods of Payment

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

-The expense-incurred method in which the insured submits claims that the insurance company then pays to either the insured or to the institution up to the limit set down in the policy.

-The indemnity method in which the insurance company pays benefits directly to the insured in the amount specified in the policy without regard to the specific service that was received.

Both methods require that eligibility for benefits first be met.

Determining Benefit Length

While the daily benefit is typically the first choice made, the second choice is just as important to

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

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

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:

-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.

-Total Asset Protection: All assets are protected when a state-defined minimum benefit package is purchased by the consumer. In this case, as long as the individual buys the minimum required benefits under the state plan, all his or her assets are protected from Medicaid spend-down requirements even if the assets exceed the total policy benefits purchased. Only New York and Indiana had this option. Total asset protection plans are not offered in any of the new Partnership plans.

-Hybrid: This Partnership program offered both dollar-for-dollar and total asset protection. The type of asset protection depended on the initial amount of coverage purchased.

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

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

Policy Structure

We have seen much legislation by the states directed at long-term care policies. Even the federal government has been involved in this with the tax-qualified plans. Since only the federal

government can allow a federal tax deduction, tax-qualified plans always come under federal legislation whereas non-tax qualified plans come under state legislation. Each state will have specific policy requirements. Partnership plans come under federal requirements and will be tax-qualified. The states will assign descriptive names in an effort to identify policies in a way that consumers can comprehend. Such terms as Nursing Facility Only policy, Comprehensive policy or Home Care Only policy will be used. Each state will have their specific way of labeling policies. Long-term care policies often do not pay benefits for years after purchase. An error on the part of the agent can have devastating consequences.

Home Care Options

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

Inflation Protection

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

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

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

-Applicants under 61 years old must be given compound annual inflation protection;

-Applicants 61 to 76 years old must be given some level of inflation protection; and

-Applicants 76 years old or more must be offered inflation protection, but they do not have to accept it.

Traditional long-term care plans continue to make inflation protection an option, which may be rejected by the applicant. Many in the health care field state that the amount of increase offered is not adequate, but it will help to offset the rising costs of long-term care. The inflation

protection, usually a five percent compound yearly increase, may eventually become part of all policies, but currently it is most likely to be just an option that the consumer must accept or reject. Some states require the consumer to sign a rejection form as proof that the agent offered the option.

Simple and Compound Protection

Inflation protection based on percentages is offered in one of two ways: simple increases in benefits or compound increases in benefits. Like interest earnings, the benefits increase based on only the original daily indemnity amount or on the total indemnity amount (base plus previous increases). Some states mandate that all inflation protection options offered must be compound protection; others allow the insurers to offer both types. Under a simple inflation benefit, a $100 daily benefit would increase by $5 each year. Under a compound inflation benefit the protection increases by 5 percent of the total daily benefit payment. This is called a compound inflation benefit because it uses the previous year's amount rather than the original daily benefit amount.

Required Rejection Forms

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

Periodic Coverage Increase Options

Some policies include the ability to increase coverage without using an inflation rider. These options vary, but usually they are periodic options that allow the insured to increase coverage by paying additional premium. If the insured refuses the increased coverage options two or more times, such offers may discontinue since they often require acceptance to continue future offering.

Elimination Periods in LTC Policies

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

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

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

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

Policy Type: Comprehensive and Non-Comprehensive

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

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

Restoration of Policy Benefits

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

Pre-existing Periods in Policies

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

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

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

statute). Policies tend to specifically list preexisting conditions in a separate paragraph in the policy.

Prior Hospitalization Requirements for Skilled Care

Under Medicare, hospitalization must have occurred for the same or related condition in order to receive Medicare's skilled care benefits (additional criteria for skilled care also exists). With traditional LTC policies, sometimes prior hospitalization is required to collect nursing home benefits and sometimes it is not. Some states do not allow insurers to require prior hospitalization, while others allow it. In states that allow prior hospitalization, policies may still offer a non-hospitalization option for extra premium.

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

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

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

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

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

-All services must be prescribed under a plan of care by a licensed health care practitioner independent of the insurance company.

-The insured must be chronically ill by virtue of either one of the two following conditions:

1. 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

2.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).

Non-forfeiture Values

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

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

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

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

-Cash Surrender Value: this is a guaranteed sum paid to the policyholder upon policy surrender or lapse of the contract. This sum is usually equal to some portion or percentage of the insurer's policy reserve at the time premium payments stop.

-Reduced Paid Up: this is the lesser or reduced amount of daily benefit payable for the maximum length of the policy's benefit period with no further premium payments required.

-Extended Term: extended term provides an extension of insurance coverage for the full amount of the policy benefits without any further premium payments, but for a limited period of time.

-Return of Premium: this provides a lump-sum cash payment equal to some percentage of the total premiums paid. The percentage returned can vary, but it is often around 70 percent. It is paid to the policyowner when he or she surrenders the policy or it lapses. Usually any claims that were previously paid under the contract would be deducted from the amount returned.

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

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

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

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

Waiver of Premium

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

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

-30 days + benefit days = waiver of premium satisfaction.

While the period of time can vary, it is common to begin after 90 benefit days. Therefore, it would be 30 days plus an additional 90 benefit days before the waiver actually became effective. If the

confinement stops, the premiums are reinstated, but the policyholder would not have to pay premiums for the previously waived time period.

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

Unintentional Lapse of Policy

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

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

Policy Renewal Features

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

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

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

Policy Exclusions: Items Not Covered by the LTC Policy

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

-Preexisting conditions, under certain circumstances
-Mental or nervous disorders, except for Alzheimer's and other progressive, degenerative

and dementing illnesses
-Alcoholism and drug addition

Treatment resulting from war or acts of war, participation in a felony, riot, or insurrection, service in the armed forces or auxiliary units, suicide whether sane or insane, attempted suicide, or intentional injury, aviation in the capacity of a non-fare-paying passenger, and treatment provided in government or other facilities for which no payment is normally charged.

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

Affordability of Long-Term Care Insurance Contracts
No matter how important asset protection might be, if the policies are not affordable they will not accomplish what was intended. The individuals who developed the Partnership programs recognized that the consumers most likely to buy long-term care Partnership coverage were also going to be sensitive to rate and premium increases. The goal was to give Partnership policies economic value to those insured, both when issued and at the time a claim occurs. Of course, they also wanted to encourage a competitive marketplace since that tends to keep prices down and values high. Low lapse rates were also a priority since a policy that is purchased but not maintained does not benefit anyone. It is necessary to have a long-term commitment to LTC policies since they are typically purchased many years prior to need. Since Partnership plans were an experiment in the four states that initially offered them, Federal law actually discouraged other states from enacting them through restrictive language. That changed in 2005 (signed into law in 2006) with the Deficit Reduction Act of 2005.

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

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

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

Benefit Duplication
It is the responsibility of every insurance company and every agent to make reasonable efforts to

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

Partnership Publication

Every applicant must be provided with a copy of the long-term care Partnership publication (which was developed jointly by the commissioner and the department of social and health services) no later than when the long-term care Partnership application is signed by the applicant.

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

Partnership versus Traditional Policies

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

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

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

Abbreviations

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

ADL = Activities of daily living

ACS = American Community Survey

CBO = Congressional Budget Office

CMS = Centers for Medicare & Medicaid Services

DOI = Department of Insurance

DRA = Deficit Reduction Act of 2005

GAO = The United State's Government Accountability Office

HHS = Department of Health and Human Services

HIPAA = Health Insurance Portability and Accountability Act of 1996

HRS = Health and Retirement Study

IADL = Instrumental activities of daily living

LTC = Long Term Care

NAIC = National Association of Insurance Commissioners

OBRA '93 = Omnibus Budget Reconciliation Act of 1993

RWJF = The Robert Wood Johnson Foundation

UDS = Uniform Data Set

Long-Term Illness Impacts Families

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

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

depleted, family members may find themselves supplementing the cost of care, affecting everyone in the family.

It's a Partnership

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

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

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

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

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

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

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

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

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

Tax Treatment

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

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

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

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

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

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

Buyers must be aware that when they are younger they may not be able to use the long-term care tax deduction because their health is good enough that they do not meet the requirements to deduct medical expenses. However, as people age they usually have increased medical expenses so even if the LTC premiums are not initially deductible they are likely to become deductible eventually. Of course, the ideal situation is to be so healthy that no medical expenses occur so premiums are never deductible. Few people will buy long-term care insurance for the tax deduction; they are purchased for protection against long-term care expenses. The tax deduction is merely an added attraction.

Group Long-Term Care Insurance

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

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

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

Deciding When to Buy

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

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

Statistically, the youngest person to file a long-term care claim was 27 and the oldest was 103. Obviously we would not expect many twenty-something people to own a policy, let alone file a claim. On the other end of the age bracket we can expect to see many older people file claims.

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

According to LTC Tree "You either have a 100% chance of needing care or a 0% chance and you don't know until the time comes." Of course, an individual can look to his family history for clues

but as we live longer that might not provide reliable hints. Still, it is a good idea to consider genetic longevity, current health and lifestyle.

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

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

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

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

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

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

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

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

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

Partnership Policy Requirements

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

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

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

A policy with comprehensive coverage pays for long-term care in nursing facilities as well as for care in home and community settings, while a policy with coverage for home and community-based settings pays for care only in these settings.

A daily benefit amount specifies the amount a policy will pay on a daily basis toward the cost of care, while a benefit period specifies the overall length of time a policy will pay for care.

A policy's elimination period establishes the length of time a policyholder who has begun to receive long-term care has to wait before his or her insurance will begin making payments towards the cost of care.

Inflation protection increases the maximum daily benefit amount covered by a policy, and attempts to ensure that over time the daily benefit remains commensurate with the costs of care.

Determining Policy Benefits

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

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

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

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

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

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

Industry Regulation

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

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

-Needing substantial assistance with at least two of the six ADLs for at least 90 days due to a loss of functional capacity, having a similar level of disability.

-Requiring substantial supervision because of a severe cognitive impairment.

HIPAA also requires that a policy comply with certain provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Act and Regulation adopted in

January 1993. This model act and regulation established certain consumer protections that are designed to prevent insurance companies from:

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

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

Medicaid

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

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

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

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

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

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

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

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

The Partnership programs are public-private partnerships between states and private long-term care insurance companies. The programs are designed to encourage individuals, especially moderate income individuals, to purchase private long-term care insurance in an effort to reduce future reliance on Medicaid for the financing of long-term care.

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

GAO used the term "accessing Medicaid" to describe the point at which long-term care policyholders first begin receiving Medicaid payments for their long-term care.

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

Protecting Partnership Policyholder Assets

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

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

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

DRA also requires Partnership policies to include consumer protections contained in the NAIC Long-Term Care Insurance Model Act and Regulation, as updated in October 2000. DRA established specific requirements for Partnership policies that do not apply to traditional long-term care insurance policies sold in the Partnership states, such as inflation protection and dollar-for-dollar asset protection. DRA prohibits states from creating other requirements for Partnership policies that do not also apply to traditional long-term care insurance policies in the four states with Partnership policies. The Partnership programs in California, Connecticut, Indiana, and New York, which were implemented before DRA, are not subject to these specific requirements, but in

order for those programs to continue, they must maintain consumer protection standards that are no less stringent than those that applied as of December 31, 2005.

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

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

In addition to asset protection, which by definition Partnership policies include, states typically require Partnership policies to include or at least offer (depending on the applicant's age) inflation protection. Partnership policies include inflation protection because the goal is to keep the policyholders financially protected over time as the cost of care goes up.

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

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

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

Partnership and traditional long-term care insurance policies both typically include elimination periods, which establish the length of time the policyholder who has begun to receive long-term care has to wait before receiving long-term care insurance benefits. Partnership programs usually limit the length of the elimination period that can be included. A commonly selected elimination period is thirty days whether the policy is a traditional one or a partnership plan. Traditional plans

offer a wide variety of options from zero days to as long as six months. In many cases, partnership plans have the same options available.

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

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

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

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

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

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

Partnership Education Requirements

Before insurance producers may sell Partnership policies, they must complete additional federally-mandated training requirements in Partnership long-term care policies. Although states with Partnership programs may have different educational requirements, in general the states require Partnership agents to undergo about an eight-hour day of training specific to the Partnership program in addition to any training that the states require for those who sell traditional long-term care insurance. In order to continue selling long-term care insurance, insurance producers must receive several hours of continuing education every 2 years. After the initial training, the "refresher" requirement comes up each license renewal period in many cases. If state credit is available, the LTC training may apply towards the state license renewal requirements.

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

Partnership Policy Buyers

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

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

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

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

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

Receiving Policy Benefits

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

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

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

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

Elimination periods work in different ways so it is important to understand what is being purchased; some elimination periods start from the first day of otherwise being qualified under the policy, while others require the insured to actually be receiving long-term care services. During the elimination period, the insured must cover any costs associated with his or her care; the insurer is not liable for these costs.

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

Adequate Coverage

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

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

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

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

Joint and Linked LTC Policies

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

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

Linked

There are advantages to each type, as long as it meets their personal needs and their needs in the future. Linked policies allow the first spouse needing care to tap into the benefit pool of the second once all the first spouse's benefit dollars have been spent on his or her care. In other words, two policies are bought (one for each spouse) and they are joined by a ride allowing couples to share each other's benefit pools. Of course, once benefits are exhausted that is the

end of it. There may be nothing left for the second spouse once the first spouse has used all benefits up.

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

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

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

Joint

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

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

The main advantage of a joint long-term care policy is the lower premiums, when compared to a linked product. Also if both spouses need extended long-term care, a joint policy still allows both to use the benefits until they are depleted. A shared care rider is not necessary.

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

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

Indemnity and Reimbursement Plans

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

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

Critical Illness Policies

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

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

Health Savings Accounts (HSA)

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

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

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